Dr A M. Tabrizi Dental Practice Limited

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Inspection Report

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Overall summary

We carried out this announced inspection on 11 July 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 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

Dr A M. Tabrizi Dental Practice Limited is in Ipswich and provides NHS and private treatment to adults and children.

There is no level access for people who use wheelchairs or those with pushchairs. Car parking spaces, including spaces for blue badge holders, are available in car parks near the practice.

Summary of findings

The dental team includes one dentist, three trainee dental nurses, one trainee dental hygienist, one dental therapist, one receptionist and the practice manager. The practice has three treatment rooms.

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.

On the day of inspection, we collected 34 CQC comment cards filled in by patients and spoke with two other patients.

During the inspection we spoke with the dentist, three trainee dental nurses 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 to Thursday from 9am to 5pm, Friday from 9am to 4pm and alternate Saturdays from 9.30am to 1pm.

Our key findings were:

- We received positive comments from some patients about the dental care they received and the staff who delivered it.
- The provider had infection control procedures which mostly reflected published guidance. The practice carried out infection prevention and control audits, but not as regularly as recommended by guidance.
- The practice appeared clean and well maintained.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The provider did not have all emergency equipment in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The provider had systems to help them manage risk to patients and staff.
- The provider had some safeguarding processes. Not all staff were aware of who the safeguarding lead was or knew their responsibilities for safeguarding vulnerable adults and children.
- The appointment system took account of patients' needs.
- There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.
- Systems to ensure the safe recruitment of staff were not robust, as essential pre-employment checks had not been completed.
- Risk assessment to identify potential hazards and audit to improve the service were limited.
- Staff did not receive regular appraisal of their performance and none had personal development plans in place. There were limited systems in place to ensure staff undertook regular training.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Full details of the regulation/s the provider was/ is not meeting are at the end of this report.

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

- Review the practice's safeguarding policy and ensure it takes into account both adults and children.
- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.
- Review the practice's protocols for completion of dental care records taking into account the guidance provided by the Faculty of General Dental Practice.

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 providing safe care in accordance with the relevant regulations.	**No action** ✓
Are services effective? We found that this practice was providing effective care in accordance with the relevant regulations.	**No action** ✓
Are services caring? We found that this practice was providing caring services in accordance with the relevant regulations.	**No action** ✓
Are services responsive to people's needs? We found that this practice was providing responsive care in accordance with the relevant regulations.	**No action** ✓
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 Actions 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.	**Requirements notice** ✗

Are services safe?

Our findings

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

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

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff received safeguarding training. However, not all staff were aware of who was the practice safeguarding lead.

Staff knew about the signs and symptoms of abuse and neglect, however we were not assured staff knew how to report concerns, including notification to the CQC.

The provider had a whistleblowing policy. However, staff were not aware of the policy, or what it referred to. We therefore could not be assured they were confident they would know how to raise concerns.

We were not assured the dentist used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. Documented risk assessment and entry in clinical notes of patient's refusal of rubber dam, reasons for the refusal, or alternative methods of isolation used was not evidenced in patients dental treatment records.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The provider had a recruitment policy and procedure to help them employ suitable staff. We looked at six staff records. The practice was unable to demonstrate that they had followed the appropriate recruitment pathway and working arrangements for one appointed overseas dentist who was employed as a therapist yet was undertaking clinical procedures on behalf of the provider beyond those of an NHS therapist. Other staff files did not contain appropriate recruitment information such as references, we noted there was no disclosure and barring service (DBS) checks or any clinical references for the newly recruited therapist. We noted the DBS undertaken for the practice manager was a standard check and not an enhanced DBS check. Staff new to the practice had not received a period of induction to ensure that they were familiar with the practice's procedures. We noted trainee dental nurses, the trainee dental hygienist and the dental therapist had not received clinical supervision, one to one meetings or appraisals since they joined the practice in some cases over two years ago. The contract for the therapist stated they were a dentist, we noted they were registered with the GDC as a dentist. However, they did not have a performer or conditional performers number (a requirement for any dentist undertaking NHS dental treatment) and were working as a therapist undertaking NHS treatment. We were not assured they were working within the scope of practice for a therapist. We shared this information with NHS England.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC). We found that the dental 'therapist' and the trainee hygienist had insurance, but did not have professional indemnity cover.

