Quality Life Centre Ltd

Quality Life Medical Centre

Inspection Report

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Date of inspection visit: 9 and 16 November 2018
Date of publication: 14/05/2018

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced comprehensive inspection of Quality Life Medical Centre over two days on 9 and 16 November 2017. This inspection was carried out 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 within the Health and Social Care Act 2008 and associated regulations after identifying concerns in governance arrangements at Quality of Life Medical Centre, a separate location registered to the provider.

We found Quality Life Medical Centre was not providing safe, effective and well led services in accordance with the relevant regulation.

The inspection was led by a CQC inspector who was supported by a second inspector and 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 that this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was not 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

Summary of findings

Quality Life Medical Centre, also known as House of Smiles Private Dental Clinic, is located in the London Borough of Haringey and provides private treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including for patients with disabled badges, are available on public roads, near the practice.

The dental team consists of one dentist and one trainee dental nurse who is a qualified practice nurse in primary health care. The service employs three further dentists on an appointment by appointment basis when certain areas of expertise are required for a patient's care or treatment. The practice has two treatment rooms although only one of these is currently equipped to carry out treatments. Reception and administrative functions are carried out by the principal dentist and the trainee dental nurse.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. At the time of the first inspection visit, the registered manager at Quality Life Medical Centre was the same person that was the registered manager at Quality of Life Medical Centre. This person did not hold any qualifications in dentistry.

On 10 November 2017, following the inspection at Quality of Life Medical Centre, because of serious concerns, we applied to Haringey Corner Magistrates Court for an urgent order to cancel the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre. This order was granted under Section 30 of the Health and Social Care Act 2008 and had the effect of cancelling the registration of the registered manager at Quality of Life Medical Centre and Quality Life Medical Centre. On 10 November 2017, the provider was also issued with an urgent Notice of Decision under Section 31 of the Health and Social Care Act 2008 to impose urgent conditions that the registered provider must not carry out any regulated activities at 573 Green Lanes, London, N8 0RL. The provider had the right to make an appeal against this decision to the First-tier Tribunal (Health, Education and Social Care Chamber), under Section 32(1) of the Health and Social Care Act 2008, within 28 days of the date of the notice. The provider did not exercise the right to appeal.

During the first inspection visit, we spoke with person who was the registered manager at the time. We also spoke with the dentist and the trainee dental nurse during both days of the inspection. We looked at practice policies and procedures and other records about how the service is managed.

Our key findings were:

- The registered manager of the service could not demonstrate that they had the experience, capacity or capability to run the service safely or ensure high quality care.
- There was no evidence the service used learning from incidents and complaints to help them improve.
- Safeguarding protocols in place contained incorrect contact information for the local safeguarding authority and staff had not received training in safeguarding children or adults.
- Processes in place to manage infection prevention and control were not effective and staff had not received training around infection control.
- Arrangements in place to manage clinical waste did not keep people safe.
- The practice had a staff recruitment policy and procedure to help them employ suitable staff but records we saw showed that this policy was not always followed.
- There was no evidence that clinical staff had completed the continuous professional development required for their registration with the General Dental Council.
- The provider, of which the service was a registered location, was in breach of Section 42 (1) of the Dentist Act 1984 as the single director of the provider organisation was not a registered dentist or a registered dental care professional.
- The service could not demonstrate how emergencies would be managed. Life-saving equipment had not been checked to ensure it would be ready for use when it was required.
- Systems in place to manage risk were not effective.

We identified regulations the provider was not meeting. They must:

Summary of findings

- 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.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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 at the end of this report).

Systems and processes to provide safe care and treatment were not effective. There was no evidence the service used learning from incidents and complaints to help them improve.

Although staff were able to describe how to recognise the signs of abuse, there was no evidence they had received training in safeguarding. Safeguarding protocols in place contained incorrect contact information for the local safeguarding authority.

The treatment room and equipment were clean and properly maintained but the service did not follow national guidance for cleaning, sterilising and storing dental instruments.

The practice had infection control systems and processes in place including an infection control policy, regular checks on equipment, however no infection control audits were being undertaken and there was no evidence of staff training for infection control.

