Guildford Health Limited

Guildford Dental Centre

Inspection Report

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Overall summary

We carried out this announced inspection on 10 March 2020 under Section 60 of the Health and Social Care Act 2008 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 Care Quality Commission, (CQC), inspector who was supported by a specialist dental adviser.

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 this practice not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Guildford Dental Centre is in Guildford and provides private dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice.

The dental team includes four dentists, one dental nurse, three trainee dental nurses, one dental hygienist and one receptionist. The practice has four treatment rooms.

The practice is owned by a company and as a condition of registration must have a person registered with the

Summary of findings

CQC 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 Guildford Dental Centre is the principal dentist.

On the day of inspection, we collected 13 CQC comment cards filled in by patients and spoke with two other patients.

During the inspection we spoke with three dentists, one dental nurse, three trainee dental nurses, and one dental hygienist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Mondays to Fridays 8am to 5pm

Our key findings were:

- The practice appeared to be visibly clean and well-maintained. Staff knew how to deal with emergencies.
- The provider had staff recruitment procedures which reflected current legislation.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had information governance arrangements however these were ineffective.
- The provider must ensure the following:
- Infection prevention and control procedures are line with guidance.
- Emergency equipment is provided in line with guidance.
- Conscious sedation is carried out in accordance with guidance,
- Control of substances hazardous to health file is completed in line with guidance.
- Medicines fridge temperature monitoring implemented.
- Removal of out of date medicines and medical equipment.
- Dental care records are correctly completed.
- A full range audits including dental implants, sedation, antibiotic prescribing, radiographs and infection prevention control are implemented.
- A central referral monitoring system is implemented.
- An effective staff appraisal system is implemented in line with guidance.

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

We are mindful of the impact of COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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

Enforcement action 

Are services effective?
We found this practice was not providing effective care in accordance with the relevant regulations.

Enforcement action 

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

No action 

Are services responsive to people's needs?
We found this practice was providing responsive care in accordance with the relevant regulations.

No action 

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

Enforcement action 

Are services safe?

Our findings

We found 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 enforcement actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

Staff did not have clear systems to keep patients safe.

Dentists knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances, but trainee staff were not so certain as they had not been trained. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse, but these had not been communicated to staff. We saw evidence that the dentists had received safeguarding training. The dentists knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC but this was not evidenced for all staff.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records, however this had not been communicated to staff.

The provider had an infection prevention and control policy and procedures, but staff told us that they were unaware of this policy. The staff did not follow 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. The provider had not ensured that infection prevention and control policy and procedures were effective. Six of the ten staff were trainee dental nurses at the practice and had started within the last six months. The provider had not ensured the trainee staff received adequate support to effectively complete decontamination procedures correctly.

We saw that staff were not completing decontamination logs, we did not see staff wearing face masks during the decontamination process, nor completing handwashing prior to starting decontamination. There was no lint free cloth available for drying decontaminated instruments. We saw a very worn out long handled scrubbing brush was being used to clean equipment and was inadequate to clean instruments.

We also saw that staff were carrying out decontamination cleaning using only water, and not using an appropriate medical cleaning solution for the process. The use of these decontamination methods were not adequate in ensuring infection prevention and control, and had the potential to place patients at risk.

The provider arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05 was not effective. The records showed equipment used by staff for cleaning and sterilising instruments was maintained but not validated in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff; however measures were not in place to ensure they were decontaminated and sterilised appropriately.

The staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised the provider that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of injury from a sharp instrument.

The staff were not aware of how to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was complete. The staff told us the provider had not told them how to deal with this situation. We did see that there was a practice policy dealing with the issue of decontaminating dental appliances but staff told us that they were unaware of this policy

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations in the assessment had been actioned and records of water testing and dental unit water line management were maintained. The provider told us that the buildings' owner intended to shortly complete significant building changes and that, consequently, the legionella risk assessment would be replaced with a newer version.

Are services safe?

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected, we saw the practice was visibly clean.

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

The provider showed us an infection control and infection prevention and control audit from June 2019 there were no other audits available or in progress. The 2019 audit showed the practice was meeting the required standards, however we identified that this was not currently the case. The audit should have identified that staff were not completing decontamination processes in line with guidance. Guidance recommends that an infection prevention and control audit take place every six month to identify service deficiencies so that they may be remedied.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

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

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at all staff recruitment records. These showed the provider followed their recruitment procedure.

We observed clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

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

A fire risk assessment was carried out in line with the legal requirements. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. Considerable building changes were being planned by the building's owner and as a consequence the fire risk assessment was going to be reviewed in line with those changes.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available.

We found only one of the dentists at the practice justified, graded and reported on the radiographs they took. The provider did not ensure all dentists carried out radiography audits every year following current guidance and legislation. The lack of an effective quality assurance processes increased the risk to patients by not identifying service deficiencies so that they may be remedied.

