Mr Peter Sharp

Thornaby Dental Centre

Inspection Report

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Overall summary

We undertook a focused inspection of Thornaby Dental Centre on 22 November 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 a specialist dental adviser.

We undertook a comprehensive inspection of Thornaby Dental Centre on 22 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 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 Thornaby Dental Centre on our website www.cqc.org.uk.

As part of this inspection we asked:

• Is the practice 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 area 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 breach we found at our inspection on 22 August 2018.

Background

Thornaby Dental Centre is in Stockton-On-Tees and provides NHS and private treatment to adults and children.

There is a step at the entrance to the practice and a portable ramp is available to aid those who require it – for example people who use wheelchairs and those with pushchairs. Car parking spaces, including a designated space for blue badge holders, are available near the practice.

The dental team includes the principal dentist, three associate dentists, five dental nurses (of whom two are trainees), a dental hygiene therapist, two receptionists and a practice manager. The practice has four treatment rooms all situated on the ground floor.

Summary of findings

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.

During the inspection we spoke with the principal dentist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday, Tuesday, Thursday and Friday 9am to 5.30pm

Thursday 8am to 5.30pm

Saturday by appointment only.

Our key findings were:

- The practice had improved their systems to help them manage risk.
- The practice had effective leadership.
- A culture of continuous improvement was evident.
- The provider had improved their staff recruitment procedures.
- Training of staff was monitored efficiently.
- Interpreter services were available for people who needed it.

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

- Review the practice's protocols for ensuring that clinical staff who cannot demonstrate adequate immunity for vaccine preventable infectious diseases, including the vaccine for Hepatitis B, have risk assessments carried out to mitigate any risks to their health.

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.

Improvements were made to the overall management of the service and in particular to the risk management systems within the practice. These risk systems include fire, legionella, recruitment and hazard substances.

The provider had set aside protected staff time for management and administration duties and clear roles and responsibilities for all the practice team were established.

The improvements provided a sound footing for the ongoing development of effective governance arrangements at the practice. The provider needed to review their systems for undertaking risk assessments for clinical employees whose immune status to the Hepatitis B vaccination was unknown. This was acted upon on the inspection day.

Are services well-led?

Our findings

At our previous inspection on 22 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 22 November 2018 we found the practice had made the following improvements to comply with the regulation:

- Management and governance systems were reviewed and made to be more effective. Protected time was provided for the practice manager to ensure they could carry out their duties appropriately. Staff were assigned roles and responsibilities and were contributing to the overall running of the practice.
- Policies were all reviewed and made practice specific. We saw the infection prevention and control and safeguarding policies were updated. Safeguarding contact details and procedures were also made readily available for staff.
- Risk assessments were completed for all hazardous materials on site. A dedicated folder with all risk assessments and safety data sheets was created. New materials would be risk assessed and a process was implemented to ensure all materials were reviewed every six months.
- A lone working policy and risk assessment was created for the cleaner. Procedures were in place to ensure their safety.
- A Legionella risk assessment had been carried out following our initial inspection. We saw evidence of the recommended control measures being completed. This included recording of water temperatures each month and staff training on the management of legionella.
- The recommended actions from the fire risk assessment had been completed. Fire drills were documented and scheduled every six months. Signage was in place to indicate the presence of combustible gas on-site.
- Safety alerts were received for medical drugs and equipment and we discussed recent alerts with the practice manager. These were available to all staff and were discussed at practice meetings.
- Local rules for radiography equipment were updated. The practice manager had assurance from the radiation protection advisor that the local rules were in accordance with regulatory requirements.
- Staff training was effectively monitored and we were shown individual training logs for all staff. Logs will be reviewed every six months to ensure any discrepancies are acted upon. The practice manager assured us protected time was assigned for this.
- Recruitment procedures were completed adequately for staff, in particular for a recently employed dentist. We saw evidence that the provider had obtained an adequate DBS check, references, photo identification, evidence of qualifications, registration and indemnity insurance and employment history. Each staff file had an index to ensure all procedures were completed appropriately.
- Protocols for obtaining immunisation status of clinical staff were in place. The provider had created a risk assessment for clinical staff whose immune status could not be confirmed; this was not completed for all staff who required it. The provider had obtained a vaccination record for the newly employed dentist; this did not confirm their immune status and a risk assessment was not carried out. This was addressed immediately by the provider and during the inspection we saw all staff completed these risk assessments.

The practice had also made further improvements:

- The practice manager had displayed a notice at reception with translation service phone numbers. Staff were advised not to use relatives as translators.
- A detailed referral book was placed at reception for staff to monitor referrals appropriately.
- The actions from the disability access assessment were all completed – an induction loop for people with impaired hearing had been fitted. The accessible toilet had a safety alarm for patients.
- Confidentiality was discussed and staff were made aware of the importance of ensuring treatment doors remained closed during appointments. This was evident at the focused inspection.

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 22 November 2018.