Processes in place to manage clinical waste did not comply with current guidance. For instance, the registered manager collected clinical waste bags and carried these by hand to another location for which they were also the registered manager. This involved walking along a busy thoroughfare which meant there was a risk that the integrity of the waste receptacle could be compromised and put members of the public at risk.

Arrangements for dealing with medical and other emergencies were not effective. For instance, the service had an automated external defibrillator but this was of a type which had been the subject of a medical device alert and had been recalled by the manufacturer. The service did not have a process in place to carry out regular checks on the device to ensure it would be suitable for use in an emergency and staff had not been trained in its use. We checked the defibrillator device and found that the batteries were not charged which meant it would not have been available for use in any event.

The practice had a staff recruitment policy and procedure to help them employ suitable staff but records we saw showed that this policy was not always followed. For instance, we looked at five recruitment files and found that required identity checks and Disclosure Barring Service (DBS) checks had not been carried out for staff who worked at the service.

There were no up to date health and safety policies to help manage potential risk.

Requirements notice 

Summary of findings

Are services effective?

Requirements notice 

We found that this practice was not providing effective 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 at the end of this report).

Staff records were incomplete which meant that we were unable to confirm that clinical staff had completed the continuous professional development required for their registration with the General Dental Council.

There was no evidence that the practice had undertaken quality improvement activity, for instance, clinical audits, as part of a system of continuous improvement and learning.

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.

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

Are services caring?

No action

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

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

The service gave told us they gave patients clear information to help them make informed choices. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The service displayed information in the waiting area which gave details of the dental services provided. Staff told us they took the time to explain the treatment options available.

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 was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to telephone interpreter services and had arrangements to help patients with sight or hearing loss.

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

Summary of findings

Are services well-led?

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 at the end of this report).

The provider, of which the service was a registered location, was in breach of Section 42 (1) of the Dentist Act 1984 as the single director of the provider organisation was not a registered dentist or a registered dental care professional.

During the inspection, the registered manager of the service could not demonstrate that they had the experience, capacity or capability to run the service safely or ensure high quality care. Although they told us they prioritised safe, high quality and compassionate care, we found that they lacked the knowledge to manage significant aspects of the safety and quality of the services provided and did not have an adequate insight into the challenges faced by the service.

The registered manager could not demonstrate an awareness of the requirements of the duty of candour and did not have systems in place to ensure compliance with the duty. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

The service did not have a full complement of policies, procedures and risk assessments necessary to support the management of the service and to protect patients and staff.

The practice was not undertaking annual radiography audits in line with current guidance.

There was no evidence available to demonstrate staff were working towards completing the required number of continuous professional development hours to maintain their professional development in line with the requirements set by the General Dental Council (GDC).

Requirements notice ✖

Quality Life Medical Centre

Detailed findings

Background to this inspection

We inspected Quality Life Medical Centre over two days, 9 November 2017 and 16 November 2017. The inspection visit on 9 November was led by a CQC Lead Inspector and included a second CQC Inspector. The inspection visit on 16 November was led by a CQC inspector, supported by a second inspector and included a Dentist specialist adviser.

During our visit we:

- Spoke with a range of staff (registered manager, principle dentist, traines dental nurse).
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the service used to deliver care and treatment plans.

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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff we spoke with were able to describe how they would manage significant events but the practice did not have written policies or procedures in place to support the reporting, investigation, and learning from accidents, incidents and significant events. There were no records to demonstrate that the practice recorded, responded to or discussed incidents to reduce risk and support future learning. Staff did not understand the process for the reporting of incidents and accidents through Reporting of Injuries, Disease and Dangerous Occurrences regulations 2013 (RIDDOR).

There was no process in place to ensure the practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were discussed with staff, acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. However, the practice did not have up to date safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. For instance, we were shown two different versions of a safeguarding policy, neither of which contained the correct details for the local safeguarding authority. There was no evidence to show that staff received safeguarding training appropriate to their role. The practice did not have had a whistleblowing policy.

We looked at the practice's arrangements for safe dental care and treatment. For instance, the dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. A rubber dam is a thin rectangle sheet usually latex rubber used in dentistry to isolate the operative site from the rest of the mouth.

The practice did not have a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice.

