Kenneth Ng Surgery Ltd

Kenneth Ng Surgery Limited

Inspection Report

62 Berners Street, Ipswich, Suffolk, IP1 3LU
Tel: 01473 254513
Website:

Date of inspection visit: 21 March 2017
Date of publication: 02/05/2017

Overall summary

During our announced comprehensive inspection of this practice on 11 October 2016 we found breaches of legal requirements of to the Health and Social Care Act 2008 in relation to regulation 17- Good Governance.

We undertook this focused inspection to check that the provider now met legal requirements. This report only covers our findings in relation to these requirements. You can read the report from our previous comprehensive inspection by selecting the 'all reports' link for Kenneth Ng Surgery Limited at www.cqc.org.uk

Are services Well-led?

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

Key findings

- The provider had failed to address many of the shortfalls we had identified at our previous inspection. However, immediately following this second inspection the provider sent us sufficient evidence to demonstrate that the practice was now adequately well-led.

There were areas where the provider could make improvements and should:

- Embed newly implemented improvements into the practice and ensure they are sustained in the long-term

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?

Are services well-led

No action

We noted some improvements had been implemented since our previous inspection. Untoward incidents were better managed, missing medical equipment had been purchased, staff rehearsed fire evacuation drills and patients' dental care records were of a better standard overall. However, the provider had failed to address many other shortfalls we had identified in our previous report. For example, there was no system to ensure MHRA alerts were managed effectively; staff did not undertake emergency medical simulations; COSHH sheets were not available for some hazardous substances within the practice and stock control was poor. Patients' referrals were not monitored, recording of patients' consent to treatment was limited and audits were not undertaken to assess the quality of patient X-rays. However, immediately following this second inspection the provider sent us adequate information to demonstrate that he now complied with the breach in regulation.

Kenneth Ng Surgery Limited

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Kenneth Ng Surgery Limited on 21 March 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 11 October 2016 had been made.

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

During our inspection we spoke with the owner, the associate dentist and two dental nurses. We reviewed a range of documentation and checked the decontamination room.

No action

Are services well-led?

Our findings

Governance arrangements

At our previous inspection in October 2016 we found a number of shortfalls in the practice's governance procedures that showed that the practice was not well led. During this inspection we noted the following improvements had been implemented since then:

- Incident recording and management had improved. The owner told us of a specific incident that had occurred a week before our inspection when a patient had been hit in the eye with a piece of porcelain. We noted that the incident had been discussed at the practice meeting and better patient eyewear had been purchased to prevent its reoccurrence.
- Missing emergency medical equipment had been purchased including airways of various sizes, although the provider had not obtained a blood glucose measuring device as recommended.
- Staff now rehearsed fire evacuation drills.
- Appropriate references and disclosure and barring checks for new staff had been completed.
- An audit had been implemented to ensure that all instruments were tracked through treatment and decontamination cycles and to ensure that none were used twice on patients, without being sterilised.
- The quality of patients' dental care records had improved. Patients' medical histories were regularly updated and signed off. Treatment planning was more coherent and patients' dental histories were present. Radiographs were taken appropriately on most occasions and were well reported on, graded and justified. Basic periodontal examinations were evident for patients, as was their smoking and alcohol usage.

At our previous inspection the owner acknowledged to us that he was finding some aspects of managing and overseeing the practice difficult. He told us he had plans in place to appoint a dedicated practice manager and that he had purchased an on-line governance tool. However, no practice manger had been appointed and although purchased, the governance tool had not been implemented to improve the service. There remained a number of areas identified at our previous inspection where the provider had failed to take any action. For example:

- The principal dentist told us that the associate dentist was responsible for monitoring and actioning MHRA safety alerts. We spoke with the associate dentist who was not aware he had been given this role and told us that principal dentist was responsible for the alerts.
- Staff did not undertake medical emergency simulation training so that they had the chance to practice what they would do in the event of an incident. A member of staff who had been employed at the practice for a month had not received any instruction on how to operate the oxygen cylinder or any emergency equipment.
- Records of staff recruitment interviews were not kept to demonstrate they had been conducted in line with good employment practices.
- There was no evidence to show that staff had completed any fire training and no fire marshals had been appointed.
- COSHH sheets had not been completed for a number of hazardous substances available in the practice that we had identified at our previous inspection.
- There continued to be a number of loose and uncovered medical consumables in treatment room drawers and a build-up of lime scale round a sink plug.
- The recording of patients' consent to treatment was still limited. There was almost a complete absence of both NHS and private written consent forms, and treatment plans in the dental care records we reviewed. Verbal consent was also not well recorded.
- Although patients' basic periodontal examinations had been recorded, there was little in the form of written risk assessments for caries and periodontal disease. Consequently, NICE guidelines were only loosely applied and not adequately recorded. Smoking cessation advice given to patients was not well recorded, and dental charting was updated in most but not all records we reviewed.
- The principal dentist had not undertaken a radiograph audit to ensure his X-rays were of good quality.

No action

Are services well-led?

- A log of referrals was still not kept so they could be tracked. The owner told us that patients received a copy of their referral form for their information. However, nurses we spoke with told us this was not the case.
- We found a bottle of liquid mercury that was kept unsecured in an unlocked cupboard. Also in this cupboard was a 'flowers of sulphur' jar dated 1994 and some out of date Pirtion medication, indicating that stock control was poor within the practice.
- The practice still did not have a portable hearing loop to assist patients' with hearing aids, or any information in other languages or formats, despite serving a large multicultural population.

However following this inspection, the provider took immediate action to rectify the outstanding shortfalls. For example, a hearing loop, bodily spillage and blood glucose measuring kit was purchased; a dental care record keeping audit was undertaken on 5 April 2017, COSHH sheets were updated, fire marshal training was organised and out of date medical consumables were removed. He sent us information to demonstrate that a medical emergency simulation had taken place, and that a patients' referrals log and MHRA policy had been implemented. He appointed one of the dental nurses as the deputy practice manager to help lead the practice.

As a result of this we consider the provider has now taken adequate action to meet the breach in regulation.