Clinical staff completed continuing professional development in respect of dental radiography.

The practice had a cone beam computed tomography X-ray machine. Staff had received training in the use of it and appropriate safeguards were in place for patients and staff.

Risks to patients

The provider did not have systems to assess, monitor and manage risks to patient safety.

The practice health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. When we spoke to staff about health and safety policies, procedures and risk assessments staff told us that they were unaware of these documents, which are intended to protect the patients and staff from workplace dangers. The provider had current employer's liability insurance.

We looked at the practice arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Staff had completed sepsis awareness training. Sepsis prompts for staff and patient information posters were not displayed throughout the practice. Sepsis display materials help to ensure staff make triage appointments effectively to manage patients who presented with a dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and

basic life support every year. There was only evidence that the principal dentist had undergone Immediate Life Support training with airway management for staff providing treatment under sedation; there was no evidence that this had also been completed by the other staff who supported sedation.

Emergency equipment and medicines were not available as described in recognised guidance. We found staff did not keep records to make sure these were available, within their expiry date, and in working order. We found two medicines which were not stored according to guidance and could potentially have caused risks to patients. There was no size zero oropharyngeal airway (the smallest size), the adult self-inflating bag with reservoir was present but would not inflate. We could not be shown a secondary oxygen cylinder, as recommended in guidance, for when sedation was carried out. The provider told us immediate arrangements would be made to rectify these deficiencies immediately.

A dental nurse worked with the dentists and the dental hygienist when they treated patients in line with General Dental Council Standards for the Dental Team. A risk assessment was in place for when the dental hygienist worked without chairside support.

We reviewed the Control of Substances Hazardous to Health (COSHH) Regulations 2002 file and saw that ten material safety data sheets were missing or out of date when newer versions were available, not all products had been risk assessed to minimise the risk that can be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Staff did not have 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 four dental care records with clinicians to corroborate our findings and observed that individual dental care records were typed. The dental care records we looked at did not reflect guidelines in that there was no evidence recorded of periodontal conditions. Two of the dental care records we looked at related to sedation and did not reflect a contemporaneous record of the process.

The principal dentist told us the records of the sedation treatment were made but destroyed after the treatment was completed. The lack of an effective system to record patient care records could increase the risk to patients.

The provider had no central referral monitoring systems for referring patients with suspected oral cancer under the national two-week wait arrangements. This placed patients at risk of urgent referrals being lost. The practice was aware of the new electronic portal for referring patients. These arrangements were initiated by NICE to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

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

There was no stock control system of medicines which were held on site. Such a system would ensure that medicines and associated medical equipment to deliver medicines did not pass their expiry date. We found a considerable amount of out of date medicines and related equipment to deliver medicines throughout the practice, in treatment rooms, desks and storage areas. The lack of a stock control system increased the risk of the accidental use of out of date materials or equipment and could have placed patients at risk. One of the dentists told us that they purchased their own dental materials to remove the possibility of causing patient harm.

Medicines were not always stored according to guidance, for example we found Gulcagon, an emergency medicine was being stored in an unmonitored fridge. If the temperature of medicines is not monitored this can cause a risk to patients.

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

Antimicrobial prescribing audits were not carried out annually. The antimicrobial audits should confirm that the dentists were following current guidelines and are required by guidance and increased the risk to patients by not identifying service deficiencies so that they may be remedied.

Track record on safety, and lessons learned and improvements

The provider had not implemented systems for reviewing and investigating when things went wrong. There were

Are services safe?

comprehensive risk assessments in relation to safety issues but these had not been communicated to staff. Staff did not monitor or review incidents. The monitoring and reviewing of incidents should help staff to understand the potential risks and lead to effective risk management systems in the practice as well as safety improvements.

In the previous 12 months there had been no safety incidents. Staff told us that any safety incidents should be investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

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

We have taken urgent enforcement action and served a notice of decision to impose conditions on the provider's registration in respect of regulated activities. We have taken this urgent action, as we believe a person will or may be exposed to the risk of harm if we do not do so.

We have imposed the following condition:

- The registered provider must not carry out conscious sedation of service users for the purposes of dental treatment without the prior written agreement of the Care Quality Commission.

We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice. Whilst clinicians told us they assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols this was not evidenced in the dental care records we saw.

The practice offered conscious sedation for patients. This included patients who were very anxious about dental treatment and those who needed complex or lengthy treatment. The provider gave us a written and verbal undertaking that they would not provide further conscious sedation services, or use an external service, until they were completely confident that these were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

We looked at two sedation dental care records. The dental care records indicated gaps in monitoring. The provider told us that contemporaneous monitoring of patients took place, but these notes were destroyed after the treatment and not appended to dental care records. Therefore, we could find no technical details of titrated medication used, recovery issues or discharge notes. We also looked at records of medicines issued to patients' and found these did not match records in patient dental care records during the sedation process.

