Dr. Sean Hasnain

300 Great Western Street

Inspection Report

300 Great Western Street
Rusholme
Manchester
M14 4LP
Tel: 0161 2262548
Website: www.rusholmedental.co.uk

Date of inspection visit: 15 February 2019
Date of publication: 25/04/2019

Overall summary

We carried out this unannounced inspection on 15 February 2019 and a further announced inspection on the 20 February 2019 (which was a continuation of the inspection process) under Section 60 of the Health and Social Care Act 2008 in response to information of concern, and as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser and a second CQC inspector.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

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

Background

300 Great Western Street (known locally as Rusholme Dental Practice) is in Rusholme, Manchester and provides NHS and private treatment to adults and children.

There is level access to the ground floor reception and surgeries for people who use wheelchairs and those with pushchairs. On street parking is available near the practice.

Summary of findings

The dental team includes three dentists including a foundation dentist, 13 dental nurses (eight of which are trainees), a dental hygienist, two dental hygiene therapists (one of which is a foundation therapist), two receptionists and a practice manager. The practice has four treatment rooms.

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.

On the day of inspection, we collected one CQC comment card filled in by a patient.

During the inspection we spoke with the dentists including the foundation dentist, dental nurses, the dental hygiene therapist, the foundation hygiene therapist, a receptionist 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 to Friday 9am to 1pm and 2pm to 5pm.

Our key findings were:

- The premises were clean and well maintained, with the exception of some areas which were dusty. Environmental cleaning could be improved.
- The provider had infection control procedures which reflected published guidance with the exception of the processes for manually cleaning instruments.
- Staff did not all know how to deal with emergencies. Immediate action was needed to make appropriate medicines and life-saving equipment available.
- The practice did not have effective systems to help them identify and manage risk to patients and staff.
- Improvements were needed to the safeguarding processes. The practice did not ensure that staff were up to date with training. They knew their responsibilities to report any safeguarding concerns.
- The provider did not have thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The systems to document and deal with complaints required improvement.
- The provider did not have suitable information governance arrangements.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- 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.
- Act in accordance with the Duty of Candour.

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

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

- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Review staff awareness of the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related

Summary of findings

guidance' (In particular, the arrangements for transporting instruments, the illuminated magnification device and standards of environmental cleaning).

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 safe?

Requirements notice 

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

The practice did not document, investigate or learn from incidents effectively.

Not all staff received training in safeguarding and insufficient information and safeguarding resources were available. Staff knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles. The practice did not complete all the necessary recruitment checks or ensure the induction process was effective.

The premises were clean and well maintained, with the exception of some areas which were dusty. Environmental cleaning could be improved.

The practice followed national guidance for sterilising and storing dental instruments. Improvements could be made to the processes for transporting, manually cleaning and inspecting instruments.

The practice did not have suitable arrangements for dealing with medical emergencies. Immediate action was necessary to address this. Not all staff were familiar with the emergency equipment provided.

Risks were not effectively assessed and acted on. For example, hazardous substances, staff immunity and health and safety.

Are services effective?

No action 

We found that this practice was providing effective care in accordance with the relevant regulations.

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records. We highlighted a minor improvement could be made to the information provided for dental hygiene therapists to provide the appropriate treatment.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The provider supported staff to complete training relevant to their roles and had systems to help them monitor this.

The staff were involved in quality improvement initiatives such as clinical supervision and regular clinical discussion as part of its approach in providing high quality care, this was evident during the inspection.

Summary of findings

Are services caring?

No action

We found that this practice was providing caring services in accordance with the relevant regulations.

We received feedback about the practice from one person. They were positive about the services the practice provided. They told us their dentist listened to them.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. The use of CCTV had not been assessed in line with the General Data Protection Regulation (GDPR).

The practice was involved in a community project to clean the alleys, reduce fly-tipping and rubbish, and restore pride and a sense of community.

Are services responsive to people's needs?