Medical emergencies

We were told that as the service had been open for less than a year, no member of staff had been yet been trained in training in emergency resuscitation and basic life support by the service. Staff we spoke with were able to describe how they would manage medical emergencies but told us this training had been provided in previous employments.

We reviewed emergency equipment at the service and found that although oxygen was available, there were no paediatric masks to treat children in an emergency. The service had an Automated External Defibrillator but this had not been checked and staff had not been trained in its safe use. We noted that the device had been the subject of a medical device alert issued by the MHRA and this particular model had been recalled due to a defect which could cause the device to fail. However, staff did not have access to medical safety alerts and were unaware that the device could be unfit for purpose when it was needed. The provider maintained a stock of emergency medicines which reflected the regulated activities carried out and these were all within expiry date, however we found that one item which required refrigeration was stored in a refrigerator which was also used to store food and there was no temperature monitoring of this refrigerator.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff but records we saw showed that this policy was not always followed. For instance, we looked at five recruitment files and found that required identity checks and Disclosure Barring Service (DBS) checks had not been carried out for staff who worked at the service. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Clinical staff were qualified and registered with the General Dental Council (GDC), however, staff files were incomplete and copies of professional indemnity cover arrangements were not stored for all staff.

Monitoring health & safety and responding to risks

The practice carried out some risk assessments with a view to keeping staff and patients safe. For examples risk assessments undertaken included Control of Substances Hazardous to Health (COSHH), however, a fire risk

assessment had not been completed, there had been no regular checks on the fire alarm, emergency lighting or firefighting equipment and no fire drills had been carried out.

The were no up to date health and safety policies to help manage potential risk.

Infection control

The reception area and treatment rooms were clean and well maintained at the time of our inspection however we found that the patient and staff toilet within the practice was dirty and cleaning products were stored within the toilet facilities which posed a hazard to patients who may come in contact with these. We discussed this issue with staff and the cleaning products were then transferred to be stored appropriately There were also no Control of Substances Hazardous to Health (COSHH) safety data sheets for the cleaning products used.

We reviewed cleaning arrangements at the location and found that there was only a single mop available for cleaning clinical and non-clinical areas of the premises. It is recommended to use different cleaning equipment to prevent cross contamination between clinical and non-clinical areas. A risk assessment had not been carried out for staff who are unknown responders to the Hepatitis B vaccination who are carrying out exposure prone procedures.

The practice had infection control systems and processes in place including an infection control policy, regular checks on equipment, however no infection control audits were being undertaken and there was no evidence of staff training for infection control. There were protocols in place for the safe management, segregation of clinical, non-clinical, and used sharp instrument waste. The dentist and trainee dental nurse we spoke with were aware of the Sharps Instruments in Healthcare Regulations 2013 and were able to describe the procedure to follow in the event of a sharps injury. However, arrangements for the management of sharps boxes and the disposal of clinical waste were not in line with current guidance. None of the sharps boxes were labelled with the start date of use. It is recommended that sharps boxes are disposed of within three months of use or earlier if the sharps box is two thirds full. We were told that the registered manager collected clinical waste bags and carried these by hand to another location for which they were also the registered manager. This involved walking along a busy thoroughfare which meant there was a risk that the integrity of the waste receptacle could be compromised and put members of the public at risk.

There were no arrangements in place to ensure that spillages of bodily fluids, including blood and vomit, could be safely cleaned. There were no biohazard spillage kits available for staff to use and we found that a Legionella risk assessment had not been completed. (Legionella is a bacterium that can grow in contaminated water and can be potentially harmful).

The practice followed the majority of essential requirements for infection control as set out in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05; National guidance from the Department of Health for infection prevention control in dental practices).

A separate area was available for decontamination of used instruments. Instruments were transported between the treatment rooms and the decontamination room in designated containers. Personal protective equipment such as gloves, masks and eye protection were provided for staff to use. Staff showed us the steps they would undertake while cleaning and decontaminating instruments. This was in accordance with the procedure for decontamination of instruments which was displayed for staff to follow.

