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Waters Green Dental and Implant Clinic

Inspection Report

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Overall summary

We carried out a follow up inspection on 8 August 2017 at Waters Green Dental and Implant Clinic.

On 4 January 2017 we undertook an announced comprehensive inspection of this service as part of our regulatory functions. During this inspection we found breaches of the legal requirements.

A copy of the report from our comprehensive inspection can be found by selecting the 'all reports' link for Waters Green Dental and Implant Clinic on our website at www.cqc.org.uk.

After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breaches. This report only covers our findings in relation to those requirements.

We revisited the practice on 8 August 2017 to confirm whether they had followed their action plan and to confirm that they now met the legal requirements in the Health and Social Care Act 2008 and associated regulations. We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We reviewed the practice against one of the five questions we ask about services: is the service well-led?

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

Our findings were:

Are services well-led?

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

Background

Waters Green Dental and Implant Clinic is a general dental practice located near the centre of Macclesfield. There is level access to facilitate entrance to the practice for people who use wheelchairs and for pushchairs. Car parking is available near the practice.

The practice provides private dental services for adults and children.

The practice is open:

Monday and Friday 9.00am to 5.00pm

Tuesday 11.00am to 8.00pm

Wednesday 9.00am to 7.00pm

Thursday 9.00am to 8.00pm.

Summary of findings

The practice team includes a principal dentist, an associate dentist, a hygiene therapist and three dental nurses. One of the dental nurses is currently training to be the practice manager.

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.

Our key findings were:

- The practice had systems in place to help them monitor and improve the service.
- The practice had a detailed procedure in place for dealing with complaints.
- The practice had a leadership structure. Staff felt involved and supported and worked well as a team.
- The practice monitored staff training to ensure essential training was completed.
- The practice had systems in place to help them assess risk but measures to reduce risk were not fully in place.
- The practice had staff recruitment procedures in place, but these could be improved.

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 recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Ensure specified information is available regarding each person employed

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services well-led?

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

After the comprehensive inspection on 4 January 2017 the practice provided an action plan explaining the new arrangements the practice was putting in place to comply with the regulations.

We reviewed the provider's systems for monitoring and improving the quality and safety of the service. We found that most policies and procedures were now customised to the practice's circumstances and scheduled for review. The practice had introduced safeguarding, infection control and health and safety policies and procedures. Staff were aware of these.

There was a management structure in place and staff felt supported.

Improvements had been made to the storage of the paper records.

We saw that the provider had a system in place to review and monitor staff training.

The practice monitored clinical areas of their work to help them improve and learn but we found that learning outcomes were not identified and shared with staff.

We found that the provider had assessed most risks associated with dental practices but had not put in place all the reasonably practicable measures to reduce these risks.

We found that improvements could be made to the staff recruitment processes. The trainee practice manager forwarded us details of new arrangements after the inspection.

Requirements notice ✖

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice. One of the dental nurses was training to be the practice manager and was attending a course to obtain a qualification in this. We saw staff had access to supervision and support for their roles and responsibilities.

The trainee practice manager was currently in the process of reviewing and developing the practice's systems.

We reviewed the provider's systems and processes for monitoring and improving the quality and safety of the service.

The practice had policies, procedures and risk assessments in place to support the management of the service and to guide staff. We saw that many of these were now customised to the practice's circumstances and scheduled for review.

We found that the provider had put in place safeguarding arrangements, including a policy and procedures. Staff were familiar with these arrangements. The provider had put in place a comprehensive health and safety policy. Policies and procedures in relation to infection control and whistleblowing had been implemented and staff were familiar with these.

We found that recruitment arrangements had not been improved since our comprehensive inspection in January. Two new staff had started in July 2017. We found that not all the appropriate pre-employment checks had been carried out and not all the prescribed information had been obtained. There was no photographic identification, no references, no evidence of qualifications, and no Disclosure and Barring Service check, in relation to one and in relation to the other, no photographic identification and no references. We found that the recruitment records were stored on open shelves which did not prevent unauthorised access. The trainee practice manager produced and implemented a practice recruitment policy and checklist immediately after the inspection and forwarded this to us. We saw that these reflected the requirements of the current legislation.

We reviewed the provider's systems for assessing, monitoring and mitigating risk. The provider had arrangements in place to ensure most risks were assessed but we found limited improvements in relation to mitigating these risks.

