Dr. Baber Khan

Dr Baber Khan - The Crescent

Inspection Report

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Overall summary

We carried out this announced inspection on 13 September 2019 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.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice is in Spalding, a market town in the South Holland district of Lincolnshire. It provides private dental treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs at the rear of the premises. There are no car parking facilities, but on road parking is available for a limited time. There are also public car parks within close proximity to the practice. These include parking for blue badge holders.

The dental team includes one dentist, one dental hygienist and a practice manager. The practice manager

Summary of findings

had recently qualified as a dental nurse. A the time of our inspection, the provider was in the process of recruiting a dental nurse, as one working in the practice had recently left.

The practice has two treatment rooms, one on ground floor level and a separate decontamination room.

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

We sent 50 comment cards in advance of our visit to the practice for patients to complete. On the day of inspection, we collected 7 CQC comment cards that had been filled in by patients. This represented a 14% response rate.

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

The practice is open: Monday, Tuesday, Thursday and Friday from 9am to 5pm. It is closed on Wednesdays.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance. We noted some improvements could be made when manual cleaning of dental instruments took place.
- All but one member of staff had received formal training in how to deal with emergencies. Appropriate medicines were available, but not all life-saving equipment.
- The provider had insufficient systems to help them manage risk to patients and staff.
- The provider did not have adequate safeguarding processes and not all staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider did not have a recruitment policy or procedure. We noted areas where legislative requirements were not met such as obtaining of references or other evidence of previous satisfactory conduct in employment for staff.
- We were not assured that clinical staff always provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- Staff were aware of the importance of patient confidentiality.
- The provider used a comment box to obtain feedback from patients.
- The provider had not received any formal complaints.
- The provider did not demonstrate effective leadership and a culture of continuous improvement.
- Staff changes had impacted upon the smooth running of the service.
- The provider demonstrated they were taking responsive action after the day of our visit.

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

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Ensure care and treatment is provided in a safe way to patients.
- 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:

- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of dental dams for root canal treatment.

Summary of findings

- Take action to ensure the clinicians take into account the guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when promoting the maintenance of good oral health.
- Introduce protocols regarding the prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Implement processes and systems for seeking and learning from patient feedback with a view to monitoring and improving the quality of the service.
- Take action to ensure the service takes into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

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?	**Requirements notice** ✖
Are services effective?	**Requirements notice** ✖
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The practice did not have clear systems to keep patients safe.

Not all staff knew their responsibilities regarding the safety of children, young people and adults who were vulnerable due to their circumstances. The provider held a brief safeguarding policy document which referred to another dental practice owned by the provider. We noted that external protection agency contact details for reporting concerns were posted on a notice board in the patients' waiting area and also in a folder kept in the reception area. We noted that the contact details on each document were different. The principal dentist told us they did not have a process for checking that the information was up to date, so it was unclear if the relevant details were held.

The principal dentist was the lead for safeguarding concerns. There was no documentation to show that they had completed safeguarding training; the principal dentist told us this had not been undertaken within the previous three years. We saw evidence that only the hygienist had completed safeguarding training to level two.

The hygienist showed awareness of the type of safeguarding concern they would refer to the principal dentist. We were not assured that the principal dentist was fully aware about the signs and symptoms of abuse and how to report concerns.

The provider held a brief policy document regarding whistleblowing. This did not include enough detail regarding whistleblowing procedures and it referred to a council and not the dental practice. It did not include details to whom concerns within the practice should be reported or those of any external organisations. A member of staff we spoke with told us they would look in the contact information folder held in the reception area to check for external contact details. When we viewed this document, it did not include these details. The member of staff told us they would seek to contact the police if a circumstance arose.

The dentist did not use dental dams as frequently as recommended in guidance from the British Endodontic Society, when providing root canal treatment. The dentist told us of other measures used in place of rubber dam; these would not provide suitable airway protection for the patient, however. The day following our inspection, we were informed that dental dam had been purchased.

The provider did not have a formal business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. The principal dentist told us they did have an informal arrangement with another local dental practice that patients could be referred to in the event of the premises being un-useable.

