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Mile End Dental Clinic

Inspection Report

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Overall summary

We undertook a focused inspection of Mile End Dental Clinic on 17 August 2018. 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 who was supported by two specialist dental advisers.

We undertook a comprehensive inspection of Mile End Dental Clinic on 26 April 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 in accordance with the relevant regulations 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 Mile End Dental Clinic on our website www.cqc.org.uk.

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.

As part of this inspection we asked:

• Is it well-led?

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 26 April 2018.

Background

Mile End Dental Clinic is in Colchester and provides NHS and private treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including one space for blue badge holders, are available at the rear of the practice.

The dental team includes eight dentists, eight dental nurses, two dental hygienists, two receptionists, one implant nurse/manager and one practice manager/ dental nurse. The practice has six treatment rooms.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

Summary of findings

During the inspection we spoke with one dentists, one dental nurse and the implant nurse manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday from 9am to 5.30pm.

Tuesday from 9am to 5.30pm.

Wednesday from 9am to 7pm.

Thursday from 9 am to 6pm.

Friday from 9am to 5.30pm.

Saturday from 9am to 1.30pm.

Our key findings were:

- The practice was giving due regard to the tests, quality checks and operator training for the cone beam computed tomography (CBCT) machine.
- Staff not directly involved in radiography were provided with information sufficient to ensure their continued safety.
- Suitable systems were in place for the recording, investigating and reviewing of accidents or significant events.
- Systems were in place for recording the servicing and maintenance of equipment used for sedation.
- The provider had appointed a training co-ordinator and training administrator to plan training for staff according to their needs.
- Systems were in place to ensure when sedation was provided this was with a single medication and all equipment and medicines were checked again prior to sedation.
- Staff had undergone ILS (Immediate Life Support) training, the dental nurses had undertaken SAAD (Society for the Advancement of Anaesthesia in Dentistry) training. The principal dentist had undergone advanced life support training.
- The practice had implemented information packs for patients undergoing sedation and for patients' escorts which detailed what to expect before, during and following the procedure.
- The provider had undertaken a Legionella risk assessment by an external provider on 5 June 2018. We noted recommendations and actions identified in the report had been completed.
- The practice was in the process of re-auditing infection control to ensure the next audit was within six months of the previous April 2018 audit.
- Audit procedures had been reviewed with the practice undertaking regular record keeping audits for all clinicians.
- Patient dental records we looked at had detailed recording procedures, and included medication used and information given to the patient.
- Patient dental records detailed that where scans were taken these were justified by dentists.

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 in accordance with the relevant regulations.

The provider had made improvements to the management of the service. This included improvements in systems to monitor the quality of the service provided including quality checks and operator training for the cone beam computed tomography (CBCT) machine, X-ray audits and a legionella risk assessment. Systems had been introduced for recording accidents and incidents. The provider had appointed a training co-ordinator and training administrator to plan training for staff according to their needs. The practice was in the process of reviewing their bi-annual infection control audit, process and staff training and had undertaken an audit of dental care records for all clinicians.

The improvements provided a sound footing for the ongoing development of effective governance arrangements at the practice.

Are services well-led?

Our findings

At our previous inspection on 26 April 2018 we judged it was not providing well led care and told the provider to take action as described in our requirement notice. At the inspection on 17 August 2018 we found the practice had made the following improvements to comply with the regulation(s):

The practice was now giving due regard to the tests, quality checks and operator training for the cone beam computed tomography (CBCT) machine. The provider was able to demonstrate that CBCT equipment was undergoing periodical quality control tests to ensure that the performance of the machine remained within acceptable margins. The provider undertook a review of all radiography within the practice with their radiation protection adviser. This included an assessment of the risks, location and adequacy of warning signage for the CBCT. We noted there were 14 recommendations following this assessment. We were told the practice were working through these recommendations, but did not have a structured action plan to ensure when and how these recommendations would be addressed and completed. We discussed this with the provider and implant manager and were told this would be put in place. We noted a completed radiation protection file was available in the practice managers office as recommended in the assessment.

The principal dentist, specialist oral surgeon and an associate dentist had attended training on 3D dental imaging and CBCT. Following the training course, the principal dentist had notified referring practices to undertake appropriate training as the practice did not report on the scans provided to each practice. The practice undertook a staff meeting where all staff were updated on dental CBCT. We were told staff not directly involved in radiography were provided with information sufficient to ensure their continued safety. In particular, the significance of the CBCT room warning signs and the restrictions on access to the room.

The provider had implemented systems for the recording, investigating and reviewing of accidents or significant events which would help to prevent further occurrences and ensure that improvements were made as a result. We were shown incident and accident reporting template forms. The provider said that there had been no accidents or incidents since the last inspection. There was scope for the practice to expand this into a more comprehensive educational tool by reviewing a wider range of incidents as events. We discussed this with the provider and implant manager during the inspection. We were told that systems had been put in place to ensure any learning was shared with all staff.

The provider had implemented a system for recording the servicing and maintenance of equipment used for sedation. The provider was able to demonstrate that emergency equipment and medicines were itemised and undergoing periodical quality control tests. The implant manager had implemented a sedation file which contained checklists of the emergency bag, medicines, the contents and maintenance/expiry dates. The provider had implemented anxiety state checklists for patients undergoing proposed sedation which were logged in the patient records and the sedation file. We were told when sedation was provided this was with a single medication and all equipment and medicines were checked again prior to sedation. We saw staff had undergone ILS (Immediate Life Support) training, the dental nurses had undertaken SAAD (Society for the Advancement of Anaesthesia in Dentistry) training, the principal dentist had undergone advanced life support training. We noted the practice had implemented information packs for patients undergoing sedation and for patients' escorts which detailed what to expect before, during and following the procedure and what was expected of the escorts including establishing their emergency contact information and who to contact following the procedure should the patient deteriorate. We noted audit procedures had been reviewed with the practice undertaking regular record keeping audits for all clinicians. The practice had also implemented a sedation audit, which we were told would run constantly to ensure on-going oversight of the sedation process, procedures and outcomes.

The provider had appointed a training co-ordinator and training administrator to plan training for staff according to their needs. We noted that staff involved with dental sedation had undertaken relevant training including SAAD sedation course and ILS training. All seditionists had undertaken specific training in sedation, and attended regular courses to update their skills. We noted that staff undertook annual renewal of the ILS course or had reviewed their ALS (Advanced Life Support) qualification.

Are services well-led?

The provider had a new Legionella risk assessment undertaken by an external provider on 5 June 2018. Evidence was available to demonstrate that hot water temperatures had been increased to 55' as recommended. Quarterly dip slide testing and sentinel water temperatures were being monitored and records showed that these were at the required temperature. Systems were in place to manage dental water lines and documentation was in place to demonstrate this.

The practice had also made further improvements:
At our previous inspection we noted the practice had undertaken infection control audits in February 2017 and April 2018. We discussed bi-annual infection control audits with the implant manager and were told they were in the process of re-auditing infection control to ensure the next audit was within six months of the previous April 2018 audit. The implant manager described the process the practice was undertaking with the infection control lead nurse to review infection control auditing procedures, ensure all staff had undergone regular infection control training and updates and all staff were working within the same procedures. We were told due to annual leave this was an on-going process.

We noted that scans were justified by dentists and detailed in the patient records.

These improvements showed the provider had taken action to improve the quality of services for patients and comply with the regulations: when we inspected on 17 August 2018.