No action

We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice's appointment system took account of patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for patients with a disability and families with children. The practice did not have access to interpreter services.

The practice valued compliments from patients. The systems to document, investigate and respond to complaints required improvement.

Are services well-led?

Enforcement action

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

There was a clear management structure and staff felt supported and appreciated.

The lack of effective governance had resulted in safety issues and incidents occurring. Systems were not in place to identify and manage risks.

The provider did not have thorough staff recruitment or induction procedures.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely. Staff records were not held securely.

The provider monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff.

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had some systems to keep patients safe.

The provision of training and information to report concerns about the safety of children, young people and vulnerable adults could be improved. The practice had some information about identifying, reporting and dealing with suspected abuse, but this was generic and did not identify who the safeguarding leads were. We asked for evidence of safeguarding training for staff. The provider was unable to provide evidence of this for all staff. We saw certificates of attendance at safeguarding training for eight members of staff. Information was not available that would support staff to recognise if patients were at risk of child sexual exploitation, modern-day slavery, trafficking or female genital mutilation.

Staff told us they would report any concerns they had to the principal dentist or practice manager. Concerns. We discussed the requirement to notify the CQC of any safeguarding referrals as staff were not aware. We also highlighted where staff training and access to the local safeguarding team and resources would support staff at risk of verbal abuse and aggression. Incidents such as these were not recorded or reported.

The practice had a whistleblowing policy, this was kept in the office, we highlighted the need to make this readily available to staff. Staff said they could raise concerns without fear of recrimination.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record and a risk assessment completed.

The business continuity plan was not up to date with the necessary information which would be needed if events disrupted the normal running of the practice.

The practice did not have appropriate recruitment procedures to help them employ suitable staff. We looked at the staff recruitment records. Essential recruitment checks were not consistently carried out before new employees could commence work. For example, Disclosure and Barring Service (DBS) checks, obtaining references or evidence that individuals had the right to work in the UK. Of the members of staff listed as trainee dental nurses in the staffing matrix, it was unclear whether some individuals had commenced employment or were on a trial basis shadowing staff as preliminary training contracts were not consistently in place and there were no terms of the arrangements of their employment or work experience in the staff files.

Records of up to date General Dental Council (GDC) registration and professional indemnity cover were not maintained by the provider. Evidence was obtained from staff when we returned to the practice on 20 February.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced. We highlighted where a rear fire exit was blocked by chairs and staff found the door difficult to open.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation.

The practice did not ensure that clinical staff were up to date with continuing professional development (CPD) in respect of dental radiography.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were ineffective.

We asked to see the practice's health and safety policies and procedures, these were not available. The provider showed us a health and safety risk assessment template, which they completed in advance of our return visit to the

practice. They had highlighted areas where action was required to help manage potential risk. These included further risk assessments of trainees, young workers, display screen equipment and the practice environment.

We noted the practice's employer's liability insurance had expired in July 2018. We were not assured that current cover was in place until the insurer was contacted and provided the necessary evidence.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and recently reviewed and discussed with staff. Safe needle systems were in use by some clinicians. Safer needle removal and resheathing devices had been provided for clinicians who used traditional syringes.

The provider did not have an effective system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. Of the clinical staff, evidence of hepatitis B immunity was provided for 10 people. There were no results for eight members of staff.

A trainee dental nurse was in the process of receiving their vaccinations. They did not have an individual risk assessment in place, despite carrying out decontamination procedures.

We were not assured that staff were familiar with the equipment to enable them to respond to a medical emergency. Evidence of up to date training in emergency resuscitation and basic life support was not available for 11 members of staff. The practice induction included showing the staff the location of the emergency kit, but this did not include ensuring staff were familiar with the correct use of the equipment provided. As a result, staff did not know how to operate the emergency medical oxygen and did not recognise what the portable suction device was, or what it was for.