The provider did not have a recruitment policy or procedure to help them employ suitable staff. We looked at five staff recruitment records in respect of current and former members of staff to check compliance with legislative requirements. These showed some of the legislative requirements were met, but we also noted exceptions. For example, references or other evidence of previous satisfactory conduct had not been sought for all the staff members. One former member of staff did not have a photograph held on their file and a ported Disclosure and Barring Service (DBS) check was present that was dated two and a half years prior to their employment starting at the practice. A risk assessment had not been completed for the staff member. We noted that one current member of staff had a basic and not enhanced DBS check on their file, as required for staff working in a clinical capacity.

Clinical staff were qualified and registered with the General Dental Council (GDC) where applicable. The hygienist was currently under supervision as they had trained outside the UK in a country within the European Union. The practice manager had recently qualified as a dental nurse and was waiting for their GDC registration. We saw that the principal dentist had professional indemnity cover. We were informed that the cover extended to other staff within the clinical team, but we were unable to confirm this with the documentation made available to us.

Are services safe?

Staff ensured that equipment was safe to use, although there was no evidence that electrical five-year fixed wiring testing had been completed.

We noted that portable electrical equipment was subject to testing. We were informed that the boiler had recently been installed and therefore did not yet require an annual safety check.

Records showed that fire detection and firefighting equipment had been tested and serviced within the previous 12 months by an external contractor. We were told that fire drills had been undertaken but there was no documentary evidence to support this.

The practice had recently obtained new X-ray equipment. We were not provided with some of the documentation regarding the safe installation of the X-ray equipment. This included critical exam and acceptance paperwork and a radiation risk assessment. The provider had not yet registered under the new system with the Health and Safety Executive (HSE). Following our visit, we were sent a copy of the critical exam and acceptance document and evidence regarding the provider's efforts to register with HSE.

A radiation protection file was held.

We saw evidence that the dentist justified, graded and reported on the radiographs they took. We viewed a radiography audit; we noted the sample size was small; however, the dentist did not take many X-rays. The audit did not include review of the grading of radiographs or identify areas for improvement.

We saw that the dentist had completed one hour of dental radiography update training in 2018. The hygienist had undertaken training in this area. The GDC recommends five hours of radiation protection in each five year cycle.

Risks to patients

There were insufficient systems to assess, monitor and manage risks to patient safety.

We found information contained in the health and safety at work file was a collation of health and safety documents rather than practice specific policies. We noted that some of the information had been obtained in 2014; the practice had written on a cover sheet that they had reviewed it each year, but changes or updates did not appear to have been included.

Not all risk assessments required with a dental setting were held. It was not evident that those that were held, were subject to regular review.

We looked at the practice's arrangements for safe dental care and treatment. The practice had not implemented a safer sharps system as described in the EU directive. The dentist used traditional needles. The hygienist told us that only the dentist handled used needles. The practice also used traditional matrix bands that required dismantling. The hygienist told us they would use forceps as a preventative measure to reduce the risk of injury. A sharps' risk assessment had not been undertaken. After our inspection, we were told that a risk assessment had been completed and that disposable matrix bands had been purchased.

The provider did not have a robust system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We reviewed documentation relating to six staff (including former staff). Of these, three of the files contained the required information. One of the current staff members was undergoing a course of vaccinations, however a risk assessment had not been completed whilst their immunity levels to Hepatitis B were unknown.

Most staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year. Training was last completed in May 2019. The hygienist had started work for the practice after this date and had yet to complete formal training in this area. They told us they had received it elsewhere and some in-house.

Emergency medicines were available as described in recognised guidance. We found that not all equipment was held, however. For example, there were no child or adult self-inflating bags with reservoir, no clear face masks for self-inflating bags, size one oropharyngeal airways was missing and there was no portable suction available. The practice did not have access to an automated external defibrillator (AED) and had not completed a risk assessment. Following our inspection, the provider placed an order for an AED and we were sent evidence of this. They also placed orders for some of the missing kit.

Are services safe?

There were three monthly checks on medicines held, these were logged. We found staff did not keep records of their checks of equipment held; they told us they undertook these on a quarterly basis. Whilst the checks were undertaken, they were not as frequently as recommended in guidance.

