Paris P Limited

Clinic Nine

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11and 26 November 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

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 not 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
Clinic Nine provides private dental treatment, facial aesthetics and orthopaedic surgery from their clinic in Hove. The majority of the dental treatment provided is implants with some general dentistry. The practice mostly provides treatment for adults but has a very small number of patients that are children.

Practice staffing consisted of the principal dentist who is also the owner/provider, an associate dentist, an orthopaedic surgeon, one dental nurse a clinic co-ordinator and a practice manager.

The practice opening hours are 9am to 6pm Monday to Friday.

The provider is the registered person. A registered person is registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Eighteen people provided feedback about the service. We viewed fifteen comment cards and spoke with three patients. All had positive comments about the staff and the services provided. Comments focused on the ease of obtaining an appointment and the friendliness of staff. Negative comments referred to the lack of clarity with the amount they were required to pay.

Summary of findings

Our key findings were:

- The practice had oxygen, an automated external defibrillator (AED) and appropriate medicines to respond to a medical emergency in line with British National Formulary and Resuscitation Council (UK) guidance. These had been checked and maintained.
- The practice did not have systems and processes to record, investigate, respond to and learn from significant events or knowledge of what a significant event was.
- Some medicines were not being stored and dispensed in a safe way.
- Single use items were used more than once on patients.
- The practice did not hold regular staff meetings and formal staff appraisals, and the appraisals undertaken did not identify training needs.
- Where risk assessments had been carried out the practice had not implemented the actions required to minimise the risks identified.
- The practice had not carried out audits in key areas, such as infection control, sedation and the quality of X-rays.
- Dental care records were inconsistent or did not contain enough information of the treatments provided. Some patient's visits did not have any records documented at all.
- The provider used an unregistered laboratory for crowns, bridges, inlays, veneers and dentures.
- The practice was covered by CCTV externally and internally but there were no signs informing patients and visitors that CCTV was in use. The Practice had not registered with the Information Commissioners Office that they were using CCTV on the premises.

We identified regulations that were not being met and the provider must**:**

- Ensure that staff understand what constitutes a significant event, and establish systems and processes to investigate respond to and learn from significant events.
- Ensure that medicines are stored, packaged and dispensed in line with legal requirements.
- Ensure that single use items are disposed of in line with the manufactures instructions and only used on one patient.
- Ensure that the practice is in compliant with its legal requirements under Ionising Radiation Regulations (IRR99) and the Ionising Radiation (Medical Exposure) regulations (IR(ME)R) 2000
- Ensure procedures are in place to assess the risks in relation to the Control of Substances Hazardous to Health (COSHH) 2002 Regulations.
- Ensure that audits are regularly completed for infection control, the quality of X-rays taken and sedation and the results acted upon.
- Ensure that guidance is followed with respect to sedation carried out at the practice in line with the National standards for conscious sedation in dental care 2015.
- Ensure that appropriate governance arrangements are implemented for the safe running of the service by establishing systems to identify and minimise any potential or perceived risks.

You can see full details of the regulations not being met 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/Enforcement section at the end of this report)

The practice held all of the recommended medicines and equipment which were checked regularly, to use in the event of a medical emergency. All staff had received training in medical emergencies.

The practice had a system to record significant events however, staff were not able to recognise a significant event that had occurred or learn from it. The practice had not consistently carried out risk assessments and where risk assessments had been conducted, risks identified had not been addressed. The practice had not complied or maintained a working radiation protection file. Critical exam reports were not available and the operating parameters were not documented. There was no record of Health and Safety Executive notification and no maintenance logs were in place.

The practice was using items that are marked as single use more than once on patients.

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 Requirement Notices/Enforcement section at the end of this report).

We could not establish that the practice provided evidenced based care in accordance with relevant published guidance, for example from the National Institute for health and Care Excellence (NICE). Staff explained treatment options but this had not been routinely recorded. Health promotion advice was not routinely recorded such as diet and nutrition or smoking status and cessation advice.

Staff had engaged in some of the mandatory requirements for their continued professional development. However we found that some areas, such as sedation had not been covered. Staff were not meeting their full training requirements of the GDC.

Patients were not informed that CCTV was in operation externally and internally, including in treatment areas and had not been given the opportunity to consent to being filmed.

Are services caring?

