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Dental Surgery - Stonegate

Inspection Report

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Overall summary

We carried out this announced inspection on 23 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We told the NHS England area team and Healthwatch that we were inspecting the practice. We did not receive any information of concern from them.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Dental Surgery - Stonegate is in York and provides NHS and private treatment to adults and children.

Due to the practice being located on the first and second floor, patients with mobility requirements are referred to a local practice that can help with access more easily.

The dental team includes one dentist, three dental nurses, and a receptionist.

The practice has one surgery a decontamination room for sterilising dental instruments, a staff room/kitchen and a general office

Summary of findings

The practice is owned by an individual who is the principal dentist. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection we collected 79 CQC comment cards filled in by patients and spoke with three other patients. This information gave us a positive view of the practice.

During the inspection we spoke with one dentist and two dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday – Friday 9am – 12 pm & 2pm – 5pm

Our key findings were:

- Environmental cleaning of the practice was not carried out in line with recommended guidance.
- The practice had infection control procedures in place which reflected out of date guidance.
- Staff were not confident they knew how to deal with medical emergencies. Not all appropriate emergency medicines and life-saving equipment were available.
- The practice did not have effective systems to help them manage risk. There were no fire safety management systems in place.
- The practice was not registered to receive medical device alerts from Medicines and Healthcare Products Regulatory Authority (MHRA).
- The disposal process and security of clinical waste and items identified under Control of Substances Hazardous to Health was not always adhered to.
- The practice did not have effective safeguarding processes and staff were not fully aware of their responsibilities for safeguarding adults and children.
- The appointment system met patients' needs.
- The practice did not have thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment mostly in line with current guidelines but improvements could be made.
- Staff treated patients with dignity and respect. We found areas of concern relating to patients privacy and confidentiality.
- The practice did not have effective leadership. Staff were involved but did not feel supported.
- The practice asked staff and patients for feedback about the services they provided.
- The practice had a complaints process but improvements could be made.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's testing protocols for equipment used for cleaning used dental instruments taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the practice protocols and procedures taking into account guidelines issued by the National Institute for Health and Care Excellence (NICE), the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention', the Faculty of General Dental Practice regarding clinical examinations and record keeping, the British Society of Periodontology and ensure the practice is in compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 in relation to recording in the patient's dental care records.

Summary of findings

- Review the storage of archived dental care record to ensure they are protected from environmental and fire risks.
- Review the practice complaint handling procedures and establish an accessible system for patients. Make sure a process is in place for identifying, receiving, recording, handling and responding to complaints by service users.

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 Enforcement section at the end of this report).

The practice had limited systems and processes in place to provide safe care and treatment.

There was no system in place to report, record and analyse significant events or RIDDOR.

The practice was not registered to receive alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

Staff received training in safeguarding but were unsure how to recognise signs of abuse and how to report concerns.

The practice's risk management processes were not effective. We identified areas where risks to staff and patients safety had not been identified. Risk awareness within the whole team was minimal.

The provider had carried out a basic sharps risk assessment but it was not enforced. It did not include the steps taken to minimise the risk from other sharp instruments and devices.

The provider had no fire safety management systems in place and no risk assessment had been carried out. After the inspection day we confirmed with the local fire service the practice had taken action to have a fire risk assessment carried out.

The recruitment process was not effective and did not reflect current legislation.

Management of medical emergencies and medical emergency equipment was not effective. Processes in place to check emergency medicines and equipment was not in line with recommended guidance. Basic life support training had not been carried out within the last 12 months.

The practice had infection control procedures in place which reflected out of date guidance. Validation of some of the equipment used to in the decontamination process could not be confirmed on the inspection day.

The disposal process and security of clinical waste and items identified under Control of Substances Hazardous to Health (COSHH) were not always adhered to.

Environmental cleaning of the practice was not carried out in line with recommended guidance.

Enforcement action

Summary of findings

Are services effective?

No action

We found that this practice was providing effective care in accordance with the relevant regulations. We found there were elements of the effectiveness key question that required improvement. These are detailed in the main body of the report under monitoring and improving outcomes for patients, health promotion and prevention and consent to care and treatment. We shared this information with NHS England the commissioner of local dental services, an agency that could help the provider to improve the effectiveness of clinical care for people who use the service.

Patients described the treatment they received as excellent and outstanding.

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

Staff were responsible for driving their own performance and to complete training relevant to their role. There was no system in place to monitor the training.

Are services caring?

No action

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

We received feedback about the practice from 82 people. Patients were positive about all aspects of the service the practice provided. They told us staff were kind and helpful.

They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them.