The hygienist was currently working with the dentist when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team. They were providing interim support until a new dental nurse was appointed.

The provider had current employer's liability insurance.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care.

We saw that the principal dentist had updated their training in infection prevention and control in February 2018. The practice manager had recently qualified as a dental nurse and the hygienist had not yet completed formalised training in the UK. They told us that the principal dentist had provided guidance and direction on infection and prevention control training.

The provider had suitable arrangements for transporting, checking, sterilising and storing instruments in line with HTM 01-05. We noted that when manual cleaning took place, the dilution was incorrect as the solution was placed on the brush and then the dental instruments scrubbed in water.

The practice used an ultrasonic cleaner. Whilst weekly protein tests were undertaken to validate the equipment, foil tests were not completed, and the equipment had not been serviced. The autoclave was validated, and servicing had taken place. There were suitable numbers of dental instruments available for the clinical staff. We found staff had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

A legionella risk assessment had been undertaken in January 2014 by an external agent. Details of the risk assessment and recommendations were not available for our review. We saw correspondence with the Health and Safety Executive (HSE) at the same time regarding a concern raised regarding legionella control at the practice. The correspondence showed that the HSE was satisfied that appropriate measures had been taken and no further action on their part was planned. The principal dentist had recently arranged for a further assessment to take place. The practice was not testing its water temperatures to check whether legionella bacteria could grow, and they did not undertake dip slide testing. Appropriate dental unit water line management was in place.

The practice utilised self-employed cleaners to maintain the general areas of the premises. They attended the practice once a week. We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had a policy and procedures in place to ensure clinical waste was segregated and stored appropriately. A contract was held with an external agent for them to collect two clinical bags of waste a month and three sharps bins. We noted that five bags of waste had been collected on 9 September 2019. A sharps bin in the surgery downstairs was undated and staff were not aware of guidance that advises them to dispose of sharps bins after every three months.

The provider had historically carried out infection prevention and control audits, however the latest one we viewed was dated in 2016.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were legible, kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

Are services safe?

The provider had most systems for appropriate and safe handling of medicines. We noted some areas that required strengthening.

There was a suitable stock control system of non emergency medicines eg antibiotics, which were held on site. This ensured that medicines did not pass their expiry dates.

We noted that the dentist was not aware of the latest guidance regarding antibiotic prescribing, they stated they would prescribe a course of antibiotics for seven days rather than five and at a lower doseage. Labelling on medicines did not include the practice's name and address. Action was taken after the day of our inspection to include labelling on medicines. Expiry dates were always checked on medicines to ensure they were within date.

There had been a comprehensive prescribing tracker completed up until three months prior to our inspection. This was in place until a staff member left the practice.

A written protocol was not in place to prevent a wrong tooth extraction based on the Locssips (Local Safety Standard for Invasive Procedures) tool kit.

Track record on safety, and lessons learned and improvements

The provider did not demonstrate that they had all comprehensive risk assessments in relation to safety issues, for example a sharps risk assessment. Whilst there was a protocol if a needlestick injury occurred, flow diagrams were not visible in the practice. We located a protocol in one of the information folders, dated as reviewed in February 2018. It did not include contact details for the occupational health department, where staff would be referred to in the event of an injury.

There were insufficient processes for the documentation and investigation of accidents, when they occurred. An accident book was held, and we saw that five reports had been extracted from the book. The practice manager was unable to tell us where the completed reports were held. They said they recalled that one in around 2017 involved a needlestick injury and the staff member had been referred to the occupational health department.

We viewed documentation on incident reporting which included definitions for the type of incident to report. We also looked at historic reports completed in 2014; we did not see reports after this time. We also viewed practice meeting minutes dated within 2019. We identified an incident in the minutes dated March 2019 that had not been identified and reported as such. It was therefore not evident that the practice had robust systems to learn when things went wrong.

A system was not in place for receiving and acting on safety alerts. Staff were unaware about alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We received positive feedback from seven patients in CQC comment cards. They described treatment received as 'a high standard', 'professional' and 'first class'.