Emergency equipment and medicines were not as described in recognised guidance. Staff kept records of weekly checks of these to make sure appropriate medicines and equipment were available, within their expiry date, and in working order. The practice had not ensured that the individuals responsible for checking these were appropriately trained to carry out this task. These checks had failed to identify that needles and syringes were not in place to administer emergency adrenaline in the event of anaphylaxis (a severe allergic reaction). Immediate action was taken to obtain these. Other items were missing from the emergency kit, these included oropharyngeal airways, a child-sized self-inflating oxygen bag and child sized masks, and a range of adult and child-sized oxygen masks. Glucagon was unrefrigerated and the expiry date had not been changed in line with the manufacturer's instructions. This was brought to the attention of the principal dentist to review the arrangements against the required standards as described in Resuscitation Council UK guidance. The General Dental Council requires dental practices to follow this.

A dental nurse worked with the dentists and the dental hygienists and hygiene therapists when they treated patients in line with GDC Standards for the Dental Team.

The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. An incident had occurred in June 2018 where the incorrect solution had been used in one of the dental unit waterlines.

The practice had a generic infection prevention and control policy. This was not personalised to the practice. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care, with the exception of processes for manually cleaning instruments. The practice had suitable arrangements for sterilising and storing instruments in line with HTM 01-05. Improvements could be made by providing clear procedures for the manual cleaning of instruments; including the correct temperature and concentration of the solution to be used. Staff completed infection prevention and control training and received updates as required, and trainee dental nurses were supported by qualified staff when working in the decontamination room. We noted the illuminated magnification device, which is used to inspect instruments before sterilisation was broken, and staff did not transport instruments from the dirty room to the clean room in sealed waterproof containers.

The records to show equipment used by staff for cleaning and sterilising instruments was validated were not up to date and the practice could not assure us that these were

carried out. This evidence was obtained from the member of staff responsible and provided on the second day of inspection. We saw evidence the equipment was serviced and used in line with the manufacturers' guidance.

The practice had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

A Legionella risk assessment had been carried out in October 2018. We noted the report stated that evidence of monthly water temperature testing were not available at this time. These records were still not available when we requested to see them. When we attended on the second day, these had been obtained from the member of staff responsible. These showed the practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

The practice could improve the general cleanliness of the premises by providing cleaning schedules for staff to follow, or to ensure they were familiar with the areas that different coloured mops and cloths should be used in. The majority of the premises were visibly clean when we inspected, but some surfaces were dusty.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice had not carried out any infection prevention and control audits since March 2017. There was no evidence that the findings of the last audit had been reviewed. We spoke with the practice manager about carrying out six-monthly audits in line with the guidance in HTM01-05.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance. We discussed with the principal dentist how referrals to the dental therapists could be improved by providing patient specific instructions rather than relying on standardised templates.

Safe and appropriate use of medicines

The provider did not have reliable systems for appropriate and safe handling of medicines.

The stock control system of medicines held on site had not identified local anaesthetic in one of the dental surgeries which expired in November 2017. This was immediately removed and brought to the attention of the principal dentist. The practice stored NHS prescriptions as described in current guidance. The prescription logging process would not identify if a prescription form was missing. This was discussed with the practice manager to review the process.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety and Lessons learned and improvements

Arrangements to record, investigate and learn from incidents and accidents were not effective. We discussed incidents that had not been recorded, and therefore action had not been taken to address these in a timely way. For example, incidents related to verbal abuse and aggression, a member of staff not returning their keys to the practice after leaving and the loss of personal information from staff files had not been reported, and action was not taken to secure the premises until 19 February 2019.

The practice had systems for staff to report any incidents. We saw that accident reports from sharps injuries were poorly recorded and no evidence could be shown that these were followed up appropriately.

The systems for reviewing and investigating when things went wrong required improvement. For example, the investigation after the incident in June 2018 did not include a thorough review of the hazardous substance involved and a patient affected by this incident had not been provided with a full account of the event in line with the

Are services safe?