We identified areas of concern in relation to patient privacy and confidentiality when being dealt with in the treatment room and waiting room.

We identified an area of concern relating to the security of postal mail delivered at the practice.

Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

Patients said staff treated them with dignity and respect.

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 had a complaints process which was not accessible to patients who wished to make a complaint.

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

Summary of findings

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

The practice requested feedback and valued compliments from patients.

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 Enforcement section at the end of this report).

The practice had minimal governance arrangements to ensure the smooth running of the service. Policies and procedures were not regularly reviewed, were not all practice specific and there was no evidence staff read and understood them.

Systems for the practice team to monitor and discuss the quality and safety of the care and treatment provided were not robust. This included audit of X-rays and infection prevention and control.

The registered provider was responsible for the day to day running of the practice.

Staff reported the registered provider was approachable; they were able to raise issues or concerns at any time although action was not taken when issues were identified. Staff did not always feel supported in their role.

The registered provider showed little commitment to learning and improvement.

The practice sought feedback from patients in order to improve the quality of the service provided. No action plans were in place to review and discuss the feedback provided from patients.

Enforcement action 

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had no policies and procedures in place to investigate, respond to and learn from significant events. Staff were not aware of reporting procedures but were encouraged to raise safety issues to the attention of colleagues and the registered provider. Staff gave an example of an incident that had occurred which should have been analysed to identify the cause and to avoid repetition; this had not been done.

Staff had no understanding of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was no RIDDOR documentation in place.

We saw the practice had an accident book which had no entries recorded in the last 12 months; no evidence was available to show how the practice responded to accidents or significant events and there was no awareness of what constituted a significant event or that the CQC should be notified of such an event.

The practice did not receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). The registered provider told us they had not registered to receive alerts and staff were not aware of what MHRA was. There was no system in place to protect patients from harm in the event of using equipment or materials which had been recalled or identified not to use by the MHRA.

Reliable safety systems and processes (including safeguarding)

Staff received training in safeguarding but were unsure how to recognise signs of abuse and how to report concerns.

We reviewed the practice's safeguarding policy and procedures in place for safeguarding vulnerable adults and children using the service. There was a child protection protocol in place which included contact details for the local authority safeguarding team, social services and other relevant agencies. The policy was last reviewed and updated in 2014. There was information regarding safeguarding adults and vulnerable children but no separate policy in place for safeguarding adults. Safeguarding training had been carried out by all staff in November 2017.

A staff member described a safeguarding incident which they had identified but did not know who to approach to raise their concerns. The safeguarding issue was not discussed with the registered provider and was not taken any further in respect of asking for professional advice. As a result of this, action had not been taken to address concerns until we intervened. Safeguarding processes were not robust and procedures to safeguard patients were not in place.

There was a generic whistleblowing policy in place. The policy was not practice specific, it referred to a practice manager who was not employed at the practice and had no external contact numbers documented. Staff were not aware of with whom to raise concerns with if they could not approach the registered provider.

Monitoring health & safety and responding to risks

We looked at the practice's arrangements for safe dental care and treatment.

There was a basic sharps risk assessment in place for the handling of needles but it was not enforced by the dentist. The risk assessment did not include the risk from other sharp dental items.

The dentist did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. We were told that occasionally alternative methods would be used. There was no risk assessment in place to mitigate the risks associated with the alternative procedures.

The practice was registered with an authorised contractor for the collection and safe disposal of clinical waste. The contract did not include the collection of X-ray chemicals, lead foil, amalgam capsules or amalgam sludge. We found a full container of amalgam capsules and several amalgam sludge containers in the cellar. The cellar was accessible to an attached business on the ground floor. We also found significant amounts of waste developer and fixer in a secured outbuilding which was only used by the practice. These were not in the correctly identifiable COSHH waste containers. The provider told us that a separate contract was in place to collect these items when a substantial amount had been accumulated but no evidence of this was seen.

The manual X-ray processing equipment was located in an un-heated room; we discussed how the provider monitored

the temperature sensitive nature of processing X-rays to ensure X-rays are processed properly to avoid over or under development. The provider told us they carried the chemical tanks individually to the sink and used hot water to heat the tank until the chemicals were at the correct temperature. There was no risk assessment in place to mitigate the risks associated with this procedure or processes to prevent spillage into the drainage system. There was no X-ray processing protocol in place to ensure the X-rays were processed correctly.

There was no fire safety management system in place at the practice. No fire risk assessment had been carried out at the practice due to the low numbers of permanent staff employed. The practice is a shared building which is owned by the registered provider. The practice is situated over three floors with an attic and shared cellar. We noted there were no smoke detectors, emergency lighting or alarm system in place. There was no evidence of fire drills being carried out.

