Mr Gehad Philobbos

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Inspection Report

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Overall summary

We undertook a follow up focused inspection of Mr Gehad Philobbos on 19 December 2018. This inspection was carried out to review in detail the actions taken by the registered provider to improve the quality of care and to confirm that the practice was now meeting legal requirements.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We undertook a comprehensive inspection of Mr Gehad Philobbos on 29 August 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found the registered provider was not providing safe, effective or well led care in accordance with the relevant regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time we were considering significant enforcement action. Since then the provider has engaged, employed support staff and worked with external stakeholders to reduce the risk. You can read our report of that inspection by selecting the 'all reports' link for Mr Gehad Philobbos on our website www.cqc.org.uk.

When one or more of the five questions are not met we require the service to make improvements and send us an action plan. We then inspect again after a reasonable interval, focusing on the areas where improvement was required.

As part of this inspection we asked:

- Is it safe?
- Is it effective?
- Is it well-led?

Our findings were:

Are services safe?

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

The provider had made some improvements, these were insufficient to put right the shortfalls we found at our inspection on 29 August 2018.

Are services effective?

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

The provider had made some improvements, these were insufficient to put right the shortfalls we found at our inspection on 29 August 2018.

Are services well-led?

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

The provider had made significant improvements to the governance of the practice. These improvements were insufficient to put right the shortfalls we found at our inspection on 29 August 2018.

Background

Summary of findings

Mr Gehad Philobbos is in Oldham and provides NHS treatment to adults and children.

There are two steps leading to the entrance of the premises. On street parking is available near the practice.

The dental team includes one dentist, a trainee dental nurse and a practice manager who also carry out reception duties. The practice has one treatment room.

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.

During the inspection we spoke with the dentist, the practice manager and the trainee dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Tuesdays and Thursdays 9.30am to 12.45pm and 2pm to 5.30pm

Our key findings were:

- Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.
- Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support. The medical emergency kit required review.
- The recommendations in the health and safety and fire risk assessments had been implemented.
- There were suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05.
- The premises were visibly clean when we inspected. Some areas would benefit from renovation.
- Systems to identify and respond to risk required improvement. For example, in relation to radiographic safety, the destruction of clinical records and appropriate servicing of the steriliser.
- The improvements made were insufficient to demonstrate that care and treatment was assessed and delivered in line with current legislation.
- Significant improvements had been made to the governance of the practice.
- The practice had a recruitment policy and procedure to help them employ suitable staff, these reflected the relevant legislation.
- Audits were not effective. Discussions with the provider showed they lacked understanding of the issues highlighted by the audit process.

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

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- 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 is not meeting are at the end of this report.

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

- Review the practice's process for the destruction of confidential waste. In particular, dental care records are reviewed and assessed for destruction appropriately and are destroyed securely.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

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 section at the end of this report).

The practice had safeguarding policies and procedures. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

The recommendations in the health and safety and fire risk assessments had been implemented. The staff followed relevant safety regulation when using needles and other sharp dental items.

There were suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05.

The findings of the legionella risk assessment had been reviewed and the recommendations acted upon. Dental unit water lines were now disinfected but we noted that staff had not ensured that this had been implemented correctly.

The registered person had not ensured the safety of the radiographic equipment in use. The steriliser had not been serviced in response to the engineer's recommendations during the recent pressure vessel testing and validation.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support. The medical emergency kit required review to ensure items were available as described in Resuscitation Council UK guidance.

The security of prescriptions had been reviewed, these were now stored securely. We noted the logging system would not identify if a prescription was missing.

Requirements notice 

Are services effective?

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 Enforcement Actions section at the end of this report).

Some improvements were noted in the way that treatment needs are assessed and documented. Dental records included a little more detail than previously seen. For example, where X-rays were taken.

Staff showed an understanding of the Mental Capacity Act 2005 and Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances.

The practice had systems for referring patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

Enforcement action 

Summary of findings

The improvements made were insufficient to demonstrate that care and treatment was assessed and delivered in line with the regulation. Nationally agreed evidence-based standards were not followed.

The care provided was not supported by clear clinical pathways and protocols. For example, selection criteria and frequency of radiographs, documentation of discussions of treatment planning, options, risks and benefits, and carrying out periodontal assessments and care.