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

We received fifteen completed CQC comment cards and spoke with three patients. The feedback was positive in relation to the care they had received and described staff as helpful and professional. We did receive some negative feedback in relation to the clarity of fees patients were required to pay.

Are services responsive to people's needs?

We found that this practice was not providing responsive 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/Enforcement section at the end of this report).

Summary of findings

Patients had appropriate access to the service and had no problems obtaining an appointment. Information for patients was confusing. The practice provided dentistry, facial aesthetics and orthopaedic surgery. However, the front window, website and practice brochure indicated that other procedures were available such as cosmetic surgery. Also outdated information was displayed and used with regard to which regulatory body the practice was registered with.

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/Enforcement section at the end of this report).

Policies and procedures were not effective to ensure the smooth running of the practice; staff could not demonstrate sufficient understanding of the policies and procedures. There were no clear governance arrangements in place. Practice meetings were not held regularly and there were no mechanisms to update staff. There were limited processes to oversee staff development. Staff appraisals did not demonstrate any learning or progression had occurred as a result. Audits were carried out, however they lacked information and actions identified were not always carried out. Audits in key areas had not been conducted at all.

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Detailed findings

Background to this inspection

We carried out these inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. These inspections were planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The two inspections were carried out on 11 November and 26 November 2015. The inspection 11 November was announced and conducted by a CQC inspector, two dental specialist advisors and a GP specialist advisor. The inspection 26 November was unannounced due to concerns raised at the previous inspection and was conducted by a CQC inspector and two dental specialist advisors.

Prior to the first inspection we asked the practice to send us some information which we reviewed. This included the complaints that they had received their latest statement of purpose, the details of their staff, their qualifications and proof of registration with their professional bodies.

We also reviewed information we held about the practice which did highlight an area of concern. We used this information to guide us during both of our inspections.

We informed NHS England area team and Healthwatch that we were inspecting the practice; that highlighted the same area of concern we were already aware of.

During our first inspection we spoke with the provider, the practice manager, the clinic co-ordinator and the dental nurse. We spoke with one patient and reviewed the fifteen comment cards that we had left prior to our visit. On our second inspection we spoke with one dentist, the dental nurse, the practice manager, the clinic co-ordinator and the dental technician. We spoke with two patients.

On both inspections we reviewed policies, procedures and other documents. Looked around the premises, observed the decontamination process and looked at the equipment.

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

Systems and processes to identify risks and improve patient safety were not robust. The practice had a system for reporting a significant event or incident; however when we asked for the evidence of any investigations carried out, so we could view the process we were informed that there had never been any significant events or incidents since registering with the Care Quality Commission (CQC) in 2011. However, we looked at the accident book and found an entry for an accident which would be classed as a significant event. No reporting of the accident had occurred. We were not assured that the practice carried out continuous monitoring or evaluations of the services provided to drive improvement. Staff spoken with did not know how to raise a concern or what constituted a significant event.

The staff could not demonstrate an understanding of their responsibilities in Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) and were unable to provide the appropriate recording forms.

Staff meetings were not convened regularly although staff told us the meetings occurred every month. The most recent meeting minutes were dated April 2015. The minutes available did not evidence information shared or any learning.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for child protection and safeguarding vulnerable adults. This included contact details for the local authority safeguarding team.

All staff had completed safeguarding training. The provider was the safeguarding lead and had completed a level two safeguarding training.

There was a whistleblowing policy but staff we spoke with were unaware of what to do if they suspected that another member of staff's performance was unsafe or not meeting the General Dental Council standards. Staff told us that they did not know who to raise such issues with if needed.

The practice had not carried out risk assessments with the purpose of keeping patients and staff safe in the practice. For example, there was no practice wide risk assessment to cover topics such as fire safety, safe use of pressure vessels (the autoclave and compressor), the safe use of X-ray equipment, clinical waste and the safe use of sharps. The practice had not carried out a risk assessment with regard to sedation as required by the national publication, Standards for Conscious Sedation in the Provision of Dental Care 2015.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies and the principal dentist was the lead for this. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff received annual training in how to use this. The practice had the emergency medicines set out as advised in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines.

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The practice monitored the expiry dates of medicines and equipment so they could replace out of date items promptly.

Staff recruitment

The practice staff consisted of the principal dentist, an associate dentist, one dental nurse, a clinic co-ordinator and a practice manager. Other professionals such as an orthopaedic surgeon used the practice operating theatre to carry out foot surgery on a rental basis once a month.