The dentist told us they kept up to date with current guidelines such as the National Institute for Health and Care Excellence (NICE) by reviewing dental journals and receiving dental updates.

We were not assured that the clinician always assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. This included for example, dental dam use, ensuring better oral health, patient consent and aspects of record keeping around the consent process.

Helping patients to live healthier lives

The dentist did not demonstrate that they were providing the most effective preventive care to patients as they were not aware of national guidance contained regarding the Delivering Better Oral Health toolkit.

They did not routinely use fluoride varnish for patients, as recommended in guidance.

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

Staff were aware of national oral health campaigns in supporting patients to live healthier lives. For example, smoking cessation. They directed patients locally for further support.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice and taking plaque and gum bleeding scores. We did not see evidence of six-point pocket charting. Those with high scores and advanced cases were referred to an external provider or seen several times within the practice for deep cleaning.

Consent to care and treatment

We looked at how staff obtained consent to care and treatment and whether this was in line with legislation and guidance.

The dentist told us they understood the importance of obtaining patients' consent to treatment. The dentist told us they gave patients written information about treatment options and the risks and benefits of these, so they could make informed decisions. The dentist utilised a comprehensive folder with pictures available to aid the process. We looked at a small sample of patient records; we noted that there was insufficient detail regarding the consent process. For example, in one patient's record, a crown preparation was described, but there was no mention of a prior discussion as to why or the options provided.

Patient feedback in one CQC comment card included that their dentist listened to them and gave them clear information about their treatment. They told us that the dentist 'always listened and gave expert advice on planning ahead'. Other comments were complimentary about treatment provided.

Our discussions with the practice manager showed they were aware about obtaining valid consent from relevant parents or guardians for children and young people. We were not assured that the dentist understood whom could give valid consent if a young child presented with a relative such as a grandparent.

The practice held documented information about the Mental Capacity Act 2005 (MCA). We did not view training records for the practice manager or hygienist. We noted that the dentist had completed some training many years beforehand. We were not assured that staff understood their responsibilities under the MCA when treating adults who might not be able to make informed decisions.

Documentation was also held regarding Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. Staff were not aware of the need to consider this when treating young people under 16 years of age.

Are services effective?

(for example, treatment is effective)

The dentist described how they involved patients' relatives or carers to help in the consent process. They said they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept sufficiently detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories.

No documentation was provided to us to demonstrate that practice audited patients' dental care records to check that the dentist recorded the necessary information.

Effective staffing

The dentist was supported by a hygienist who had qualified outside of the UK and was waiting for a period of supervision to conclude, prior to them working as a hygienist. At the time of our inspection, they were working as a dental nurse to provide support to the dentist. The practice manager had recently qualified as a dental nurse and also provided chairside support to the dentist as well as undertaking some administrative tasks.

Staff new to the practice had a period of induction based on a programme. Induction sheets we viewed had not been signed by staff or management, or tasks marked as completed.

We viewed certification to show that the dentist had completed some of the continuing professional development recommended for their registration with the General Dental Council.

We looked at a small sample of appraisals for current staff and those who had previously worked for the practice. We found there was not a systematic approach to when appraisals took place. For example, a trainee dental nurse had worked in the practice from November 2015 to May 2019 had a appraisal completed in 2015, but we did not see evidence recorded after this date. We noted that the hygienist had started work in June 2019 and had received an appraisal in August 2019. This included a review of their performance. We did not see that clear objectives were set as part of the appraisal process.

Staff told us the principal dentist was approachable and they could discuss training needs or requirements as and when they arose. We saw that job roles were discussed in a practice meeting in September 2019.

Co-ordinating care and treatment

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

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

The provider also had systems for 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.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were pleasant, empathetic and professional.

We saw that staff treated patients respectfully and appropriately and were friendly towards patients at the reception desk and over the telephone.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort. Feedback on one CQC comment card referred to the dentist seeing the patient with a dental emergency on the same day. On the day of our inspection, we saw that a patient with an urgent need was seen on the same day as them making contact.