Duty of Candour. They had taken some actions to ensure the wellbeing of the person involved but not provided them with a full explanation of the circumstances, or an apology for the incident that had occurred.

There was no system for receiving and acting on safety alerts, and the principal dentist and practice manager were not aware of these until examples were shown to them. We checked to ensure that medicines and equipment were not affected by any relevant alerts. The practice manager gave assurance that they would ensure that future alerts are received, acted upon and retained for reference. The practice learned from external safety events, such as national publications, bulletins and alerts received from the NHS England area team.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The staff were involved in quality improvement initiatives including regular clinical discussion as part of their approach in providing high quality care. They were also a member of a 'good practice' certification scheme. The principal dentist provided mentorship and held regular clinical discussions with the foundation dentist and dental hygiene therapist to support their development and progression.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children and adults based on an assessment of the risk of tooth decay.

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services.

The dentists and dental hygiene therapists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

The practice had recently been selected to take part in the government's Dental Prototype Agreement Scheme, to trial a new NHS dental contract that aims to offer a new way of providing dental care, with an increased focus on disease prevention and the provision of interim care which can be provided by dental hygiene therapists.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. We noted not all staff were familiar with the process to gain consent where patients lacked capacity. For example, where family members may have power of attorney or the patient did not have any family. We highlighted the availability of local and national guidance in relation to this. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw the practice audited patients' dental care records to check that the clinicians recorded the necessary information. We highlighted where the dentists could document instructions to the dental hygiene therapists more clearly in the dental care records.

Effective staffing

The systems to ensure staff had the skills, knowledge and experience to carry out their roles could be improved. For

Are services effective?

(for example, treatment is effective)

example, the induction checklist did not document arrangements to ensure staff were familiar with correct safeguarding processes or medical emergency arrangements. The induction process had not been completed fully for all new members of staff.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Practice information and magazines were provided in the waiting room for patients to read.

The practice was involved in a community project to clean the alleys, reduce fly-tipping and rubbish, increase recycling, and improve the environment for residents and businesses to restore pride in the area.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff could take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely. The provider had installed a closed-circuit television system, (CCTV), externally and internally in the corridor, reception and the waiting areas. The provider had not displayed information informing patients for what purpose the CCTV was in use and to make them aware of their right of access to footage which contains their images.

A privacy impact assessment had not been carried out to ensure the CCTV was proportionate and the images stored and accessed appropriately. This was raised with the practice manager to address.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the

requirements under the Equality Act. They were not familiar with the Accessible Information Standard. This is a requirement to make sure that patients and their carers can access and understand the information they are given.

Staff did not have access to interpreter services for patients who did not understand or speak English. Patients were told about multi-lingual staff that might be able to support them or brought family members who could speak English to help them understand any care proposed or provided.

Staff communicated with patients in a way that they could understand and communication aids and easy read materials were available.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, models and X-ray images shown to the patient/relative to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment. For example, patient dental care records were flagged if they were unable to access the first-floor surgery. The practice had made some reasonable adjustments for patients with disabilities in line with a disability access audit. These included step-free access for wheelchair users through a side entrance and an accessible toilet. We highlighted that grab rails and a call bell could also be installed in the patient toilets.

The practice provided a private prayer room which was available to staff and patients.

Patients could choose to receive appointment cards and postal reminders for forthcoming appointments. Staff telephoned some patients on the morning of their appointment to make sure they could get to the practice. Staff said that many patients dropped into the practice to arrange appointments.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their information leaflet and on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested urgent advice or care were offered an appointment the same day. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice's website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. In addition, the practice was part of a local scheme to provide urgent dental care to one patient per working day who did not have a dentist. These patients were scheduled by a central booking office who were responsible for providing the necessary information to the practice.