- We saw that personal protective equipment was now used when staff were decontaminating used instruments.
- We saw that the provider had improved arrangements for waste disposal and was segregating waste appropriately.
- The provider had put in place arrangements to ensure equipment, including the X-ray machines, was regularly tested.
- We saw that paper dental care records, for example, consent forms and referral letters were now stored securely.
- We saw that some risk assessments were in place in relation to hazardous substances in use in the practice but some had not been carried out. The trainee practice manager assured us this would be addressed as soon as possible.
- The provider was currently undertaking renovation in the practice and planned to carry out a fire risk assessment on completion of the renovation. We saw that the previous fire risk assessment had identified that all doors inside the practice should be kept closed. We observed that the doors to the treatment rooms, kitchen and the decontamination room remained open during the inspection.
- We observed that no compressed gas warning signs was displayed in relation to the medical emergency oxygen, and no radiation warning signs were displayed.
- We found that no risk assessment was in place in relation to two staff working in a clinical environment prior to the effectiveness of the Hepatitis B vaccination being established, or where their immunisation status was unknown. We observed that one of the staff, whose immunity was unknown had received a recent injury from a used sharp instrument.

Are services well-led?

- The provider had subscribed to receive national alerts in relation to the safety of medicines and equipment from the Medicines and Healthcare products Regulatory Agency but no system was in place to review and act on recent alerts.
- The provider had no procedures in place to report, analyse and learn from significant events. Staff told us no significant events had occurred. The trainee practice manager assured us procedures would be introduced. Accidents were reported but we observed that these were not followed up appropriately and insufficient detail was recorded.

Leadership, openness and transparency

We reviewed the practice's systems in place to support communication about the quality and safety of the service for staff.

Staff told us that as it was a small practice issues were discussed and resolved as they arose. Formal staff meetings were not held but the trainee practice manager said these would be introduced now that the practice had grown in size. Staff added items to a daily list and these were discussed as they arose.

Learning and improvement

The practice had some quality assurance processes in place to encourage learning and continuous improvement. These included, for example, audits. We reviewed audits of X-rays. We observed that there were no identified learning outcomes and action plans associated with these to encourage continuous improvement. Staff had carried out an infection control audit on 2 August 2017. We saw that there was an associated action plan in place for improvements to the infection prevention and control systems.

We saw that complaints were recorded and responded to but no learning outcomes were identified. We observed that the complaints procedure now contained details of alternative organisations people could complain to should they not wish to complain directly to the practice or be dis-satisfied with the response of the practice to their complaint.

We saw that dental professionals' continuing professional development was now monitored by the provider to ensure they were meeting the requirements of their professional registration with the General Dental Council. Staff were supported to meet the requirements by the provision of essential training.

The practice was introducing a system of appraisals to help identify individual training needs. Staff told us the practice provided support and training opportunities for their on-going learning.

Practice seeks and acts on feedback from its patients, the public and staff

The provider had placed a comments box in the reception area to seek the views of patients about all areas of service to identify areas for improvement.

The practice gathered feedback from staff through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

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 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** There were no systems or processes that ensured the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular: • Staff recruitment records were not held securely 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: • The registered person had not identified learning points and produced action plans where necessary in relation to X-ray audits carried out and complaints received by the practice. 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 mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • Risk assessments were in place in relation to some hazardous substances in use in the practice but others had not been carried out.

This section is primarily information for the provider

Requirement notices

- During the inspection the registered person kept the doors to the treatment rooms, the kitchen and the decontamination room open despite the fire risk assessment specifying that all doors inside the practice should be kept closed.
- No compressed gas warning sign in relation to the medical emergency oxygen was displayed, nor radiation warning signs
- No risk assessment was in place in relation to staff working in a clinical environment prior to the effectiveness of the Hepatitis B vaccination being established, or where their immunisation antibody status was unknown.
- No review of recent alerts from Medicines and Healthcare products Regulatory Agency had been carried out.
- No procedures were in place to report, analyse and learn from significant events.
- Accidents were reported but not followed up appropriately and insufficient detail was recorded.

Regulation 17(1)

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons

How the regulation was not being met

The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular:

- The registered person had not obtained photographic identification, references, or a Disclosure and Barring Service check, in relation to one recently employed member of staff, and in relation to the other, had not obtained photographic identification or references.

This section is primarily information for the provider

Requirement notices

The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular:

- The registered person had not ensured that a recently employed member of staff had appropriate qualifications or a suitable employment history.

Regulation 19(1)&(2)

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- The registered person had no photographic identification, no references, no evidence of qualifications, and no Disclosure and Barring Service check, available in relation to one recently appointed member of staff, and in relation to the other recently employed member of staff, no photographic identification and no references available.

Regulation 19(3)