Some of the needles, syringes and intravenous lines we found in the treatment room to deliver those medicines were out of date. The provider told us they brought the equipment they needed for sedation but were unable to show us evidence of this. We found there were no sedation trained nurses at the practice as required in guidance to support the procedure.

The practice had not undertaken an audit of sedation treatments as recommended in guidance. A sedation treatment audit helps a practice to ensure that it is providing safe treatment and remedy any issues identified.

The practice did not have a second emergency oxygen supply which is recommended when carrying out sedation. The practice did not have the reversal agent Flumazenil which is also required in sedation guidance. Flumazenil is a reversal agent used during sedation to reverse the effects of sedation medicines in an emergency situation. We found a number of out of date medicines in the providers treatment room, including metronidazole and diazepam and intravenous equipment. This created the potential for out of date medicines and equipment to be used on a patient.

The two dental care records we looked at for sedation did not include notes about emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training, monitoring during treatment, discharge and post-operative instructions.

The patient care records we saw did not record that the operator-sedationist was supported by a trained second individual.

The practice offered dental implants. These were placed by the principal dentist who had undergone appropriate post-graduate training in the provision of dental implants. We saw the provision of dental implants was not in accordance with national guidance. We could not be shown any sterile gowns, drapes or gloves, nor equipment servicing information, or purchase/servicing information for the surgical drill unit.

Are services effective?

(for example, treatment is effective)

The practice had not undertaken any dental implant audits as recommended in guidance. A dental implant audit helps a practice ensure that it is providing safe treatment and remedy any issues identified.

Helping patients to live healthier lives

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

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

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

Staff told us that patients with severe gum disease were recalled at more frequent intervals for review and to reinforce preventative advice although this was not adequate record in four dental care records we saw.

Consent to care and treatment

Staff told us they obtained consent to care and treatment in line with legislation and guidance, although this was not adequately recorded in the patient care records we saw.

The practice team told us they understood the importance of obtaining and recording patients' consent to treatment. The staff told us they were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentists told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this information was not well documented in four dental care records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice consent policy included information about the Mental Capacity Act 2005. The team told us they understood their responsibilities under the act when treating adults who might not be able to make informed decisions but were not aware of the practice consent policy. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age, but had not seen the policy.

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 dental care records which did not fully reflect FGDP guidelines. FGDP guidelines provide a framework for clinical examination and record keeping for primary dental care practitioners. We found four records which did not reflect periodontal issues and or fully reflected sedation procedures. The dental care records we looked at did not contain information about the patient's current dental needs, past treatment and medical history. The dentists should assess patient's treatment needs in line with recognised guidance.

The provider had limited quality assurance processes to encourage learning and continuous improvement. There were no X ray and dental care records audits for two dentists. The provider had carried out a dental care record audit on himself, but it had not identified any issues as we found in patient dental care records for sedation. The provider had not completed sedation or implant audits as recommended in guidance. The lack of an effective quality assurance process increased risks to patients by not identifying service deficiencies so that they may be remedied.

Effective staffing

We found some staff did not have the skills, knowledge and experience to carry out their roles.

Staff new to the practice did not have an effective structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

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

Are services effective?

(for example, treatment is effective)

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

Are services caring?

Our findings

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

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.

Patients commented positively that staff were efficient, caring and professional. We saw staff treated patients respectfully and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Information folders were available for patients to read.

Privacy and dignity

Staff 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 privacy when reception staff were dealing with patients. If a patient asked for more privacy, the practice would respond appropriately. 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, but this did not include sedation care records which were destroyed after completion of treatment.

Involving people in decisions about care and treatment

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

the requirements of the Equality Act. The Equality Act is a requirement to make sure that patients and their carers can access and understand the information they are given. We saw:

- Interpreter services were available for patients who did not speak or understand English. Patients were also told about multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way they could understand, and communication aids and easy-read materials were available.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Staff 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 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 X-rays which enable an image to be taken of the tooth being examined or treated and 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

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

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 about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of support which may be needed by more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

Patients described high levels of satisfaction with the responsive service provided by the practice.

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service.

- 13 cards were completed, giving a patient response rate of 26%
- 100% of views expressed by patients were positive.

Common themes within the positive feedback were professional and effective staff, friendliness of staff and easy access to dental appointments.

We were able to talk to two patients on the day of inspection. Feedback they provided aligned with the views expressed in completed comment cards.

The practice currently had no patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made reasonable adjustments for patients with disabilities, this included step free access.

The practice had not undertaken a disability access audit. ADisability Access Auditthelps a practice to improve facilities for disabled people.