After the inspection day we confirmed with the local fire service the practice had taken action to have a fire risk assessment carried out.

We also noted the open gas fire in the waiting room was not guarded by a full screen guard. There was a low fender which did not provide substantial protection. The waiting room was not monitored by staff.

Medical emergencies

Staff had received continuous professional development training in the form of a presentation day covering basic life support and medical emergencies in November 2017. No hands on basic life support training had been completed within the last 12 months.

Not all emergency equipment and medicines were available as described in recognised guidance. We found an airway was past its expiry date. We saw records of the checks to make sure these items were available, within their expiry date, and in working order but these were not carried out in line with recognised guidance. For example, medical oxygen and the Automated External Defibrillator (AED) were not checked weekly. The emergency medicine glucagon was stored in the fridge, and the fridge was temperature monitored. We noted some of the recorded fridge temperatures had exceeded the accepted range and no remedial action had been taken.

The medical emergency oxygen cylinder was not of an appropriate size to deliver an adequate flow rate of 15 l. per minute. This is not in line with recommended guidance.

We highlighted these areas of concern to the registered provider and dental nurse who assured us that processes would be reviewed.

Staff recruitment

The practice had a basic staff recruitment policy in place which did not reflect relevant legislation. We looked at four staff recruitment files and these showed the practice did not follow relevant legislation when recruiting new staff. Two members of staff had a DBS in place but these were not practice specific. No risk assessment was in place to support this. Identification was not present for three staff members, contracts of employment, references, professional certificates and indemnity certification was not available in the staff files.

Monitoring health & safety and responding to risks

There was limited evidence the practice had undertaken any risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice.

The practice had completed Control of Substances Hazardous to Health (COSHH) risk assessments for all materials and safety data sheets were in place.

The provider did not have a thorough system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. People who are likely to come into contact with blood products, and are at increased risk of injuries from sharp instruments, should receive the Hepatitis B vaccination to minimise the risks of acquiring blood borne infections. We saw immunisation certificates for the registered provider and two dental nurses. A certificate for one dental nurse was not available in the staff file.

A dental nurse worked with the dentist when they treated patients. The dental nurse was also required to manage the arrival and departure of patients and answer telephone calls when there was no receptionist. We were told the receptionist works three to four days per week.

We highlighted these concerns to the registered provider and were assured improvements would be made.

Are services safe?

Infection control

The practice had basic infection prevention and control policy in place, no lead was identified on the policy. The policy made no reference to the specifics of the practice or the decontamination process. For example, both the decontamination room and treatment room had only one sink. Hand washing and decontamination of instruments was carried out at the same sink in the decontamination room. Staff were able to describe the procedures they undertook to manage the both activities but no protocol was in place to support this. The decontamination room was located above the treatment room and was not frequently occupied or secured.

Staff had completed infection prevention and control training November 2017.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. We were unable to confirm that equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance. We saw a checklist showing some validation was being carried out but no evidence of a foil test or protein test was available for the ultrasonic bath and no evidence of an automatic control test was seen for the steriliser as recommended by guidance. The practice was not working to the updated version of Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices.

We found PPE including gloves and wipes used in the decontamination process disposed of in a black refuse bag. These items should be disposed of in an identifiable, labelled clinical waste bag.

The practice did not carry out infection prevention and control audits in line with recommended guidance. An audit had been carried out once but we were unable to confirm when. The registered provider was not aware that infection prevention control audits should be carried out twice a year. The audit was not reviewed and there was no resulting action plan or learning outcomes in place.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment.

The practice was clean when we inspected and patients confirmed this was usual. We reviewed the practice cleaning processes and found there were no cleaning schedules in place and equipment used for cleaning the premises was not in line with recommended guidance. The system was not operating effectively and no system was in place to monitor cleaning standards.

Equipment and medicines

We saw servicing documentation for the equipment used.

The practice had suitable systems for prescribing. The practice stored and kept records of NHS prescriptions as described in current guidance.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file. We noted that the most recent routine test of the X ray machine had recommended the use of a rectangular collimator to reduce the level of radiation to the patient. A collimator was available but was not used.

We saw evidence that the dentist graded and occasionally reported on the X-rays they took but justification was not always recorded in the patient's notes. The practice carried out X-ray audits every year following current guidance and legislation but analysis for learning and improvement was not carried out.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dental care records we reviewed did not contain detailed information about the patient's current dental needs and past treatment. The dentist carried out an examination and recorded the medical history information within the patients' dental care records. We were told that at all subsequent appointments the dental nurse asked patients to review their medical history but this was not consistently recorded or signed by the patient.