Staff ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection and firefighting equipment were regularly tested and serviced. We noted that a fire risk assessment undertaken by an external provider in August 2018, identified six medium risks which required action. There was no evidence that these had been reviewed or completed. The practice manager told us that some actions had been undertaken however there was no evidence to support some of these requirements. For example, we noted one action included upgrading the ceiling between the cellar and the fire escape stairs to provide a minimum of 30 minutes fire compartmentalisation. Another action required the replacement of the door between the cellar and the ground floor to provide 30 minutes fire compartmentalisation. There was no evidence that these actions had been addressed.

The practice had some arrangements to ensure the safety of the X-ray equipment and we saw the required information was in their radiation protection file. We were told the practice Orthopantomogram (OPG) a scan that gives a panoramic view of the jaw and teeth), was out of order and had been decommissioned. There was no

Are services safe?

information with the OPG to indicate this was the case and the equipment should not be used. The practice could not evidence a record of the critical examination and acceptance test for this equipment. The practice manager told us they would speak with the radiation protection advisor and establish if there was a copy of this test, however to date we have not had any information from the practice to confirm any action has been taken.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. We viewed one radiography audit which had been completed by the dentist.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

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

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. We found that not all the members of the team had the effectiveness of the vaccination recorded in their records.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. However, staff did not regularly rehearse emergency medical simulations so that they had a chance to practise their skills or refresh their knowledge.

Emergency equipment and medicines were not available as described in recognised guidance. There was no bronchodilator, oropharyngeal airway or adult ambubag. In addition, there was no portable suction, eyewash station and no scissors available with the AED or first aid kit. We found staff kept monthly records to make sure these were within their expiry date, and in working order. However, these were not undertaken as frequently as recommended.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team. A risk assessment was not in place for when the dental hygienist worked without chairside support.

There were suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

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

The practice staff told us they occasionally used locum and/or agency staff. We were not assured that these staff received an induction to ensure that they were familiar with the practice's procedures or that the practice ensured they held the appropriate recruitment information before they worked at the practice.

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. Staff completed infection prevention and control training and received updates as required.

The provider had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. We noted the practice manager was the infection control lead.

Systems to ensure that any work was disinfected prior to being sent to a dental laboratory were in place. However, systems to ensure work was disinfected before treatment was completed were inconsistent. We discussed this with the practice manager and the trainee dental nurses and we were told a systems would be put in place to ensure all work was disinfected before being fitted to the patient.

Are services safe?

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted the practice did not use the correct coloured bags in clinical waste bins. We discussed this with the practice manager and trainee dental nurse and noted they took immediate action to rectify this.

The practice carried out infection prevention and control annually, but not as regularly as recommended by guidance. The latest audit showed the practice was meeting the required standards.

Information to deliver safe care and treatment

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 not all individual records were written and managed in a way that kept patients safe. Some dental care records we saw were sparse and lacked adequate detailed documentation.

We noted records were kept securely and complied with General Data Protection Regulation (GDPR) protection 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

The provider had some systems for appropriate and safe handling of medicines.

There was a stock control system of emergency medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required. However, we found there was no log of fridge temperatures in place to ensure the glucagon, a hormone that is involved in controlling blood sugar (glucose) levels, was stored correctly.

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

The dentist were aware of current guidance with regards to prescribing medicines.

Antimicrobial prescribing audits had not been undertaken.

Track record on safety and Lessons learned and improvements

Staff we spoke with were not aware of any policies in relation to the reporting of significant events, or of other guidance on how to manage different types of incidents. We found staff had a limited understanding of what might constitute an untoward event and they were not recording all incidents to support future learning. We were told of one accident regarding a broken waiting room chair at the practice in March 2019 which had not been recorded in the practice accident book or as a significant event.

We were not assured that the system for receiving and acting on safety alerts was effective. There was no evidence to demonstrate that these were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

Systems to keep dental practitioners up to date with current evidence-based practice were inconsistent. From our review of patient dental care records and our discussion with the principal dentist there was limited evidence to confirm that the clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay. However, there was limited and inconsistent supporting evidence documented within the patient's treatment records.

From our discussions with the dentist we were not assured they were aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. Evidence in patients' dental records was inconsistent and did not confirm that the clinicians always discussed smoking, alcohol consumption and diet with patients during appointments. We were not assured that the dentist had an understanding and was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. There was limited and inconsistent evidence supporting this documented within the patient's treatment records.

