Hillcrest Ionian Limited

Mydentist - Laughton Road - Dinnington

Inspection Report

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Overall summary

We undertook a follow up desk-based focused inspection of Mydentist - Laughton Road - Dinnington on 2 January 2019. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector.

We undertook a comprehensive inspection of Mydentist - Laughton Road - Dinnington on 8 August 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing well led care and was in breach of regulations 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can read our report of that inspection by selecting the 'all reports' link for Mydentist - Laughton Road - Dinnington on our website www.cqc.org.uk.

As part of this inspection we asked:

• Is it well-led?

When one or more of the five questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

Our findings were:

Are services well-led?

We found this practice was providing well-led care in accordance with the relevant regulations.

The provider had made improvements in relation to the regulatory breaches we found at our inspection on 2 January 2019.

Background

Mydentist Laughton Road Dinnington is in Sheffield and provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

The dental team includes three dentists, five dental nurses (two of whom are trainees), a receptionist and a practice manager. The practice has four treatment rooms.

Summary of findings

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Mydentist Laughton Road Dinnington is the practice manager.

Prior to the desk based focussed inspection, we received supporting evidence and written confirmation of action taken by the practice to address the areas previously identified as a breach of regulation.

The practice is open:

Monday and Tuesday 9am – 6pm, Wednesday, Thursday and Friday 9am – 5pm

Our key findings were:

- Infection prevention and control processes were embedded and carried out in line with published guidance.
- The management of safe sharps systems were now effective.
- Systems to monitor training and gather relevant training records were now effective.
- Effective recruitment procedures and relevant evidence gathering processes were now in place.
- The clinical waste segregation procedures were now embedded and in line with guidance.
- The practice had reviewed and improved its culture of continuous improvement.
- Clinical and information governance arrangements were updated and embedded within the team.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services well-led?

No action

We found that this practice was providing well-led care and was complying with the relevant regulations.

The provider had made improvements to the management of the service. This included additional staff time for management, administration and establishing clear roles and responsibilities for all the practice team. The improvements provided a sound footing for the ongoing development of effective governance arrangements at the practice.

The processes to manage safe sharps systems had been improved. Staff training had taken place to reinforce sharps management in line with reviewed policies and procedures and an annual review of sharps incidents was introduced.

The provider had reviewed and embedded its infection prevention and control (IPC) processes and submitted evidence to support where changes had taken place.

The process to manage voided prescriptions was updated and embedded within the team.

The practice's quality assurance and audit processes for X-rays, IPC and patient referrals had been improved.

Information governance and clinical governance arrangements, including local rules for X-ray equipment and clinical waste segregation had been reviewed. These were brought in line with current guidance and regulations and related processes embedded within the team.

Areas identified for improvement during the previous inspection relating to the practice's recruitment procedures had been reviewed and updated.

Are services well-led?

Our findings

At our previous inspection on 8 August 2018 we judged the provider was not providing well led care and was not complying with the relevant regulations. We told the provider to take action as described in our requirement notice. At the inspection on 2 January 219 we found the practice had made the following improvements to comply with the regulation(s):

Improvements had been made to ensure sharps management processes were embedded and reinforced in line with the risk assessment. For example:

- Incident reporting procedures in respect to sharps injures was reviewed with all staff during a practice meeting in October 2018.
- The sharps risk assessment was reviewed in October 2018 and an annual review/audit process was set up to identify trends or areas of concern. All staff had signed the risk assessment.
- The provider had also made arrangements for additional one to one staff training.

The provider had reviewed its IPC processes and submitted evidence to support where changes had taken place. For example:

- An IPC training module was carried out by all staff in October 2018. The IPC lead and practice manager arranged to attend an external IPC course in January 2019 to identify any changes to the guidelines in order to feedback to the team.
- On-going instrument decontamination process spot checks were now in place for all support staff and additional one-to-one training made available if required.
- Support from the company regulatory and compliance officer was in place and an arrangement to review the company IPC process was on-going with the company clinical team.

A review of the practice's prescription management had taken place. We saw that all staff had received training on the process to follow when voiding a prescription. This process was covered in one to one meetings and at a staff meeting in October 2018.

The practice's quality assurance and audit processes had been improved to ensure data was gathered and recorded accurately to encourage suitable outcomes, learning and continuous improvement. For example:

- X-ray audits were now assigned to an appropriately trained staff member. Arrangements were made to ensure clinical staff received support and training on how to correctly grade radiographs.
- Infection prevention and control audit procedures were reviewed to ensure audits were completed correctly and accurately. An additional IPC audit was completed in October 2018 and an action plan was in place. The action plan dated 5 October 2018 identified areas where improvements could be made as a result of the audit.
- The patient referrals process was now effectively monitored and tracked. A revised referral log was in place, follow up actions were recorded and an audit of the new system had been implemented.
- Staff meeting minutes dated October 2018 supported that improvement in these areas had been covered and staff training was carried out where relevant.

Areas identified previously for improvement in relation to clinical governance and information governance arrangements had been updated and embedded within the team. For example:

- The local rules for X-ray equipment now reflected the Ionising Radiations Regulations 2017 (IRR17). An additional log was created to capture any future changes to these regulations.
- Improvements had been made to effectively monitor, embed and update processes in respect to the General Data Protection Regulation (GDPR) requirements. GDPR has been incorporated into practice meetings as a permanent agenda item and annual training put in place. GDPR news articles and an internal quick reference guide were made available for all staff to access.
- Reinforcement of the practice's waste segregation processes had taken place to ensure the process was carried out in line with guidance. For example, a practice meeting held in October 2018 confirmed this was discussed and the correct procedures reinforced. In addition, monthly spot checks were in place, waste segregation posters made available to guide staff and the health care waste policy was reviewed by the whole team.

Are services well-led?

The practice's recruitment process to ensure appropriate document gathering and staff checks were in place has been reviewed and improved upon. Improvements were also made to ensure relevant training took place and training certificates were evidenced in a timely manner. For example:

- Supporting evidence sent to us showed the recruitment policy was reviewed and adjusted in October 2018 to ensure that internal and external character references were requested prior to the employment or internal transfer of a new staff member.
- Supporting evidence showed that all appropriate indemnity certificates were in place.
- Staff immunity status in respect to Hepatitis B, was now recorded and retained on site. Risk assessments had been carried out for those who had a low response to the Hepatitis B vaccine and a process was now in place to review this.
- Measures were taken to improve the process to ensure staff training was carried out in a timely manner. A spreadsheet was implemented and shared with staff to ensure continued awareness of any gaps in training which will be closely monitored by the practice manager.
- Staff meeting minutes confirm that all staff have been made aware of the new staff training procedures and where appropriate were reminded of the need to hand in training certificates to complete the audit trail. The IT used by the company has been updated to prompt upcoming staff training to prevent any future oversight.

These improvements showed the provider had taken action to improve the quality of services for patients and comply with the regulation: when we inspected on 2 January 2019.