A clear flow from dirty to clean area was maintained to minimise infection risks however clearly designated dirty and clean areas within the treatment rooms were not marked. A separate sink was available for rinsing instruments. An illuminated magnifier was used to inspect the instruments to check the effectiveness of the decontamination process. Sterilized instruments awaiting usage were stored in clear pouches however our inspection found the pouches were not dated. HTM01-05 defines the storage time of pouched instruments to be one year providing the pouch is not damaged in any way. Therefore, it would be difficult to know how long instruments had been stored without the date being recorded. The practice protocol for sterilising and storing of dental instruments stated pouches should be dated. We discussed this with staff who made arrangements to date all further pouches of instruments.

Are services safe?

Staff showed us the various checks that were undertaken on equipment such as the autoclave and the ultrasonic bath. Staff followed recommended protocols to manage the dental unit water lines (DUWL).

Equipment and medicines

We found that the equipment used at the practice had been recently procured as new and had been well maintained since installation. The practice maintained a list of equipment including dates when maintenance contracts were renewed. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner. For example, we saw documents showing that the X-ray equipment had been inspected and serviced. With the exception of the AED, all of the electrical equipment was less than one year old which meant that Portable appliance testing (PAT) had not yet been undertaken. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the radiography equipment. They met current radiation regulations and had the required information in their radiation protection file.

We saw evidence that the dentist justified, graded and reported on the radiographs they took. The practice was not carrying out radiography audits in line with current guidance.

Clinical staff had undertaken continuous professional development in respect of dental radiography.

<Summary here>

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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 that the practice audited patients' dental care records to check that the dentists recorded the necessary information.

There was no evidence that the practice had undertaken quality improvement activity, for instance, clinical audits, as part of a system of continuous improvement and learning.

Health promotion & prevention

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

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

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

Staffing

The service had a structured induction programme for newly employed staff. We noted that staff records were incomplete which meant that we were unable to confirm that clinical staff had completed the continuous professional development required for their registration with the General Dental Council. We discussed this with the principal dentist who told us that with the exception of themselves, all other dentists were employed on a part time basis and only attended for individual appointments where their specialist skills were required. All of these clinicians held substantive employment with other dental providers. We were also told that the service was less than a year old which meant that no dentist had yet completed a full year of employment.

As the service had been in operation for less than a year, annual appraisals had not yet taken place; however, staff told us they discussed training needs during informal meetings.

Working with other services

Dentists confirmed they would refer patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This would include 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.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

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. The policy also referred to Gillick competence and the dentist and trainee dental nurse were aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

<Summary here>

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave 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.

We observed staff spoke politely to patients over the telephone and took steps to ensure confidentiality was maintained.

Staff told us doors were always closed when patients were in the treatment room. The treatment room was situated away from the waiting area so conversations could not be overheard.

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Involvement in decisions about care and treatment

The service gave told us they gave patients clear information to help them make informed choices. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The service displayed information in the waiting area which gave details of the dental services provided. Staff told us they took the time to explain the treatment options available. They spent time answering patient's questions and gave patients a copy of their treatment plan. Each treatment room had a screen so the dentists could show patients photographs, videos and X-ray images when they discussed treatment options. Staff also used videos to explain treatment options to patients needing more complex treatment.

<Summary here>

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice demonstrated their appointment system and we saw that this was an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. This inspection was unannounced which meant we were unable to seek the views of patients in advance. The practice did not have any appointments arranged on the day of the inspection which meant we were unable to speak with patients using the service.

Staff were knowledgeable on which types of dental treatments or reviews would require longer appointments. The dentist also specified the timings for some patients when they considered that the patient would need an appointment that was longer than the typical time.

Promoting equality

The practice made reasonable adjustments for patients with disabilities. These included step free access and accessible toilet.

Staff said they could provide information in different formats and languages to meet individual patients' needs. Staff spoke a range of different languages including Romanian, Italian and Turkish which were amongst the most prevalent community languages in the area.

Access to the service

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

The practice was committed to seeing patients experiencing pain urgently The website provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice website had a contact email address although there was no specific information to explain how to make a complaint. The principal dentist told us they would be responsible for dealing with complaints but we were told that the service had not yet received any complaints Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

<Summary here>

Are services well-led?

Our findings

Governance arrangements

The provider, of which the service was a registered location, was in breach of Section 42 (1) of the Dentist Act 1984 as the single director of the provider organisation was not a registered dentist or a registered dental care professional. Section 42 (1) of the act states that a body corporate commits an offence if it carries on the business of dentistry at a time when a majority of its directors are not persons who are either registered dentists or registered dental care professionals.