Listening and learning from concerns and complaints

The systems to document complaints and concerns should be reviewed to ensure they are investigated and responded to appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The practice manager was responsible for dealing with these. Staff would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Where complaints were dealt with and resolved verbally, these were not documented. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We asked to see how comments, compliments and complaints the practice received were handled. The most recently documented complaint investigation that could be found was from September 2017. This was a response to a patient, there was no information about which patient this response was to or whether it had been sent to them.

We highlighted the importance of documenting and responding to concerns appropriately to improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

We found the principal dentist needed to prioritise the leadership of the practice, and ensure that staff in lead roles are provided with the experience, capacity and skills to deliver the practice strategy and address risks to it.

Staff were lacking in knowledge about issues and priorities relating to the governance and quality of services. During the inspection, they recognised there were deficiencies, understood the challenges and demonstrated a commitment to address them.

Staff changes had affected capacity to ensure that leadership and governance systems were up to date and functioning effectively. The principal dentist had prioritised the delivery of the new prototype NHS contract, providing clinical support to staff, and ensuring patients could access dental care during this time.

Vision and strategy

Staff were familiar with the challenges of providing services to meet the high needs of the local population. They were aware of the local demographics of the population, which includes a large student population, and high levels of social and economic deprivation. They were involved in a project to clean up the local area and strengthen community relationships.

Culture

The practice had a culture of high-quality sustainable care.

Staff stated they felt respected and supported. The practice focused on the needs of patients and ensuring they could access care. They were keen to develop the skill mix of clinical staff to facilitate this.

Openness, honesty and transparency were not demonstrated when responding to incidents and complaints. The provider did not have systems to ensure compliance with the requirements of the Duty of Candour. There was no evidence that they had acted fully in line with the Duty of Candour when a recent incident had occurred. They had taken some actions to ensure the wellbeing of the person involved but not provided them with a full explanation of the circumstances, or an apology for the incident that had occurred.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service.

The system of clinical governance was inadequate to support the delivery of services and incidents had occurred as a result of this. Many policies, protocols and procedures were generic, not appropriate to the systems in the practice or missing. There was no evidence that these were reviewed on a regular basis, except for sharps safety which had been reviewed and discussed with staff in January 2019.

There were ineffective processes for identifying and managing risks, issues and performance. Opportunities were missed to identify these areas when completing the annual self-assessment document which is required for dental practices who provide foundation training.

For example:

- The provider had failed to ensure appropriate medical emergency arrangements were in place.
- A lack of systems to receive, or knowledge of patient safety alerts.
- Evidence could not be provided to show that appropriate action had not been taken to follow up after sharps injuries.
- Safeguarding arrangements were ineffective.
- Incidents were poorly documented, not investigated inadequately and the Duty of Candour had not been followed.
- Staff recruitment and induction processes were ineffective.
- Hazardous substances were not appropriately assessed and expired medicines were identified.
- Complaints were not documented, investigated or responded to appropriately.
- The practice were not assured that public liability insurance and individual medical indemnities were up to date until evidence of these was requested.
- The practice did not ensure that staff were up to date with training, including safeguarding, medical emergencies and basic life support.
- The provider could not be assured that staff carrying out key roles, did so appropriately. For example, Legionella checks and the validation of sterilisation equipment. We

saw records showing that medical emergency equipment checks were carried out by a person who had only done a short period of shadowing and work experience at the practice.

Appropriate and accurate information

The processes to ensure the security of, and act on appropriate and accurate information were not effective.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. The practice manager told us they had identified that staff's personal information had gone missing. Due to the disorganisation of staff files, it was difficult to identify exactly what was missing from the files which, at the time, had been unlocked and accessible to all staff. The CCTV arrangements had not been reviewed in line with GDPR requirements.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used verbal comments to obtain patients' views about the service.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. Of the most recent 20 responders, 55% would recommend the service to a friend or family member.

The practice gathered feedback from staff through meetings and informal discussions. New members of staff told us that they spent time shadowing and learning from more experienced members of the team. Staff knew to report any issues or concerns they had to the principal dentist or practice manager.