We saw no evidence of a discussion of treatment options or the risks and benefits with the patient. Diagnosis and a full assessment of each patient's needs were not consistently recorded.

Oral health was not always monitored in line with NICE guidelines. We saw that gum scores and basic gum treatments were carried out for most patients but treatments for more complex gum conditions were not evident. The dentist told us he did not carry out periodontal pocket charting as a means of monitoring progress of disease or response to treatment as recommended by the British Society of Periodontology. We were told that advice to the patient on the extent of their periodontal condition was discussed but we did not see evidence of this.

The practice was not in line with current guidelines in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentist was not applying the guidance from The Faculty of General Dental Practice (FGDP(UK) on X-ray frequency and was unsure of how to access that guidance. We were told that they took X-rays only if they felt there was a problem or to try to identify the source of pain. The dentist told us that they did not take X-rays to assess bone loss in patients where gum scores indicated significant periodontal disease.

Health promotion & prevention

The dentist told us they did not always use all elements of Department of Health's policy, the 'Delivering Better Oral Health' toolkit; this includes information on fluoride applications. Fluoride treatments are a recognised form of preventative measure to help protect patients' teeth from decay. They did not use fluoride varnish for children based on an assessment of the risk of tooth decay and relied upon fissure sealant when they felt that a child was at risk.

The dentist told us they discussed smoking, alcohol consumption and diet with patients during appointments. We found no evidence of this documented in the patients notes. There was no evidence the dentist assessed or recorded patients' risk categories.

Staffing

We saw no evidence that induction processes were in place for locum staff or staff new to the practice.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Staff told us they informally discussed training needs at annual appraisals. Staff told us they had annual informal appraisals and training requirements were discussed at these. Staff felt they could approach the registered provider at any time to discuss continuing training as the need arose but staff told us they had to drive their own development.

Working with other services

The dentist told us they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. These included 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. A referrals log was not maintained.

Consent to care and treatment

Staff told us they understood the importance of obtaining consent to treatment and that consent was largely based on discussion and was not routinely documented in the patients' records. The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions but we saw no evidence of this documented in the patients' records.

Patients told us their dentist listened to them and gave them clear information about their treatment.

Are services effective?

(for example, treatment is effective)

There was no consent policy in place and staff were not aware of the Mental Capacity Act 2005. The team did not understand their responsibilities under the act when treating adults who may not be able to make informed decisions

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients commented positively that staff were helpful and caring. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients.

The reception desk and telephone were situated in the treatment room. We saw that patients' privacy and confidentiality would be difficult to maintain whilst attending to the patient in the dental chair and answering a query from a caller. We also saw that appointments were made and payments were taken openly in the waiting room. We were unable to observe how patients were treated at the reception desk or over the telephone.

We observed the staff to be welcoming and caring towards the patients. Staff told us that if a patient asked for more privacy they would take them into another area of the practice.

They stored paper records securely. Archived paper records were stored in cardboard boxes in the attic. The attic was secured but the records were not currently protected from environmental or fire damage.

We noted that postal mail for the practice was deposited by the postal service on the floor of the ground floor hallway. Potentially sensitive personal information was accessible by people entering and leaving the building. We drew this to the provider's attention and were told that they were aware of the potential confidentiality issue but had not considered an alternative mail collection device.

Involvement in decisions about care and treatment

Patients told us that the dentist discussed treatment options with them but there was no evidence of this in the records we reviewed.

The 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

The practice had an appointment system to respond to patients' needs. We saw that the dentist tailored appointment lengths to patients' individual needs and patients could choose from morning and afternoon appointments.

Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice had no patients' advice leaflets or practice information leaflets available in the waiting areas.

Tackling inequity and promoting equality

Reasonable adjustments had been made to the premises. The practice could not accommodate restricted mobility patients. The staff worked closely with a local practice and would refer patients to them.

The practice did not have an equality and diversity policy to support staff and no training had been provided or undertaken to provide an understanding to meet the needs of patients. The practice had access to translation services for those whose first language was not English.

Access to the service

The practice did not display its opening hours in the premises.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept some appointments free for same day appointments. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a complaints process which was not accessible to patients who wished to make a complaint; we saw that contact information about external agencies was incorrectly documented. The practice did not have information about how to complain in a practice leaflet. The practice had received no complaints in the last year, and no historical evidence could be found to review if the process had been carried out appropriately.

Are services well-led?

Our findings

Governance arrangements

The registered provider had overall responsibility for the management and clinical leadership of the practice. Staff knew the management arrangements and their roles and responsibilities.