Records we reviewed indicated that patients with more severe gum disease were not consistently recalled in accordance with risk assessments and NICE guidelines.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions and we saw this documented in patient records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team had limited understanding of their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to 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. Staff were not fully aware of the need to establish and confirm legal responsibility when seeking consent for children and young people.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly. One patient we spoke with told us he 'didn't always understand what the dentist was asking him, but thought he got the gist of it'.

Monitoring care and treatment

Dental care records we reviewed contained limited information about the patients' current dental needs, risks of key oral and dental disease, past treatment and medical histories. Information to confirm the dentist and 'therapist' had assessed patients' treatment needs in line with recognised guidance was also limited.

Audits of the quality of dental care records were not routinely undertaken as recommended by guidance to ensure they met national standards. We saw the dentist had completed one patients' dental care record audit, this was a self-audit. This had not identified the lack and inconsistent documentation of treatment options having been discussed with patients.

Effective staffing

There was limited evidence that confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Are services effective?

(for example, treatment is effective)

The practice manager told us they did not undertake one to one meetings, inductions or appraisals with staff. The practice manager was unable to confirm how the practice addressed the training requirements of staff.

We were not assured staff had the skills, knowledge and experience to carry out their roles.

Co-ordinating 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.

There were 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. However, there were no systems in place to ensure the practice monitored any referrals to make sure they were all dealt with promptly.

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 excellent, lovely and very gentle. We saw that staff treated patients appropriately and kindly and were friendly towards patients at the reception desk and over the telephone. One patient commented that staff were friendly and caring as they were really nervous about having an extraction. They fitted them in with an appointment as they were experiencing a lot of pain. They told us the dentist was very patient and didn't rush them. As a result, they told us they felt a lot more relaxed about the visiting the dentist now.

Patients said staff were compassionate and understanding. One patient told us that all their experiences recently at the practice had been good their treatment had been thorough.

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

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

All consultations were carried out in the privacy of treatment rooms and we noted that doors were closed during procedures to protect patients' privacy. The reception area was not particularly private but patient information was not overlooked. Patients' notes were stored in lockable drawers, we were told these were locked when reception was not manned.

Involving people in decisions about care and treatment

The practice had access to interpretation services. We were told multi-lingual staff were available to support patients, languages spoken included Italian, Lithuanian, Romanian, Danish, German, Indian and Farsi. The practice manager described how they sometimes relied on family members to interpret for other languages. The practice could not ensure what was being communicated was in the best interests of the patient. We discussed this with the practice manager who agreed to urgently review this practice.

We noted a high proportion of patients who did not speak or understand English arrived at the practice during our inspection, wishing to register as they were aware of the variety of languages spoken by staff.

Staff communicated with patients in a way that they could understand. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. Patients stated in CQC comment cards that staff had given them clear information and answered all their questions.

The practice's 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 pictures, models and X-ray images.

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 delivered services to meet patients' needs. It took account of patient needs and preferences. In addition to general dentistry the practice also provided a hygienist and 'therapist' service.

The practice had made reasonable adjustments for patients with disabilities.

Due to the building exterior, the steep front steps and the limited layout inside, access for patients who used a wheelchair was restricted. Staff told us they supported some patients with limited mobility to access the two ground-floor treatment rooms. However, X-ray facilities, the patient toilet, main waiting room and the third treatment room were positioned on the first floor accessed by further steep stairs. Staff ensured patients were aware of the limited access to the practice when they first contacted the practice and where necessary staff referred patients to an alternative practice for treatment.

Staff described examples of patients who were anxious about visiting the dentist and the methods they used to try and reduce their anxiety. We saw that staff were friendly and chatted to patients to distract them whilst they waited to see the dentist. Patients said that staff were kind and caring and made them and their children feel at ease.

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

Patients who had given consent were sent a text message reminder of their appointment.

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 seen 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 practice was open two Saturdays each month for appointments from 9.30am to 1pm.

The staff took part in an emergency on-call arrangement with the NHS 111 out of hour's service.

The practice's information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open.

Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice had a policy detailing how it would manage patients' complaints, which included information about timescales for responding to them. A poster detailing how patients could raise their concerns was displayed in the waiting room, making it accessible to patients.

The practice manager aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice manager had dealt with their concerns.

It was not possible for us to assess how the practice managed patient complaints as we were told none had been received.

Are services well-led?

Our findings

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 Actions 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 overall responsibility for the management and clinical leadership of the practice. He was supported by the practice manager who was responsible for the day-to-day running of the practice.