Some information for patients was held in a folder in the waiting area. There were magazines and a television in the waiting area to occupy patients whilst they waited to be seen.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and the separate waiting area provided some privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff could take them into another room or private area. The reception computer screen was not visible to patients and staff did not leave patients' personal information where other patients might see it.

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

Involving people in decisions about care and treatment

We looked at how staff helped patients to be involved in decisions about their care and their awareness of the requirements under the Equality Act.

We saw:

- Staff were not aware of interpreter services for patients who did not speak or understand English. There were multi-lingual staff who may be able to assist some patients. Patients were invited to bring a friend/relative who might be able to assist. This could present a risk of mis-communications.
- Staff were not aware of how they could obtain information in other formats such as easy read. We were informed that information for patients could be printed in large font size.

Staff gave patients clear information to help them make informed choices about their treatment. Feedback in some CQC comment cards supported that staff listened to patients, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, software, screens, photographs, models, X-ray images and leaflets.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and mostly delivered services to meet patients' needs.

Staff were clear on the importance of emotional support needed by some patients when delivering care. The practice manager told us about a patient who was nervous and how they provided reassurance for them.

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

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. Longer appointments could be allocated if required, although we were informed that time always allocated for appointments ensured that patients were never rushed.

The practice had made some reasonable adjustments for patients with disabilities. This included step free access by using the door at the rear of the premises and a downstairs treatment room. The practice did not have a hearing loop or a magnifying glass/reading glasses. Whilst there was a patient toilet facility on the ground floor, this did not have a handrail or call bell. It was sited away from the reception desk, so it was not clear how staff would be able to respond in the event of a patient requiring assistance.

A disability access audit had not been completed.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it in their information leaflet.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The staff took part in an emergency on-call arrangement with some other local practices.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily.

Listening and learning from concerns and complaints

The provider told us they took complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

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

The practice manager was responsible for dealing with these. Staff told us they would tell the practice manager about any formal or informal comments or concerns to enable patients to receive a quick response.

The practice manager aimed to settle complaints in-house. They told us about a verbal complaint received in 2018 involving a patient who was unhappy with how they were spoken to by a member of staff. The practice manager had been unable to fully resolve the matter as the staff member in question had left the practice on a period of leave and had not returned. The incident had not been formally recorded, so we were unable to see how it was managed. Staff told us that no written complaints had been received, so we were unable to look at the systems for how formal complaints operated.

Information was available about organisations patients could contact if not satisfied with the way the practice manager had dealt with their concerns. This included details of the Parliamentary Health Service Ombudsmen but not the Dental Complaints Service who can address private patients concerns.

Are services well-led?

Our findings

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

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The principal dentist had capacity and skills to deliver clinical care for patients. However, we found a significant number of improvements could be made to improve the service and ensure that all risks were identified and suitably managed.

Following our visit, we noted that staff were making efforts to rectify some of the shortfalls we identified. This included obtaining relevant paperwork for the X-ray equipment, obtaining items for the emergency medicines kit, an AED, obtaining dental dams, labelling for antibiotics and a new legionella risk assessment. The provider told us they would seek help externally for assistance with policy provision.

Leaders were approachable. Staff told us they worked closely with them.

Vision and strategy

The provider had a statement of purpose that included their aim to meet the general and routine dental care needs of their patients and to achieve high levels of oral health by adopting a preventative approach.

The provider had plans to sell the practice and it was currently for sale.

Culture

Staff stated they felt respected and supported. The hygienist told us that they enjoyed their work, patient interaction and the dentist was popular and well-liked by patients.

We noted that the practice had a high turnover of staff; the latest staff member had chosen to leave unexpectedly within the weeks prior to our visit. The turnover of staff had impacted upon the smooth running of the service; at present the hygienist and practice manager were providing support to the principal dentist in the surgery room.

We saw examples where staff focused on the needs of patients, for example, we saw their responsiveness to a patient who had a dental emergency on the day of our visit. We noted an example where a patient had recently been referred to an external specialist when they were averse to receiving treatment.

