Barton Dental Surgery

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Inspection Report

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Overall summary

We undertook a focused inspection of Barton Dental Surgery on 20 September 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.

We undertook a comprehensive inspection of Barton Dental Surgery on 15 February 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 Barton Dental Surgery 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 area 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 breach we found at our inspection on 15 February 2018.

Background

The practice is located in Barton Le Clay in central Bedfordshire. It provides NHS and private treatment to patients of all ages.

There is level access for people who use wheelchairs and pushchairs. There are no patient car parking facilities available; although patients with disabilities can be offered a space in the practice's private car park. Public roadside car parking is available within a short walking distance of the practice.

The dental team includes three dentists, four dental nurses (including the head nurse), one trainee nurse, one dental hygienist and one receptionist. The head nurse was also undertaking management duties and had taken on the role of practice coordinator.

The practice has three treatment rooms; two of these are on the ground floor.

Summary of findings

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Barton Dental Surgery is one of the dentists who owns the practice.

We were advised on the day of our comprehensive inspection that two of the four partners had left. We told the principal dentist to take action to ensure the CQC registration of the practice is correct. We found that the registration of the practice was still not correct at the time of our follow up visit. The dentist who owns the practice told us they had been making efforts to resolve the issues.

The practice is open: Monday, Tuesday, Wednesday, Thursday from 8.30am to 4.30pm and Friday from 8.30am to 2pm. The practice is closed at lunchtimes from 1pm to 2pm Monday to Wednesday and from 2pm to 3pm on Thursday.

Our key findings were:

- The practice had implemented a policy and process for reporting and investigating significant events.
- The practice had improved systems for monitoring and improving quality, for example audit activity.
- A policy for safeguarding vulnerable adults had been implemented.
- A risk assessment had been conducted for the non-clinical staff member working without disclosure barring service (DBS) check clearance. The practice had ensured that clinical staff had a DBS check in place.
- A policy had been implemented regarding staff employment and recruitment. We saw that policy was being applied in relation to the appointment of new staff.
- The practice had implemented a system for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).
- The risks presented by legionella and fire were being effectively addressed.
- The practice had obtained rectangular collimators for their X-ray equipment.
- The practice had started to take steps by encouraging clinicians to follow the guidelines issued by the British Endodontic Society regarding the use of rubber dam.
- Waste handling protocols had been reviewed and now reflected guidance issued in the Health Technical Memorandum 07-01 (HTM07-01).
- Prescription pad security had been improved.
- Staff were up to date with their mandatory training and continuing professional development (CPD).
- Staff had completed or were in the process of completing training in the Mental Capacity Act (MCA) 2005.
- The practice had not yet taken action regarding the installation of a hearing loop to assist those who used a hearing aid. An external agent was due to undertake a risk assessment of the premises.

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

- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

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: implementing policies and improving procedures such as recruitment, addressing the risks presented by legionella and fire, implementing a system for the review and action of patient safety medicines alerts and improving the quality of audit activity.

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 15 February 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 20 September 2018 we found the practice had made the following improvements to comply with the regulation:

- The practice had implemented a policy and process for reporting and investigating significant events. We noted that two incidents had been reported; staff had discussed them and taken proportionate action in response.
- The provider had implemented a system for monitoring and improving quality of the service. For example, robust radiography audits had been completed for each practitioner. Where issues were identified, actions were taken. For example, a bent plate had been replaced.
- A policy had been implemented for safeguarding vulnerable adults. Staff were made aware of the policy and we noted contact details for reporting any safeguarding concerns.
- The provider had undertaken DBS checks for their clinical staff. A risk assessment had also been completed for the non-clinical member of staff who did not have a DBS check in place. Risk assessments had been completed for those staff who were still waiting for confirmation of their immunity levels for Hepatitis B. We saw that action was being taken to obtain the information.
- Recruitment policy and procedures had been implemented and strengthened. In addition to policy, the provider had formulated a checklist for all staff; this contained details of the information required in Schedule 3 such as proof of identity including a recent photograph and reference checks. A new member of staff had recently been recruited and we saw that appropriate checks had been made for this person.
- A system had been implemented for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). We saw that a detailed log had been completed; this showed whether any action was required in response to alerts issued. Staff were informed by memo if an alert had any relevance to the practice and were required to sign to acknowledge they had understood the information. Alerts were also saved separately in an electronic folder on the practice computer system.
- Risks had been mitigated in relation to legionella. Water temperature testing was taking place monthly and records held with the results. Tests for biofilm were also being undertaken.
- The provider had taken reasonable steps to address the risks presented by fire. For example, a fire marshal was appointed and they had completed training to undertake the role. The provider was considering nominating a second staff member to assist in the absence of the nominated individual being on site, in the event of an emergency. Other staff had also completed online fire training and a fire drill had been undertaken.
- Rectangular collimators had been obtained and fitted to X-ray equipment.

The practice had also made further improvements:

- Policy provision included that if rubber dam was not used by the dentists for root canal treatment, notes should be included in patient records explaining why it was not used. We discussed this issue with the provider and they told us that they would consider this issue for inclusion in dental record keeping audits.
- The provider had reviewed its waste handling protocols and had entered into a contract with a new waste collection agent. We were shown recent consignment notices; these showed that a suitable system was now in place.
- Procedures for the security of prescription pads had improved. These included recording the numbers on prescription pads received and a log of individual prescription numbers. Records were kept when a prescription was issued.
- We noted that staff were up to date with mandatory training and their continuing professional development (CPD).
- We were informed that most staff had undertaken training in relation to the Mental Capacity Act 2005 or

Are services well-led?

plans were in place for its completion. Plans were in place to gauge staff understanding of the Mental Capacity Act 2005; this included peer review for the dentists led by the principal dentist.

- The practice had not yet undertaken a review of its responsibilities to the needs of people with a disability including those with hearing difficulties. The provider told us that an external agent had been consulted with to undertake a risk assessment of the premises and a decision would be made following this taking place.

These improvements showed the provider had taken action to improve the quality of services for patients and comply with the regulation following our inspection on 20 September 2018.