On our first inspection we were given the practice staff files to look through. On the second inspection we saw a staff file for a dental technician whose information had been removed from the file prior to our announced inspection.

We looked at all of the staff files available and found that most files contained the required checks carried out when appointing staff. However, one recently recruited member of staff did not have any references and the Disclosure and Barring service check (DBS) was four years old and had been carried out by a different employer. The Disclosure and Barring Service carries out checks to 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. We

Are services safe?

found that four staff did not have a current DBS check . Where DBS checks had been photocopied only a partial reference number and an incomplete date was visible and two did not have the enhanced check information page. We could not be assured that staff were suitable to work with children of vulnerable adults.

Monitoring health & safety and responding to risks

The practice had a health and safety policy, but staff we spoke with were not aware of the information contained within it and no practice wide risk assessment had been conducted to ensure the environment was safe for both patients and staff. There were a range of other polices at the practice including infection control and fire safety. However we could not be assured that systems and processes were implemented to monitor and manage the risks to patients, staff or visitors. Staff did not have a sufficient understanding of health and safety requirements.

The practice did not have effective arrangements to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is a law that requires employers to control potential hazardous substances they use to minimise risks and keep people safe. There was no COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified.

The practice had a business continuity plan which described situations which might interfere with the day to day running of the practice and treatment of patients. This included extreme situations such as loss of the premises due to fire. The document contained information including contact details for utility companies and practice staff. The provider told us that they could use another practice they owned in the area if required.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We were not assured that the practice was meeting the HTM01- 05 essential requirements for decontamination in dental practices. The dental nurse held lead responsibility for infection prevention and control (IPC).

We saw that the two dental treatment rooms, operating theatre, decontamination room and the general environment were clean, tidy and clutter free. The staff were responsible for environmental cleaning at the practice and we saw that cleaning equipment was safely stored in line with guidance about colour coding equipment for use in different areas of the building. The practice had carried out an audit of cleanliness at the practice in August 2015.

We saw that the practice had a supply of personal protective equipment (PPE) for staff. There was also a supply of wipes, liquid soap, paper towels and hand gel available. However, the decontamination room did not have a designated hand wash basin separate from those used for cleaning instruments. Staff told us that the only sink was used for both instrument scrubbing and hand washing.

The practice used single use dental instruments which we found had been re-used on other patients. In dental treatment room one we found a box containing implant components used at different stages of implant treatments. The box was soiled and released a foul odour when opened. Staff told us when questioned that these components would be selected at the planning stage for implants and then put through the decontamination process for use on a patient. Following our inspection we contacted the manufacturer of the components who informed us that they were a single use item and were not designed for processing to re-use as this could not attain a sufficient level of cleanliness. We also found some files that are used in root canal treatment that had visible debris on them. These files were in a box in the surgery and intended for use on patients.

Staff showed us how the practice cleaned and sterilised instruments between each use. The practice had a system which separated dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. The practice had a separate decontamination room where the dental nurse cleaned, checked and sterilised instruments. The nurse at the practice had been trained so that they understood this process and their role in making sure it was correctly implemented.

Staff showed us the full process of decontamination including how they rinsed the instruments, checked them for debris and used the autoclave (equipment used to sterilise dental instruments) to clean and then sterilise

them. However we noted that staff did not use an enzymatic detergent to facilitate the manual scrubbing process. We saw that instruments were scrubbed in plain water and were not immersed. There was no illuminated magnifying tool to check that instruments were free of debris. Therefore, decontamination processes were not carried out according to current HTM 01-05 guidelines. Instruments were packaged and date stamped before being stored for re-use. Staff confirmed that they checked to make sure that they did not use packs which had gone past the date stamped on them. Any packs not used by the date shown were processed through the decontamination cycle again.

Staff showed us how the practice checked that the decontamination system was working effectively. They showed us the paperwork they used to record and monitor these checks. These were fully completed and up to date. The practice could not produce when asked, the maintenance information showing that the practice maintained the decontamination equipment to the standards set out in current guidelines. However, the practice sent the most recent engineer report to us following our inspection on 26 November 2015 which had been carried out in March 2015.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. Legionella is a bacterium which can contaminate water systems in buildings. However requirements recorded in the 2012 risk assessment had not been actioned. The requirements were to check and record regular checks of water temperatures and to carry out dip slide tests at regular intervals as a precaution against the development of legionella. We asked if these had been carried out and were told that they had not. Flushing of the water lines was carried out but this was not in accordance with the manufacturer's instructions and current guidelines. Staff when questioned could not demonstrate how this procedure was carried out. Staff admitted they did not know what the manufactures instructions were and handed us the manual.