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 section at the end of this report).

Requirements notice 

The provider had made significant improvements to the management and governance of the service. This included employing staff for management and administration, establishing clear roles and responsibilities for the practice team. The improvements provided a sound footing for the ongoing development of effective governance arrangements at the practice.

A system was in place for staff to report any incidents, accidents or dangerous occurrences.

First floor rooms were now kept locked and unnecessary clutter had been cleared out from these areas.

The practice now had a recruitment policy and procedure to help them employ suitable staff, these reflected the relevant legislation.

Audits were not effective. Discussions with the provider showed they lacked understanding of the issues highlighted by the audit process.

Systems to assess needs and deliver care and treatment were in line with current legislation and nationally agreed evidence-based standards were ineffective and not supported by clear clinical pathways and protocols.

Systems to identify and respond to risk required improvement. For example, in relation to radiographic safety, the destruction of clinical records and appropriate servicing of the steriliser.

Are services safe?

Our findings

At our previous inspection on 29 August 2018 we judged the practice was not providing safe care in accordance with the relevant regulations. We told the provider to take action. At the inspection on 19 December 2018 we found the practice had made some improvements. The improvements were not sufficient to ensure compliance with the regulations:

Health & safety and risk management awareness had improved. Health and safety policies, procedures and risk assessments were now in place to help manage potential risk, and health & safety recommendations had been actioned. For example:

- Hazardous substances had been identified, staff had obtained safety data sheets for these and were in the process of carrying out risk assessments to ensure their safe use and storage. Bottled dental mercury had been disposed of and we saw consignment notes to demonstrate this. Surface wipes were now in use and the unidentified spray previously used to clean surfaces had been removed from use. Opportunities had been missed to ensure the correct use of the dental water unit disinfectant, to ensure that manufacturer's instructions were followed.
- The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and a safer syringe system was now in use. Staff understood that only the dentist could handle and dispose of the syringes and this was documented on the risk assessment. Staff understood the need to report any sharps injuries, sharps safety information was displayed in clinical areas.
- The practice had an infection prevention and control policy and procedures. 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. These were relevant to the processes in use and these were available to staff. The decontamination area and process had been reviewed, and equipment that was not in use had been removed to provide a clear workflow. Staff had completed infection prevention and control training and recognised that the previous way of working was not acceptable. There were suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The trainee dental nurse was aware of the need for validation of the ultrasonic cleaner, they could describe the process and reasons why foil and soil tests now also need to be implemented. Laboratory work was disinfected appropriately. An infection prevention and control audit had not been completed. This was discussed with the practice manager to implement.
- The findings of the legionella risk assessment had been reviewed and the recommendations acted upon. Water quality testing had been carried out on several taps and the dental unit water line, the microbiological report showed these samples met potable water standards. Monthly water temperature testing was in place and documented along with flushing of a lesser used outlet. Dental unit water lines were now disinfected but we noted that staff had not ensured that this had been implemented correctly. For example, by carrying out a full biofilm removal protocol before the maintenance solution was introduced, and following the instructions for removing and cleaning the water bottle as described by the product manufacturer. This was highlighted to the team to review their use of this product.
- The recommendations in the health and safety risk assessment had been implemented. These included the removal of a trip hazard, removal of clutter from the practice and implementing fire safety arrangements. Electrical safety testing had been carried out as per the requirements of the provider's public liability insurance policy. This showed the electrical systems in the premises were satisfactory.
- The recommendations in the fire safety risk assessment had been implemented. Smoke alarms were in place and working. These were tested monthly (although testing was not documented). Rechargeable torches had been obtained to provide emergency lighting, new and appropriate fire extinguishers had been obtained and were wall mounted centrally. Large quantities of

combustible clutter had been removed from the practice. Evacuation processes and emergency signage were displayed. The team were in the process of identifying suitable fire safety training.

- Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support. The medical emergency kit had been reviewed and new automated external defibrillator pads and oropharyngeal airways had been obtained. A new adult-sized oxygen mask had been obtained but we noted the packaging had been opened. A new Glucagon had been obtained, this was kept in the emergency kit but the expiry date had not been changed in line with the manufacturer's instructions. The dentist confirmed they would identify when this was obtained to change the expiry date accordingly. A child sized self-inflating oxygen bag and mask was not available. A process for checking the AED and emergency oxygen daily was in place and the whole emergency kit was checked monthly. We noted the checklist did not include the masks, airways and supplementary items. This was discussed with the practice manager who confirmed she would add these and check the kit weekly as described in Resuscitation UK guidance.
- We saw that the premises were visibly clean. Cleaning equipment was now colour coded and a cleaning schedule was in place. Some rooms would benefit from renovation. For example, the treatment room and the bathroom. Attempts had been made to clean the bathroom walls but the textured wall coverings prevented effective cleaning. The waiting room and reception area had been repainted and appeared fresh and clean.
- The security of prescriptions had been reviewed, these were now stored securely. We noted the logging system still would not identify if a prescription was missing. This was discussed with the dentist to review.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances.

- The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. These included the correct numbers for the Oldham Multi Agency Safeguarding Hub. Additional safeguarding information was displayed in the surgery and reception.
- Staff had completed level 2 safeguarding training. They described how this training had changed their ideas and opinions of safeguarding. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. They showed they were now aware of the importance of raising any concerns with external agencies.

We identified areas of concerns where action had not been taken, or the action taken was insufficient to ensure that risks were identified and acted upon. For example:

- The practice had taken some steps to ensure that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. Pressure vessel testing and validation had been carried out on the steriliser in October 2018. The report included a recommendation that the device should be serviced, this had not been acted upon. This was raised with the dentist who took immediate action to contact the servicing company and arrange for servicing to be carried out on 17 January 2019.
- The provider had not ensured the safety of the radiographic equipment. In response to our previous inspection, a routine test had been carried out on the X-ray machine in September 2018. The reports included concerns relating to the electrical safety and the settings used during radiographic exposures. No actions had been taken to address these concerns. The equipment remained in use and the provider did not demonstrate they understood the actions that should be taken. The provider was instructed to seek advice from their Radiation Protection Adviser (RPA) if they were unsure about this. After the inspection, the dentist sent evidence that an engineer was booked to attend on 3 January 2019. The dentist confirmed that they had taken the equipment out of use until the engineer attended. Since the inspection, we have received confirmation the equipment is safe to use.

The arrangements for dental water line management required review to ensure they were implemented in line with the manufacturer's instructions and the Control of Substances Hazardous to Health Regulations 2002.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 29 August 2018 we judged the practice was not providing effective care in accordance with the relevant regulations. We told the provider to take action. At the inspection on 19 December 2018 we found the practice had made some improvements:

Some improvements were noted in the way that treatment needs are assessed and documented. For example:

- The dentist had carried out an audit of dental care records. We noted that some improvements had been made. For example, where X-rays were taken, these were justified, graded and any clinical findings reported on in the records we reviewed.
- The practice had systems to identify, manage, follow up and where required, refer patients for specialist care when presenting with dental infections.
- Staff showed an understanding of the Mental Capacity Act 2005 and Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. Staff described when and how these would be relevant when treating adults who may not be able to make informed decisions and young people under 16 years of age in certain circumstances.
- The practice had systems for referring 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 refer 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.

We identified areas of concerns where action had not been taken, or the action taken was insufficient to ensure that care and treatment was delivered in line with current legislation, nationally agreed evidence-based standards supported by clear clinical pathways and protocols. For example:

- The dentist had attended a course on the assessment and delivery of periodontal care. They had attempted to start carrying out and documenting Basic Periodontal Examinations (BPE). BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need. The dentist did not demonstrate they understood the process to be able to accurately assess and document levels of periodontal disease. The dentist confirmed they did not carry out six-point pocket charting or bleeding indices as indicated in national guidance.
- The dentist did not document discussions of options, risks and benefits of procedures in line with General Dental Council Standards for the Dental Team. We asked to see clinical records to demonstrate improvements in this area. The records we reviewed showed no evidence of treatment planning or discussion of this, or options, risks and benefits with the patient. As a result there was limited evidence of valid consent. There was no evidence of care planning beyond the treatment to be provided at each visit and it would have been difficult for another dentist to follow the treatment or to know what was planned. The trainee dental nurse and the dentist assured us that these discussions do take place with patients but there was no evidence of this.
- Although the number of radiographs taken appeared to have increased, the dentist was still not familiar with, or following nationally recognised Faculty of General Dental Practitioners standards for the frequency of radiographs. We also noted that the quality of the radiographs we viewed were poor and this was reflected in a recent audit. The dentist had reviewed the quality of 25 radiographs taken since July 2018. They did not conduct any analysis of why X-ray films appeared very dark, and many were of limited or no diagnostic value. We identified and discussed possible reasons for this with the dentist. For example, poor technique, beam aiming devices used incorrectly, over exposure as incorrect setting used on the X-ray machine and poor developing processes using developing tanks without regard for fluid temperature variations. The dentist had not considered, and showed little understanding of the possible reasons for the poor quality of radiographs taken.

Are services well-led?

Our findings

At our previous inspection on 29 August 2018 we judged the practice was not providing well led care and told the provider to take action. At the inspection on 19 December 2018 we found the practice had made the following improvements:

Significant improvements had been made to the governance of the practice. An external compliance company had provided a suite of up to date policies which had been personalised to, and were relevant to the practice. The provider demonstrated a better understanding of the governance systems and could now see how this had led to other improvements. For example:

- There was a system to receive and review patient safety alerts. Any relevant alerts were retained to show action had been taken. For example, the most recent defibrillator alert had been received and checked against the device at the practice. Information was also available about the 'yellow card' adverse reaction reporting system.
- A system was in place for staff to report any incidents, accidents or dangerous occurrences. The policy included internal investigation and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reporting processes. A new accident book had been provided and a prompt to report any incidents was displayed in the surgery. Staff understood the system and the importance of reporting these.
- First floor rooms were kept locked and unnecessary clutter had been cleared out from these areas. This included confidential patient records. The provider had taken these home and burned them. Because of this there was no evidence to demonstrate that confidential patient records had been assessed for their suitability for storage or disposal, or had been disposed of appropriately.
- The use of closed-circuit television (CCTV) had been reviewed. We saw evidence that the Information Commissioner's Office (ICO) had requested further information about its use which the provider had responded to. The ICO confirmed no further action was to be taken. Information governance policies were in place and staff signed confidentiality agreements.
- Clinical waste was segregated and stored securely. A pre-acceptance waste audit had been carried out and consignment notes were in place and retained. These showed that bottled mercury had been disposed of appropriately.

A permanently employed team was now in place which included a practice manager who was responsible for the day to day running and ensuring that servicing and tasks were completed on time. Responsibilities were discussed and shared appropriately. A recent meeting showed this and how they had identified further training they had highlighted that would be beneficial to undertake. Effective communication between the team was seen. During the inspection, staff were open to discussion and feedback to make further improvements. The provider complimented their staff and appreciated their hard work.

- The practice had a recruitment policy and procedure to help them employ suitable staff, these reflected the relevant legislation. We looked at staff recruitment records. These showed the practice had followed their recruitment procedure.
- The provider had a 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.
- We saw evidence that the trainee dental nurse had enrolled on an accredited course due to start in March 2019. The dental nurse was reviewing this as they hold a previously awarded dental nursing qualification. They were considering whether the completion of a cycle of CPD would enable them to register with the GDC rather than completing another dental nursing qualification.
- A structured induction programme was in place and this was included in staff files, including evidence sought of training completed in other locations for the practice manager.
- No temporary or agency staff were employed at the time of the inspections. Systems were in place to assess the suitability of these and carry out essential checks should they be required in the future.

Staff completed 'highly recommended' training as per General Dental Council professional standards. Records of training were retained in staff files. The dentist was in the process of completing their personal development plan.

Are services well-led?