Continuous improvement and innovation

There were some systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included the provision of clinical supervision, weekly tutorials provided by the principal dentist and reviewing the quality of dental care records and radiographs. We highlighted where the information provided to the dental hygiene therapists could be improved. There had been no audits of infection prevention and control since March 2017. We spoke with the practice manager about carrying out six-monthly audits in line with the guidance in HTM 01-05.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. Staff were complimentary about the support they received.

There were plans to ensure staff had annual appraisals. Recent staff changes had impacted on this. They discussed learning needs, general wellbeing and aims for future professional development informally and at staff meetings.

The provider did not ask staff for evidence that they completed 'highly recommended' training as per General Dental Council professional standards. This includes undertaking medical emergencies and basic life support training annually, and appropriate radiation protection and safeguarding training updates. We gave the practice the opportunity to request staff for evidence of training when we returned to complete the inspection on the second day. Four members of staff provided evidence of safeguarding training and one brought evidence of medical emergency training. There were still gaps where staff could not be contacted to provide this.

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:** **Medical emergency arrangements were ineffective. The arrangements were not in line with GDC standards and Resuscitation Council UK guidance.** • During the routine check of the medical emergency kit it was identified that there were no needles or syringes to be able to deliver emergency adrenaline in the event of anaphylaxis. Glucagon was stored unrefrigerated in the kit and the expiry date had not been changed in line with the manufacturer's instructions. • There was no paediatric self-inflating bag/mask, the required range of oropharyngeal airways were not available and two were unpouched. • The required range of oxygen masks were not available. • Expired oxygen masks were kept alongside new masks. • Staff did not know how to operate the emergency medical oxygen and did not recognise what the portable suction device was, or what it was for. The induction only included the location of the kit, and not familiarising staff with it. **Arrangements for medicine control required improvement.** • Local anaesthetic cartridges which expired in November 2017 were found in the downstairs surgery drawer ready for use. We were told this surgery was in regular use. • The prescription logging system would not identify if a prescription was missing. • There was a lack of awareness of the yellow card reporting system or sepsis.

This section is primarily information for the provider

Requirement notices

The processes for incident reporting and investigation were ineffective.

- A review of the incidents showed that these were poorly recorded. For example, some incidents in the accident book were not acted on and there was no evidence these were investigated and followed up appropriately, particularly after staff received sharps injuries.
- We were informed of incidents that had occurred but not been recorded and acted on.
- There was a lack of hazardous substance control. An incident involving a hazardous substance had occurred on 27 June 2018. There was no COSHH assessment carried out on this solution before it was put into use despite staff stating the labelling of the product was not clear. The COSHH risk assessment for the new solution now being used was incomplete as it only stated the risks and action to be taken after splashes to eyes or ingestion. It did not include how the product is to be stored or used safely and the product safety data sheet was not available.

Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular:** • The safeguarding policy was generic and did not identify lead roles, or specify local arrangements for safeguarding. • The practice did not ensure that staff completed safeguarding training to the appropriate level or updated their training at appropriate intervals. Evidence of training was only seen for seven members of staff. There was no evidence that the induction included ensuring staff were familiarised with safeguarding arrangements. • The registered person did not access safeguarding advice or resources, or work in partnership with other relevant bodies to enable staff to highlight patients

This section is primarily information for the provider

Requirement notices

living in vulnerable circumstances. For example, where children were not brought to appointments, clinical advice was not followed, or family circumstances such as drug use was suspected.
- Information about current procedures and guidance about raising concerns about abuse was not accessible to staff. For example, there was no information relating to areas of safeguarding highly relevant to the population and area, including Female Genital Mutilation, domestic violence, trafficking and modern slavery.