The practice did not carry out audits of infection control independently or by using the format provided by the Infection Prevention Society. The practice had not completed an annual IPC report in line with guidance from the Department of Health code of practice for infection prevention and control.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. We did not see any clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument or the contact details for the local occupational health department. Staff who were employed as receptionists told us that they did cover for the dental nurse on occasion and were hoping to start training to become a dental nurse. We found that staff covering nursing duties were not Hepatitis B vaccinated and therefore posed a risk to patients and themselves.

The practice stored their clinical and dental waste in line with current guidelines from the Department of Health. Their management of sharps waste was not in accordance with the EU Directive on the use of safer sharps, however, we saw that sharps containers were maintained and correctly labelled. The practice did not have a policy or used a safe system for handling syringes and needles to reduce the risk of sharps injuries.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices.

Equipment and medicines

We asked for maintenance reports of the equipment used at the practice which were not available on the day of both inspections. Following the inspection on 26 November the practice provided records of maintenance carried out in March 2015. Equipment checked, included the autoclave, dental chairs, dental suction units and compressor, both intra oral X-ray units and the CT scanner and the instrument cart in the operating theatre. However, staff told us that the autoclave often failed and that the engineer had been called on a number of occasions, there was no documentation to support this.

The practice did not manage all medicines held in line with national guidance. The medicines held in the theatre were stored in a locked cabinet. However we found three different types of medicine that had been removed from its original packaging and arranged in small plastic bags for dispensing. The original packaging had been disposed of and the expiry date could not be identified. We could not be assured that these medicines were safe to use if dispensed to patients. Staff we spoke with confirmed that these medicines were given out to patients post operatively with a printed sheet of usage instructions.

Are services safe?

The practice had arrangements in place to deal with medical emergencies at the practice and the principal dentist was the lead for this. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff had received annual training in how to use this. The practice had the emergency medicines set out as advised in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The practice monitored the expiry dates of medicines and equipment so they could replace out of date items.

Radiography (X-rays)

The practice was not working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). They had a named radiation protection adviser (RPA) and the provider was the radiation protection supervisor (RPS). We saw documentation dated October 2015 which stated the RPA would not provide their service unless a completed radiation protection file (RPF) was received. Staff told us that they had sent the completed file as requested but had not heard anything back from the RPA. However, we were given the uncompleted RPF which contained very little information. The practice could not demonstrate they held the required documentation and information with regard to a Health and Safety Executive (HSE) notification, critical examination and acceptance testing for each X-ray machine and the expected three yearly maintenance logs. We did see records sent to us following our last visit for maintenance of the three X-ray units. However, these did not contain information on the findings relating to the equipment's performance parameters, operating potential and timer accuracy. The maintenance report stated that the cone beam scanner 's X-ray isolating switch would not turn off, leaving the unit operational at all times. This was still on, and had not been addressed on our visit on 26 November 2015.

We saw evidence of the reasons why staff had taken X-rays recorded and that X-rays were checked to ensure the quality and accuracy of the images. However there had been no quality assurance of this process. They showed us their ongoing clinical audit records for the justification of X-rays they took; this showed they were partly using this process to monitor their own performance in this aspect of dentistry.

The practice could not provide certificates to show that staff involved in taking X-rays had completed the required continued professional development required.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out patient consultations, assessments, and treatments. We looked at eleven dental care records and found that seven had not been fully completed. We could not be assured that treatments were planned and delivered in line with the patients individual treatment plans. Seven dental care records had no notes recorded for nine patient visits where treatment had been carried out.

The dentist was aware of the National Institute for Health and Care Excellence (NICE) guidance. As the practice provided mainly implants we did not see guidance recorded such as recall intervals for patients. The theatre record book had entries that stated antibiotic prophylaxis had been prescribed for most patients undergoing implant surgery. There were no records that demonstrated the justification for this. Therefore we could not be assured that NICE guidance was routinely followed.

Not all of the dental care records showed that an assessment of the gums had been undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to the health of patient's gums).