Staff spoke positively of the principal dentist and practice manager and felt that both were approachable.

Vision and strategy

The practice did not have a specific vision or strategy in place, other than to keep operating as usual and managing its sizeable NHS contract. Staff we spoke with were not aware of any forthcoming plans for the practice. The practice manager described the challenges they had experienced in recruiting staff and the difficulties of establishing the trainee dental nurses on college courses.

Culture

Staff told us they enjoyed their job. Staff reported they felt able to raise concerns with the principal dentist and practice manager.

The dental nurses were all trainee dental nurses. The dental hygienist was also a trainee. There was no qualified nurse working at the practice. There were no systems in place to ensure oversight or consistency of practice across the clinical team. There were sporadic meetings to share information across the whole staff team.

The practice had a Duty of Candour policy in place, although not all staff were aware of their responsibilities under it, and there was no evidence to show the policy had been shared with the team.

Governance and management

We identified a number of shortfalls in the practice's governance arrangements including the analysis of untoward events, the recruitment of staff, the management of known risks and the availability of emergency medical equipment. At the time of our inspection one to one meetings, inductions for new and visiting staff and annual appraisals had not been undertaken so it was not clear how the performance of the trainee hygienist, the therapist, the trainee dental nurses or the receptionist was assessed. None of the staff had a training or personal development plan in place. There was no system to ensure professional registration and fitness to practice checks were undertaken for GDC registered staff. There was no evidence that the six medium risk required actions identified at the fire risk assessment in 2018 had been reviewed or completed.

Evidence in patients' dental records was inconsistent and did not confirm that the clinicians always discussed smoking, alcohol consumption and diet with patients during appointments. We were not assured that the dentist had an understanding and was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

Although the practice had a number of policies and procedures in place, we were not assured these had been read by staff. For example; staff, including the practice manager were not aware there was a whistleblowing policy, in addition they were not clear what the policy referred to. Staff told us they did not have an annual infection prevention and control statement. However, we found there was a template annual statement in the policy files which had not been populated or dated to ensure it was relevant and up to date for the practice.

Appropriate and accurate information

Some quality and operational information was used to ensure and improve performance.

Performance information was combined with the views of patients.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The provider used patient surveys and verbal comments to obtain patients' views about the service. Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. We noted feedback from patients was positive.

Are services well-led?

Continuous improvement and innovation

There were limited quality assurance processes in place. We found some audits had been undertaken. The practice carried out infection prevention and control annually, but not as regularly as recommended by guidance. We found one radiography audit which had been self-completed by the dentist. Antimicrobial prescribing audits had not been undertaken. Audits of the quality of dental care records were not routinely undertaken as recommended by guidance to ensure they met national standards. We saw the dentist had completed one patients' dental care record audit, this had not identified that records to evidence proposed treatment options had been discussed were spares and inconsistent.

Annual appraisals had not been undertaken and the practice manager had limited understanding of their purpose. The practice manager told us they like to treat staff to thank them for their work. As staff were all trainees and now undertaking college courses they told us they were not at this time able to undertake further learning and none had undertaken any additional training.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** Regulation 17 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. How the regulation was not being met; There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The registered provider had failed to ensure staff had an understanding of what constituted an untoward event and how this should be reported and shared. Appropriate medical emergency equipment was not available. Audits for dental care records, infection control and radiography were not undertaken in line with national guidance. There was no system in place to ensure the six actions identified during the August 2018 fire risk assessment had been reviewed or completed. We were not assured that fire safety management was effective. There was no system in place to ensure oversight of the receiving and responding to patient safety alerts,

This section is primarily information for the provider

Requirement notices

recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

Not all clinical staff records had evidence of adequate immunity for vaccine preventable infectious diseases.

There was no system in place to ensure good governance and effective leadership in the practice.

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

Appropriate pre-employment checks, including references and a DBS check had not been obtained for a recently recruited member of staff.

There was additional evidence of poor governance. In particular:

There was no system in place to ensure the therapist/ dentist was working within the scope of practice for an NHS therapist.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) - Staffing** There were no systems or processes that ensured persons employed by the service provider received

This section is primarily information for the provider

Requirement notices

appropriate support, training and professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform. In particular:

There were no systems in place to ensure staff received regular induction when first joining the practice.

There were no systems in place to ensure staff received regular supervision and appraisal of their performance.

None of the staff had a training or personal development plan in place.

Reg 18(2)