Regulation 13(1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **The registered person had failed to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. In particular:** • An incident had occurred on 27 June 2018. There was no evidence that the registered person had ensured that a full investigation was carried out or taken appropriate action to provide the patient affected with a full explanation of, and apology for the incident that occurred on the above date. Regulation 20(1)

This section is primarily information for the provider

Enforcement actions

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 **The registered person had systems or processes in place that operated 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 established effective systems and processes to ensure good governance in accordance with the fundamental standards of care.** • Many policies were generic, undated or out of date, not personalised to the practice, and lead roles were not identified. Several policies (IPC, recruitment, health and safety, RIDDOR and incident reporting) could not be found. • Opportunities had been missed to review the governance and safety systems during the annual self-assessment process that was required by the dental foundation training programme. • There was no system to receive patient safety alerts and the registered person was not aware of these. **The registered person had systems or processes in place that operated 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.** • The registered person had not ensured that appropriate equipment and training was provided to respond to medical emergencies. The systems for checking the availability of medical emergency kit had failed to identify missing or expired items. • Health and safety risks had not been assessed in the premises. We noted on both days that the signed fire door at the rear of the practice was partially blocked by a chair and staff struggled to undo the bolts on this door.

This section is primarily information for the provider

Enforcement actions

- There was a lack of effective system for risk assessing hazardous substances. The registered person had not ensured a thorough review of hazardous substances used in the practice after the incident.
- Incidents, including sharps injuries were poorly documented. There was a lack of effective investigation and following up of individuals after sharps incidents. We were told of incidents that had occurred, but had not been recorded or acted on in a timely way.
- Staff had not identified and removed expired medicines. Systems were not effective to ensure the security of NHS prescriptions.
- Systems were not in place to ensure that public liability insurance was up to date until the company was contacted and evidence of a current policy provided.

There was additional evidence of poor governance. In particular:

- Infection prevention and control audits (which are required on a six-monthly basis) had not been carried out since March 2017.
- Evidence and information was not available to provide assurance that key tasks were carried out effectively until individual staff members could be spoken to. For example, Legionella and protein residue testing, and the individuals tasked with carrying out medical emergency equipment checks were appropriate to do so.
- There was no privacy impact assessment or information governance processes in place for the CCTV in the reception, waiting rooms and external to the front and rear of the property.
- Verbal complaints were not documented and there was no evidence that formal complaints were documented, investigated and responded to appropriately and in a timely way.
- The lack of evidence that staff are up to date with training- evidence of up to date life support, infection prevention and control and radiographic update (IR(ME)R) training was not requested from staff.
- The practice had failed to ensure that staffs' personal information was held securely. During the inspection, a loss of personal information from staff files was brought to light.

Regulation 17(1)

This section is primarily information for the provider

Enforcement actions

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

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:

- Staff files were incomplete, the practice manager was unable to find some of the evidence requested. For example, DBS checks, evidence of identification, indemnity and immunity. Due to the poor organisation of staff files, the practice was unable to correctly identify the information that was missing.
- DBS (or risk assessments) were not carried out on all new members of staff. Nine new members of staff did not have a DBS carried out at the point of employment.
- There was no evidence that a right to work check had been carried out on one member of staff. They did not know if the college that the individual had enrolled with had carried out any checks.
- Current references were not consistently sought for new members of staff.
- The provision of preliminary training contracts was inconsistent, some new members of staff were not provided with a contract. It was unclear whether some members of staff who were listed as trainee dental nurses in the staffing matrix had commenced employment as there were no terms of the arrangements of their employment or work experience in the staff files.
- Evidence of appropriate immunity to Hepatitis B was not available for seven members of clinical staff. Five staff members had received the vaccinations but had not been asked to provide evidence that these had provided adequate protection; One trainee dental nurse had evidence of two vaccinations in November 2017 only, and there was no evidence that a dentist had received the vaccinations.
- The induction process was inconsistent and insufficient to ensure new members of staff were prepared to work

This section is primarily information for the provider

Enforcement actions

safely in the practice. For example, it did not include safeguarding or familiarity with emergency equipment. A dental nurse who commenced work in July 2018 had a blank induction checklist in their file.

Regulation 19(3)