We spoke with staff about the information recorded in the dental care records regarding treatment and advice given to patients as this was not clear. We noted that improvements needed to be made to the recording of information at every patient visit. Records we looked at were inconsistent and sometimes no information had been recorded at all. Records did not routinely contain details of discussions, options chosen, oral cancer checks, smoking status and dietary advice. Not all of the dental care records we checked contained a clear diagnosis or treatment plan and X-ray findings were not reported with adequate detail.

Health promotion & prevention

Staff told us that oral health was discussed with patients. Staff were aware of the Department of Health, Delivering better oral health toolkit; however it was not clear if this was being followed. (This is an evidence based toolkit used by dental professionals for the prevention of dental disease in a primary and secondary care setting) From the dental care records we checked we saw there was some evidence that the practice promoted good oral health. None of the records we checked contained smoking status information or any smoking cessation discussions. Smoking is detrimental to the success of implants. We did not see any evidence that high fluoride toothpaste was prescribed or fluoride therapies provided.

Staffing

The practice employed three members of staff. The provider had given practising privileges to an associate dentist and orthopaedic surgeon who worked at the practice. The provider and the associate dentist shared one dental nurse, but each worked at the practice on different days. Staff told us that should the dental nurse be off sick they would sometimes cover or they would request a dental nurse from the providers other practice. We saw in the theatre log book that a nurse from the other practice had been in to cover procedures. However, some of the procedures for orthopaedic surgery were assisted by a dental nurse and it was not clear what the assistance entailed. We could not be assured that appropriate staff were available for these procedures or that other staff were working within their scope of practice.

Staff told us and we saw records of their participation in continued professional development (CPD) as required by the General Dental Council to maintain their registration. We reviewed all of the staff files and saw some training certificates that covered mandatory training requirements. However, we did not see training or CPD activity for sedation which was carried out at the practice. National standards for conscious sedation in dental care 2015 states that "The standards apply to all who practise conscious sedation techniques, whether they are dentists, doctors, nurses or dental care professionals." Clinical skills are underpinned by validated education and training while knowledge and continuing competence must be maintained through appropriate continuing professional development.

Working with other services

Staff told us that most referrals were to other colleagues for endodontic treatments (root canal), complex oral surgery and biopsy requests. The practice was unable to provide any examples of referrals sent when asked.

The provider used a dental laboratory which was located in the upper floors of the premises. On our first visit the provider refused us entry to the upper floors. We asked what was on the upper floors and the provider told us that

Are services effective?

(for example, treatment is effective)

the areas were residential and therefore it would not be appropriate for us to go up. Also the provider stated that no key was available to unlock the door which accessed the upper floors. On our second visit we were able to inspect the upper floors and found a conference room, dental laboratory and a locked office. We spoke with the laboratory technician and saw they were registered with the GDC. However, the laboratory was not registered with the Medicines and Healthcare products Regulatory Agency (MHRA) which is a legal requirement for all dental laboratories.

Consent to care and treatment

The practice had a consent policy to guide staff. Staff understood that patients could withdraw their consent at any time and for any reason and that this would be acknowledged. We saw that signed consent had been acquired for the implants provided and some other treatments such as fillings. Dental care records did not always include treatment options had been discussed and choices the patients had made. Some records merely stated that the patient had chosen "that" treatment with no entry with regard to what "that" was or any other options given. However signed consent forms were kept by the practice for implants and sedation.

We saw evidence that staff had completed safeguarding training which also covered the Mental Capacity Act 2005(MCA). Staff could not explain the meaning of the term mental capacity or describe to us their responsibilities to act in patients best interests, if a patient lacked some decision making abilities. Staff told us that they did not have any patients where the MCA would apply. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

The practice was covered by closed circuit television internally and externally. However there were no signs either outside or inside the building to inform patients and visitors they were being filmed. Staff informed us that the CCTV was not operational and they were waiting for an engineer to come and repair it. We asked staff what areas the CCTV covered when it was working and they stated that it covered all of the rooms in the building except one (a consultation room behind reception) and the shop front. We asked why the consultation room behind reception room did not have CCTV coverage. Staff told us that it would be inappropriate as it would capture images when patients removed their upper clothing. Staff told us that female patients undressed in that room.

We asked the provider for the notification with the Information Commissioners Office (ICO). The provider told us that they had not registered with the ICO. No prior assessment or privacy impact assessments had been conducted to justify the use of CCTV. We asked the provider why the CCTV had been installed. The provider told us that the police had requested that it be installed as there had been a crime conducted in the street outside of the practice. This did not justify why there was surveillance conducted in the dental treatment rooms and the operating theatre.