We were not provided with evidence to show how the provider reviewed, understood and applied the requirements of the duty of candour. The practice had not recorded any recent significant or untoward incidents, although we identified some that should have been recorded and investigated. Whilst there had been reported accidents, documentation could not be located by the practice manager. There had been a verbal complaint, but there was no supporting documentation to show if it had been effectively managed with the complainant.

Staff told us they could raise concerns and they had confidence that these would be addressed.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager provided support to the principal dentist and this involved assisting in the day to day running of the service. Staff knew the current management arrangements and their roles and responsibilities.

The provider's system of clinical governance which should include policies, protocols and procedures required immediate review as some were not in place or were not sufficiently supporting the operation of the service. We noted that not all appropriate risk assessments had been completed, for example for sharps and for staff whose immunity levels to Hepatitis B were not known. The practice did not have access to all emergency equipment that might be required, including an AED.

We found there was scope to improve governance arrangements, for example, training in safeguarding and implementing clear policy such as whistleblowing, to ensure staff knowledge and awareness were kept up to date.

Are services well-led?

There were not clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

The practice did not readily hold all appropriate information needed. For example, a copy of the practice's legionella risk assessment. Water temperature testing for legionella did not take place, so the practice might not be aware if a concerning issue presented.

Staff were aware of the importance of confidentiality and protecting patients' personal information.

Engagement with patients, the public, staff and external partners

There was a patient suggestion box, although we did not view any feedback provided. There had not been any recent patient surveys for the provider to gauge patient satisfaction overall.

The provider gathered feedback from staff through meetings and informal discussions. Staff said they felt able to offer suggestions for improvements to the service, if any arose.

Continuous improvement and innovation

There were insufficient systems and processes for learning and continuous improvement.

The provider had some limited quality assurance processes to encourage learning and continuous improvement. These included a radiograph audit completed in August 2019. We did not view any recent infection and prevention control audits or any undertaken for record keeping. We were not assured that audit was used to drive improvement in the practice.

We saw some evidence of staff appraisals, although a systematic approach had not been implemented. We saw evidence of completed appraisals in the staff folders.

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 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must- a) be appropriate b) meet their needs, and c) reflect their preferences **How the regulation was not being met** Care and treatment was not being designed with a view to achieving service user preferences or ensuring their needs were met. In particular: • Not all staff had a clear understanding of the Mental Capacity Act 2005 and how this might impact on treatment decisions. Regulation 9 (1) (3)

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 Care and treatment must be provided in a safe way for service users. **How the regulation was not being met** The registered person had not had not done all that was reasonably practicable to mitigate the risks to the health and safety of service users receiving care and treatment. In particular:

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Requirement notices

- There was no system for the review of patient safety alerts, such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA)
- Not all equipment that may be required in an emergency was held, for example, self-inflating bags with reservoir, clear face masks, portable suction or access to an AED.

Regulation 12 (1) (2)

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 Safeguarding service users from abuse and improper treatment **How the regulation was not being met** The registered person had failed to establish systems to prevent abuse. In particular: • Safeguarding training had not been completed within a reasonable time threshold by the lead for safeguarding concerns. Staff were not fully aware about the signs and symptoms of abuse and whether they held correct details for reporting concerns. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met**

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Requirement notices

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Policy required review or implementation. For example, recruitment policy and whistleblowing.
- Effective procedures were not in place for significant event and untoward incident reporting.
- There was ineffective monitoring for staff training requirements.
- A systematic comprehensive approach had not been implemented for staff appraisals.
- There were limited systems for monitoring and improving quality. For example, radiography audit and infection prevention and control.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The provider had not identified that electrical fixed wiring testing was required to be completed.
- Risk assessments had not been implemented in relation to safety issues including:
- Sharps
- Not holding staff immunity status for Hepatitis B.
- DBS checks that had been accepted from staff previous employers
- Servicing of the ultrasonic cleaner had not taken place to ensure it was working effectively.

There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Patients' dental assessments did not include information regarding the consent process.

Regulation 17 (1) (2)

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Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons **How the regulation was not being met** • The provider had not ensured that information was held for each staff member as specified in Schedule 3. In particular: satisfactory evidence of conduct in previous employment. Regulation 19 (1) (2) (3)