The principal dentist, although not the registered manager, had day to day responsibility for the clinical leadership of the practice.

During the inspection, the registered manager of the service could not demonstrate that they had the experience, capacity or capability to run the service safely or ensure high quality care. Although they told us they prioritised safe, high quality and compassionate care, we found that they lacked the knowledge to manage significant aspects of the safety and quality of the services provided and did not have an adequate insight into the challenges faced by the service.

The registered manager could not demonstrate an awareness of the requirements of the duty of candour and did not have systems in place to ensure compliance with the duty. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There were no processes in place to identify, record or investigate significant events, for instance when things went wrong with care and treatment.

The service did not have a full complement of policies, procedures and risk assessments necessary to support the management of the service and to protect patients and staff. A number of policies that were in place were not specific and personalised for the practice. For example, the safeguarding policy had been developed by an external organisation and had not been reviewed to ensure it reflected local arrangements

The practice did not have a policy in place to manage information governance although staff were aware of the importance of these in protecting patients' personal information.

Leadership, openness and transparency

We asked the principal dentist about the Duty of Candour requirement and they were not aware of it. (The Duty of Candour is a requirement to be open, honest and to offer an apology to patients if anything went wrong). When we explained the requirements to the dentist they confirmed that they do act in this way.

The staff team was small so the practice were able to hold informal meetings daily where staff could raise any concerns and discuss clinical and non-clinical updates. Immediate discussions were arranged to share urgent information. Staff told us there was an open, no blame culture at the practice. They said the principal dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us principal dentist was approachable, would listen to their concerns and act appropriately. The principal dentist discussed concerns at staff meetings and it was clear the practice worked as a team and dealt with issues professionally.

Learning and improvement

The practice was not undertaking annual radiography audits in line with current guidance. We discussed this with the principal dentist and they told us they would improve in this area. There was no evidence that the practice had undertaken any other activity to drive performance improvement.

There was no evidence available to demonstrate staff were working towards completing the required number of continuous professional development hours to maintain their professional development in line with the requirements set by the General Dental Council (GDC).

We were told that as the service had been open for less than a year, no member of staff had been yet been trained in training in emergency resuscitation and basic life support ore fire safety awareness as part of mandatory training.

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

Are services well-led?

The practice told us they used verbal comments to obtain staff and patients' views about the service. They did not keep any records to confirm the feedback they received from patients. We asked for example of how they acted on feedback but staff were unable to provide any.

<Summary here>

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **How the regulation was not being met:** The registered persons 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: • A fire risk assessment had not been carried out. • No regular checking of the fire alarm system, emergency lighting or firefighting equipment was carried out. • A Legionella risk assessment had not been carried out. • Emergency equipment had not been checked to ensure it would be available for use in an emergency. • There were no paediatric masks available to treat children with oxygen in an emergency. • An effective policy and procedure framework was not in operation to enable staff to report, investigate and learn from untoward incidents and significant events. The equipment being used to care for and treat service users was not safe for use. In particular: • Pouches used to stored sterilized instruments awaiting usage were not dated.

This section is primarily information for the provider

Requirement notices

There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular:

- Infection prevention and control audits had not been undertaken.
- A cleaning schedule was not available.
- Only one mop was available for washrooms and treatment rooms.
- Arrangements to manage clinical waste did not keep people safe.
- A risk assessment had not been carried out for staff who are unknown responders to the Hepatitis B vaccination who are carrying out exposure prone procedures.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were limited systems or processes established to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: · The provider had not implemented a system for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority. (MHRA) · The provider had not put a system in place for receiving medical and safety alerts · Policies were not specific to the practice and did not contain sufficient information. For example, sharps, whistleblowing, safeguarding and recruitment policies. · The provider had not obtained all required information at the point of staff recruitment as detailed in legislative requirements.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had failed to ensure that Persons employed by the service provider in the provision of a regulated activity had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. In particular: • The provider had failed to ensure that staff received mandatory training including safeguarding and basic life support. • The provider had not ensured that that clinical staff had completed the continuous professional development required for their registration with the General Dental Council.