There were no signs informing patients or visitors that surveillance was used at any point externally or internally throughout the areas covered by CCTV. We could not be assured that patients had consented to being filmed during their consultations and treatments or if they were aware. The practice could not demonstrate how the footage was stored, retrieved or give a reasonable reason for its use.

Staff contracts did mention that the whole building was covered by CCTV which may be used to protect staff and patients.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We found that staff at the practice treated patients with respect. However we could not be assured that a patient's dignity or privacy had been protected as the practice treatment areas were covered by CCTV which patients were unaware of. The reception area was open plan but if a confidential matter arose, a private room was available for use.

The fifteen comment cards we reviewed reflected that patients were highly satisfied with the way they were treated at the practice by both the non-clinical and clinical staff. They said that staff were welcoming, friendly and helpful and that they had received excellent care and felt at ease when attending for appointments.

Staff spoken with understood the need to handle patient information securely and each staff file had a signed confidentiality policy to demonstrate they had read and understood the content.

We spoke with three patients who told us that staff were polite and respectful and treated them with kindness.

Involvement in decisions about care and treatment

The fifteen comment cards we reviewed reflected patients felt they had been involved in decisions about their care and treatments. The patients we spoke with said that they had everything explained to them and this had been followed up with a treatment plan. However, patients told us that the fees they would have to pay were not completely clear and this had caused some anxiety.

Dental care records were not always completed to show that discussions had taken place with regard to options for treatments offered, risks and benefits of each proposed treatment or information with regard to not undergoing treatment and patient's choices.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered private dental treatment, facial aesthetics and orthopaedic surgery. However, services offered at the practice were misleading. The external window of the building listed treatments such as cosmetic surgery, laser treatments, joint replacements plus dental procedures. This was also the case on the practice website and practice brochure. We spoke with the provider who told us that the majority of the services listed on the window and the website and brochure were no longer available and that they were in the process of re-branding which would include accurate advertising and information about the services the practice offered. We noted that the provider referred to registration with the Healthcare Commission. This was displayed on the window, referred to on the practice website and brochure and mentioned in a promotional video. We saw the same statements on headed notepaper used for correspondence. The Healthcare Commission was abolished on 31 March 2009 with its responsibilities subsumed by the Care Quality Commission. Therefore the provider was promoting false information.

Tackling inequity and promoting equality

The practice had one level access to the practice but would not be able to accommodate patients in wheelchairs as both of the dental treatment rooms and the operating theatre access involved flights of stairs. Staff told us that they would refer patients who had mobility problems to a nearby practice where all the services where on one floor.

Staff told us that all patients were treated equally regardless of their culture, religion or beliefs. There were translation services available to anyone who requested them but the practice had not had to use the service to date.

Access to the service

The practice was open Monday to Friday 9am to 6pm. Clinicians were only available on Mondays and Thursdays for dental consultations and treatments. The orthopaedic surgeon held a consultation clinic once a month on a Friday with surgery sessions in the theatre on the following Saturday. We asked staff, how they would accommodate a patient in an emergency on the days where no clinician was present. Staff told us that they could arrange appointments on a Tuesday, Wednesday or Friday and contact one of the dentists to come in. Alternatively they would ask the patient to attend the other practice owned by the provider which had clinics available Monday to Friday. Patients were given an out of hours mobile number to contact in an emergency when the practice is closed.

Patients we spoke with told us that they had no problems obtaining an appointment, including emergency appointments.

Concerns & complaints

There was no information on display in the practice, on the practice website or in the practice brochure regarding how to make a complaint. Patients we spoke with told us they did not know how to make a compliant but would speak to the staff should they have any concerns. We looked at complaints received over the past year. The most recent were two complaints received in 2014. Both had been responded to and rectified to the patient's satisfaction. The practice had conducted an audit of complaints for the period April 2015 to August 2015 but no complaints had been received during this period. We looked the previous audit which included one of the two complaints received in 2014, the complaint had been acknowledged and resolved but we could not establish that any learning or improvements had occurred from complaints received.

Are services well-led?

Our findings

Governance arrangements

The provider did not have effective governance arrangements at the practice. We reviewed the practice policies and saw that they were generic policies with little adaptation to the practice.