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 an urgent appointment were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The staff took part in an emergency on-call arrangement with the dentists working in the practice and patients were directed to the appropriate out of hours service.

The practice website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

Staff told us the provider took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

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

The principal dentist was responsible for dealing with complaints. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients could receive a quick response.

The principal dentist aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the principal dentist had dealt with their concerns.

We looked at comments, compliments and complaints the practice had received February 2019.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

We found 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 enforcement actions section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found the principal dentist did not have the capacity, values and skills to deliver high-quality, sustainable care; and were not knowledgeable about the issues and priorities relating to the quality of the service. The lack of provider leadership increased the risk to patients by not identifying service deficiencies so that they may be remedied.

Culture

The practice did not have a culture of high-quality sustainable care.

Staff stated they did not feel respected, supported and valued. They were not proud to work in the practice.

Six of the ten staff were trainee dental nurses at the practice and had started within the last six months and not discussed their training needs. Two other staff had not had annual appraisal at the time of our inspection. The dentists had not recorded, or discussed their training needs with the provider, in an appraisal.

We saw the provider did not have systems in place to deal with poor staff performance.

Openness, honesty and transparency were demonstrated by staff but there were no records of responding to incidents and complaints to confirm this. The provider was aware of, and but no systems in place, to ensure compliance with the requirements of the Duty of Candour.

Staff told us they did not feel they could raise concerns or were encouraged to do so. They did not have confidence these would be addressed.

Governance and management

Staff did not have clear responsibilities, roles and systems of accountability to support good governance and management.

The registered manager, who was the principle dentist, had overall responsibility for the management and clinical leadership of the practice. The principal dentist was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures and were reviewed regularly. We found that the provider did not communicate these documents to staff.

We saw there were no clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

Staff did not act on appropriate and accurate information.

Quality and operational information was not available for use in ensuring and improving performance. Performance information was not combined with the views of patients.

The provider had information governance arrangements and staff were aware of the importance of protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Staff did not involve patients, the public, staff and external partners to support the service.

The provider encouraged verbal comments to obtain and patients' views about the service, but there were no records made of the comments made.

The provider did not gather feedback from staff through meetings and informal discussions. Staff were not encouraged to offer suggestions for improvements to the service and said these were not listened to and acted upon.

Continuous improvement and innovation

The provider had limited quality assurance processes to encourage learning and continuous improvement. Not all staff were included in audits of dental care records, radiographs and infection prevention and control. As a result there were no clear results of these audits and the resulting action plans and improvements. The lack of an effective quality assurance process increased risks to patients by not identifying service deficiencies so that they may be remedied.

Are services well-led?

The provider's quality assurance processes had not ensured that guidance was followed, implemented, or provided for infection control procedures, emergency medicines and equipment, conscious sedation, dental implants, control of substances hazardous to health, medical fridge storage monitoring, dental care records, audited quality assurance processes, central referral monitoring system and staff appraisals. These issues could impact on patient safety and put patients at risk by not identifying service deficiencies so that they may be remedied.

Staff completed 'highly recommended' training as stated in the General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12** **Safe care and Treatment** 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. The registered person had systems or processes in place that were ineffectively operated 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 provider must ensure that the practice's infection control procedures and protocols are carried out in accordance with 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 guidance'. • The provider must ensure that patient specific dental appliances are disinfected prior to being sent to a dental laboratory and upon return. • The provider must ensure that emergency equipment and medicines are available as described in recognised guidance. The provider must ensure there is an effective system of checks of medical emergency equipment and medicines taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.

This section is primarily information for the provider

Enforcement actions

- The provider must ensure that medicines and equipment are disposed of when they pass their expiry date.
- The provider must ensure that the provision of dental implants are carried out in accordance with national guidance.
- The provider must ensure that the protocols for conscious sedation are followed and appropriate patient care records made, medical equipment provided, and staff suitably trained taking into account the guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17** **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. 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 provider must implement quality assurance processes to encourage learning and continuous improvement. These include audits of dental implants, sedation treatments, disability access, radiographs and infection prevention and control in accordance with guidance.

This section is primarily information for the provider

Enforcement actions

- The provider must ensure that the Control of Substances Hazardous to Health (COSHH) Regulations 2002 file contains the relevant information for all substances where risk can be caused to health.
- The provider must ensure that dental care records are completed in accordance with FGDP guidance.
- The provider must ensure that six monthly infection prevention and control audits are carried out in accordance with guidance.
- The provider must implement an effective system for monitoring and recording the fridge temperature to ensure that medicines and dental care products are being stored in line with the manufacturer's guidance.
- The provider must implement a performance review system and have an effective process established for the on-going assessment and supervision of all staff.
- The provider must implement an effective system for identifying, disposing and replenishing of out-of-date stock.
- The provider must implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

Regulation 17(1)