We identified areas of concerns where action had not been taken, or the action taken was insufficient to ensure that systems and processes were in place 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. For example:

- Audits were not effective. Discussions with the provider showed they lacked understanding of the issues highlighted by the audit process, and what to do to make further improvements. There was no evidence that the results of the radiography or record keeping audits were analysed, understood or any efforts made to use these as tools to make improvements, particularly to address the poor quality of radiographs. There were still no audits of infection prevention and control and these had never been carried out. These are required on a six-monthly basis.
- Systems to assess needs and deliver care and treatment were in line with current legislation and nationally agreed evidence-based standards were ineffective and not supported by clear clinical pathways and protocols. In particular, the provider was not aware of, or following nationally recognised Faculty of General Dental Practitioners standards for the frequency of radiographs or Clinical Examination and Record-Keeping. The provider did not document discussions of options, risks and benefits of procedures in line with General Dental Council Standards for the Dental Team.
- The provider had not ensured that safety systems in relation to radiographic safety were effective. They had not acted on advice in the recent routine test report to ensure the safety of the equipment and review the exposure settings until this was identified during the inspection.
- There were ineffective systems to identify and mitigate risk in relation to the management of dental unit water line. They had not ensured that the water line management system was implemented in line with the manufacturer's instructions.
- There was no evidence that clinical records had been assessed for suitability for destruction, or securely destroyed in line with General Data Protection Regulation (GDPR) requirements and guidance on how to safely destroy records from the Information Commissioner.

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:** • The registered person had not ensured the safety of the radiographic equipment. The report from the routine test carried out on the X-ray machine in September 2018 including concerns relating to the electrical safety and the settings used during radiographic exposures. No actions had been taken to address these concerns until they were raised during the inspection. • The medical emergency kit did not include a child-sized self-inflating oxygen bag and mask, and the expiry date had not been changed on the Glucagon which was now stored unrefrigerated. • The registered person had not implemented arrangements for dental water line management in line with the manufacturer's instructions. • The steriliser had not been serviced in response to the engineer's recommendations. **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 **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 did not ensure that audits were effective. There was no evidence that the results of the

This section is primarily information for the provider

Requirement notices

radiography or record keeping audits were analysed, understood or any efforts made to use these as tools to make improvements, particularly to address the poor quality of radiographs. There were no audits of infection prevention and control and these have never been carried out.

- The registered person did not ensure there were systems to assess needs and deliver care and treatment in line with current legislation and nationally agreed evidence-based standards. Care provided was not supported by clear clinical pathways and protocols. In particular, ensuring that care was provided following nationally recognised Faculty of General Dental Practitioners standards for the frequency of radiographs or Clinical Examination and Record-Keeping. The registered person did not ensure that discussions of options, risks and benefits of procedures were documented in line with General Dental Council Standards for the Dental Team. As a result there was limited evidence of valid consent.
- The registered person had not ensured that safety systems in relation to radiographic safety were effective. They had not acted on advice in the recent routine test report to ensure the safety of the equipment and review the exposure settings until instructed to do so during the inspection.
- The registered person had not ensured that advice in the pressure vessel testing report (October 2018) stating that the steriliser should be serviced had been acted upon.
- There were ineffective systems to identify and mitigate risk in relation to the management of dental unit water line. They had not ensured that the water line management system was implemented in line with the manufacturer's instructions and the Control of Substances Hazardous to Health 2002.

Regulation 17 (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 9 HSCA (RA) Regulations 2014 Person-centred care **Care and treatment was not being designed with a view to achieving service user preferences or ensuring their needs were met. In particular:** **The improvements made were insufficient to demonstrate that care and treatment was assessed and delivered in line with current legislation. Nationally agreed evidence-based standards were not followed. The care provided was not supported by clear clinical pathways and protocols. For example:** • The provider was not aware of, or following nationally recognised Faculty of General Dental Practitioners standards for the selection criteria and frequency of radiographs. The quality of the radiographs we viewed is poor. No action had been taken to improve the quality of radiographs to ensure they were of diagnostic use. • The provider did not document discussions of treatment planning, options, risks and benefits of procedures in line with Faculty of General Dental Practitioners standards and General Dental Council Standards for the Dental Team. • Periodontal assessments and care were not provided or documented in line with nationally agreed guidance from the British Periodontal Society. The provider did not demonstrate they understood the process to be able to accurately assess and document levels of periodontal disease. They confirmed they did not carry out six-point pocket charting as indicated in nationally agreed guidance. Regulation 9 (1)