The practice had undertaken a number of audits to monitor and assess the quality of their service. We looked at records of audits carried out for record keeping, IR(ME)R compliance, environmental cleaning, theatre and operations audit, patient survey, hand hygiene and complaints. Actions identified were recorded as "discuss in meetings" staff told us that meetings occurred every week, however staff meeting minutes were last recorded in April 2015. During both inspections we found that although dental care records had been audited in August 2015, the actions identified had not been implemented. There was not enough evidence to demonstrate that audits were being used effectively to improve the quality in the practice.

The practice had not carried out any audits in areas that were relevant to their practice, such as, infection control, the quality of X-rays and sedation. These three audits are requirements of HTM 01-05, IR(ME)R 2000 and the Society for the Advancement of Anaesthesia in Dentistry (SAAD) respectively. Therefore a complete system of clinical governance had not been implemented and the quality of care in these areas was not checked.

Risk assessments had been carried out in relation to fire safety and legionella. However the actions identified in the legionella risk assessment had not been implemented, such as recording water temperatures. The practice had not carried out a health and safety risk assessment nor had any information with regard to the control of substances hazardous to health (COSHH). COSHH is a requirement to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. Also staff were unaware of how to utilise information to monitor risks through the use of Medicines and Healthcare products Regulatory Agency (MHRA) alerts.

Leadership, openness and transparency

The principal dentist was responsible for the day to day running of the practice. Prior to our inspection we had been informed by the GDC that the provider had been subject to conditions to their registration. A dental professional's registration can be made subject to conditions in situations, such as complaints from patients. If the dental professional breaches the conditions, the GDC can take further action. During both of our inspections we found that treatments that the dentist had been told to refrain from had been carried out on a number of occasions. Some records had been changed to state that another clinician had carried out the work. Two of the clinicians recorded were not members of staff at the practice and there were no staff files with their details.

Learning and improvement

The practice did not have a formalised system of learning and improvement. There was no schedule of audits and we found that audits completed were not used to improve the service. Staff told us that meetings were held weekly but the last documented meeting was dated April 2015, we asked what topics had been discussed at meetings held post April 2015 and staff could not recall what the meetings had been about. The practice had no formal mechanisms to share learning. Incidents that had occurred had not been recorded as an incident and no learning achieved as a result.

Staff had completed professional development in most areas. However, continuing professional development that is required for ongoing registration with the General Dental Council had not been completed for sedation.

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

Staff told us they collected feedback from patients continuously and we saw forms available for patients to complete in the reception area.

The practice conducted a patient survey to seek the views of patients using the practice. The survey involved completion of a questionnaire and the results collated and analysed. We found that the result of the last survey carried out in August 2015 reflected that the majority of patients either found the service good or excellent.

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 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1) (e) HSCA (RA) Regulations 2014 Premises and equipment 15 (1) (e) How the regulation was not being met: The provider had not completed a working radiation protection file or could demonstrate that regular maintenance or performance checks were carried out. The practice did not hold Health and Safety Executive notification for the use of radiography at the premises.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10 (2)(a) How the regulation was not being met: The provider could not demonstrate the justification for the use of CCTV in the treatment rooms and operating theatre / recovery room. The surveillance used was not operated in line with current guidance and patients were not aware that they were being filmed as there was no signage to inform them.

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 12 (2)(a)(b)(e)(g)(h) HSCA (RA) How the regulation was not being met: The practice did not carry out any risk assessments with regard to radiography, infection control and sedation. The practice was re-processing single use items that were used on other patients against the manufactures declaration that the items are single use only. The practice did not store and dispense some of the medicines used safely. Medicines prepared in plastic bags for dispensing had been removed from their original packaging. No expiry date had been recorded and no invoice could be produced to show when the medicines had been procured. No regular infection control audits had been carried out and decontamination processes were not in line with HTM 01-05.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2)(a)(b)(c)(d) HSCA (RA) How the regulation was not being met: The practice did not have a robust system to record, respond and learn from significant events. Staff did not know what constituted a significant event and an accident that had occurred had not been recognised as a significant event. Staff did not understand their responsibilities with relation to RIDDOR. Risk assessments for key areas such as infection control,

This section is primarily information for the provider

Enforcement actions

pressure vessels, radiography and sedation had not been carried out. Where a risk assessment for legionella had been carried out the actions identified had not been implemented.