The practice had minimal governance arrangements in place. Most of the policies and risk assessments we looked at had never been reviewed and there was no evidence staff had read and understood them. Some policies provided minimal information, were generic and had not been adapted to ensure they were practice specific. For example, whistleblowing, infection prevention and control and staff recruitment.

There was no policy in place for consent to treatment, safeguarding vulnerable adults and mental capacity.

Leadership, openness and transparency

There was no policy in place and staff were not aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the registered provider encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the registered provider was approachable and would listen to their concerns. Staff told us they were not confident that appropriate action would always be taken to respond to concerns raised. We were told the registered provider discussed concerns at staff meetings but did not see evidence of this in practice minutes.

We saw little evidence to support the practice worked as a team.

The practice held meetings where staff could raise any concerns. Staff told us concerns raised were not always acted upon.

Immediate discussions were arranged to share urgent information.

Learning and improvement

The practice had some quality assurance processes in place but learning and continuous improvement was not evident. These included audits of X-rays and infection prevention and control. Records of the results of these audits and the resulting action plans and improvements were not in place. The X-ray audit was difficult to analyse and did not always correspond with patient records when reviewed together.

The registered provider showed little commitment to learning and improvement and the contributions made to the team by individual members of staff. Dental nurses had informal annual appraisals. They discussed learning needs. We did not see any process to support that the provider monitored staff professional development.

Staff told us and we saw they had recently completed recommended training, including a medical emergencies training presentation. Basic life support training had not been carried out within the last 12 months. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us they had to drive their own professional development.

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

The practice had a system in place to seek the views of patients about all areas of service delivery through the use of patient surveys.

The registered provider explained the practice had a good longstanding relationship with their patients. The practice was participating in the continuous NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. The practice had completed a patient's feedback survey in 2016; the feedback was very positive but there was no evidence that the feedback had been reviewed or acted upon.

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 **How the regulation was not being met:** **The registered provider had not ensured that care and treatment were being provided in a safe way for patients** **Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular:** • The registered provider did not have a system in place for identifying, recording, investigating and reviewing incidents, significant events and RIDDOR. • There was no system in place to protect patients from harm in the event of using equipment or materials which had been recalled or identified not to use by the MHRA. • The registered provider did not have appropriate emergency equipment in place, carrying out effective checks and ensuring adequate training had taken place. **The registered provider had failed to do all that is reasonably practicable to mitigate any such risks.** • The registered provider did not have a health and safety policy • The registered provider did not have a dental specific risk assessment. **There was no effective process in place to assess the risk of, and prevent, detect and control the spread of, infections.** • There was no hand washing systems in place in the decontamination room. • The registered provider did not have systems in place for effective clinical waste handling protocols to ensure it was segregated and disposed of in accordance with relevant regulations.

This section is primarily information for the provider

Enforcement actions

The registered provider knew the importance of assessing the risks of infection being spread as a result of unclean premises but had failed to ensure that an effective environmental cleaning process was in place.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The registered provider did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular: • The registered provider failed to ensure that effective safeguarding procedures and staff awareness was in place to protect patients who use the service. Regulation 13 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The registered provider had failed to ensure the people delivering care and treatments were aware of their responsibilities under the Mental Capacity Act 2005 and the risks relating to the health, safety and welfare of patients.

This section is primarily information for the provider

Enforcement actions

The registered provider had not assessed, monitored or mitigated its duty to be open and honest to patients or their representatives in the event of a notifiable safety incident occurring.

The registered provider failed to ensure suitable

Governance arrangements were in place.

The registered provider's systems had not alerted him to the fact that he did not have effective systems in place to ensure appropriate consent to treatment was attained and recorded.

The registered provider had failed to assess, monitor and improve the quality and safety of the services provided by not

- Ensuring there was clear signage,
- Restricting access to clinical areas; and Monitoring of the wellbeing of patients in the waiting room.

The registered provider had failed to ensure appropriate data protection and confidentiality measures were in place in relation to dealing with patients in the treatment room, waiting area and postal mail security.

The registered provider did not have systems or processes in place to assess, monitor and improvement the quality of the services provided by not:

- Completing audits at the recommended intervals, action plans; and ensuring that learning outcomes were in place.

There was additional evidence of poor governance. In particular:

- The registered provider failed to show a commitment to staff learning and improvement and no system was in place to monitor this.

Regulation 17(1)

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

How the regulation was not being met:

The registered provider had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:

- Identification for staff
- References
- DBS checks
- Medical Indemnity

Regulation 19 (3)