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Riverside Dental Surgery

Inspection report

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Overall summary

We undertook a follow up focused inspection of Riverside Dental Surgery on 18 September 2023. This inspection was carried out to review 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 second CQC inspector.

We had previously undertaken a comprehensive inspection of Riverside Dental Surgery on 25 April 2023 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 regulation 17 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 Riverside Dental Surgery on our website www.cqc.org.uk.

When 1 or more of the 5 questions are not met we require the service to make improvements and send us an action plan (requirement notice only). 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 safe?
- Is it well-led?

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

Summary of findings

Are services well-led?

We found this practice was not providing well-led care in accordance with the relevant regulations.

The provider had made insufficient improvements to put right the shortfalls and had not responded to the regulatory breach we found at our inspection on 25 April 2023.

Background

Riverside Dental Surgery is in Tamworth and provides NHS and private dental care and treatment for adults and children.

The practice is accessed via stairs meaning it is not accessible for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for disabled people, are available near the practice.

The dental team includes 1 dentist, 2 dental nurses and 1 receptionist. The practice has 3 treatment rooms but only 1 was in use at the time of inspection.

During the inspection we spoke with the dentist, 1 dental nurse and the receptionist. We looked at practice policies, procedures and other records to assess how the service is managed.

The practice is open: Monday to Thursday from 8am to 6pm.

We identified regulations the provider was not meeting. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure care and treatment is provided in a safe way for service users.

Full details of the regulations the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Implement an effective recruitment procedure to ensure that appropriate checks are completed prior to new staff commencing employment at the practice.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice** ✖
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

We found that this practice was not providing safe care. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

At the inspection on 18 September 2023 we found the practice had made the following improvements to comply with the regulations:

- The taps, work tops and flooring in the decontamination room were visibly clean.
- A log was in place for the replacement of brushes used for the manual cleaning of instruments and heavy-duty gloves.
- Storage of clinical waste had been improved. Sharps containers in use were dated.
- Risk assessment in relation to sharps had been carried out.
- Antimicrobial prescribing audits were carried out.

Although improvements had been made there were still areas where the provider was not providing safe care:

- We found 2 taps that were identified as seldom used had not been flushed though to reduce the risk of Legionella developing as recommended in the providers risk assessment. Following the inspection, the provider had contacted a plumber to arrange to have these taps removed.
- We did not see, and the provider did not submit, evidence that dental nursing staff who assisted in the conscious sedation of patients had completed required sedation training to carry out the role, as outlined in guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'. The Immediate Life Support (ILS) training had been arranged for 26 September 2023.
- Electrical fixed wire testing had been carried out in April 2023 and recorded as unsatisfactory. Actions to address the shortfalls had not been carried out. The week before our follow up inspection an electrician had been contacted to provide a quotation to carry out the required work.

Are services well-led?

Our findings

We found that this practice was not providing well-led care. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

At the inspection on 18 September 2023 we found the practice had made the following improvements to comply with the regulations:

- A fire safety risk assessment had been carried out in January 2023 in line with the legal requirements. Areas for improvement and identified actions had been carried out including the relocation of the clinical waste storage.
- Sharps containers were now labelled and dated correctly.
- The compressor had been serviced in June 2023 in line with guidelines and manufacturer's instructions.
- Medical emergency equipment was in date.

Although improvements had been made there were still areas where the provider was not providing well-led care:

- Out of date materials were found in the surgery dating back to June 2022.
- We found instruments that had been through the decontamination process were stored un-pouched in the surgery drawer. The provider stated that these were sterilized and bagged at the end of each day. Evidence to confirm this was not available and the dental nurse stated this was done at the end of each week.
- Disclosure and barring service (DBS) checks had not been carried out for 1 dental nurse at the point of their employment. Evidence of an application was seen following our inspection.
- A damaged wall unit was found in the decontamination room. Unsafe skirting had not been repaired following our inspection in April 2023. Evidence was seen following our inspection that the wall unit had been removed, repaired and replaced.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • The registered person had failed to take timely action to address shortfalls identified in the practice's electrical fixed wiring test undertaken in April 2023. • The registered person had failed to undertake regular flushing of 2 taps to reduce the risk of Legionella.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the Regulation was not being met** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • There was no system in place to ensure that dental materials were checked and fit for safe use.

This section is primarily information for the provider

Requirement notices

- There was no clear system in place to ensure that unpouched instruments were sterilized according to guidelines.
- There was no system in place to ensure appropriate pre-employment checks were undertaken for new staff.