Mr Neil Mclean

Delahays Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 4 December 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 Care Quality Commission, (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 this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Delahays Dental Practice is in Hale, Cheshire and provides NHS and private dental treatment for adults and children. The practice provides an NHS children's inhalation sedation service.

The practice is located on the first floor. Access is not possible for people who use wheelchairs. On street parking is available near the practice.

The dental team includes two dentists, three dental nurses, a dental hygienist, and two receptionists. The team is supported by a finance and administrative manager and an administrative assistant. The inhalation

Summary of findings

sedation service is provided by a visiting specialist dentist who attends accompanied by a dental nurse with additional training. The practice has two 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 45 CQC comment cards filled in by patients and spoke with two other patients.

During the inspection we spoke with three dentists, three dental nurses and a receptionist 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, Wednesday, Thursday and Friday 9am to 1pm and 2pm to 5.30 pm.

Tuesday 9am to 1pm and 2pm to 4pm.

Our key findings were:

- The practice appeared to be visibly clean, tidy and well-maintained.
- The infection control procedures should be reviewed.
- Staff knew how to deal with emergencies. Emergency medicines and life-saving equipment were not in line with guidance. Some items of equipment had passed their expiry date and insufficient amounts of adrenaline was available.
- The provider did not have systems to help them identify and manage risk to patients and staff.
- The provider had safeguarding processes in place. Not all staff had received training in safeguarding or understood their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures did not reflect current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines. The documentation of this required improvement.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had systems to deal with complaints positively and efficiently.

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

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

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

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Implement protocols and procedures in relation to the Accessible Information Standard to ensure that that the requirements of this are complied with.
- Take action to review information governance arrangements are effective. In particular; for post received at the practice.
- Improve 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. In particular: Registering the use of X-rays with the Health and Safety Executive.

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?	**No action** ✓
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 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.

The impact of our concerns in terms of the safety of clinical care, are minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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

Staff had some systems to keep patients safe.

Clinical 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 procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Clinical staff knew about the signs and symptoms of abuse and neglect and how to report concerns. There was no evidence that any member of staff other than the associate dentist had received training and reception staff were not familiar with adult and child safeguarding. We discussed the requirement to notify the CQC of safeguarding referrals in certain circumstances as staff were not aware.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication.

The infection prevention and control policy was not up to date but appropriate procedures were clearly displayed in the decontamination room for staff to follow. 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. Four members of staff had recently attended training which included the sterilisation of instruments and dental handpieces.

The provider had 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 maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately. Instrument transport boxes were not labelled effectively or colour coded to avoid confusing these. We saw evidence that single use stainless steel polishing strips were reprocessed. Staff did not carry out daily and weekly validation checks on the autoclaves.

A washer disinfector was available but the staff carried out manual cleaning of dental instruments prior to them being sterilised. We advised them that manual cleaning is the least effective recognised cleaning method as it is the hardest to validate and carries an increased risk of an injury from a sharp instrument.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

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 in the assessment had been actioned and records of water temperature testing and dental unit water line management were maintained. An external company carried out a new risk assessment and water quality testing prior to the inspection. The assessor's report had not yet been received.

We saw cleaning equipment was colour coded in line with the national specifications for cleanliness in the NHS to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean and tidy. Patients commented on the high standards of cleanliness they observed.

The provider had procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

No infection prevention and control audits were completed. Opportunities had been missed to highlight the lack of validation on autoclave operating cycles and the reprocessing of single use devices.

The provider did not have a Speak-Up policy. Staff did not know where they could raise concerns or access support

Are services safe?

outside the practice. We highlighted with the principal dentist how local contacts should be discussed with and made available to staff to allow early resolution of any concerns.

The provider had recruitment procedures to help them employ suitable staff and had checks in place for agency staff. These reflected the relevant legislation. We looked at staff recruitment records. These showed the provider followed their recruitment procedure for permanently employed staff of the practice. For the visiting sedation dentist and their nurse, no evidence of up to date competency, professional indemnity, immunity or training had been obtained. This was obtained by the provider and sent to us after the inspection.

Clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover. Dental nurses were covered by the principal dentist's indemnity policy. They were not aware of what cover this policy afforded them. We discussed the importance of ensuring that staff are provided with clear information on the indemnity provided.

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

In response to the CQC inspection being announced, a fire risk assessment was carried out in line with legal requirements. The provider had not yet received the assessor's report.

We saw there were fire extinguishers throughout the building which were serviced appropriately and fire exits were kept clear. The premises had one battery operated smoke detector. This was not tested to ensure it was in working order.

The arrangements to ensure the safety of the X-ray equipment required review. A radiation protection file was in place but this was not up to date. For example, staff no longer employed by the practice were named and local rules were not in line with legislation. The critical examination report for one of the X-ray machines included a recommendation to relocate the isolation switch. This had not been addressed. Other recommendations to ensure the partition wall was adequately shielded and dosage instructions for the machine had been actioned.

We noted that the head of this X-ray machine moved significantly when positioning to take an X-ray. We highlighted this to the provider who confirmed they would have this adjusted.

The practice had not registered their practice's use of dental X-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17). The dentist confirmed they would action this.

We saw evidence the dentists reported on the radiographs they took. They did not consistently justify or grade these. The provider did not carry out any radiography audits.

The provider did not obtain evidence that clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had not implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies were not up to date. Procedures and risk assessments were not 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 did not follow the relevant safety regulation when using needles and other sharp dental items. One safe re-sheathing device was available but not in use. The principal dentist was not familiar with safe re-sheathing techniques. A sharps risk assessment was not in place. Staff confirmed that only the dentists were permitted to assemble, re-sheath and dispose of needles where necessary to minimise the risk of sharps injuries to staff. Protocols were not in place to ensure staff reported and accessed appropriate care and advice in the event of a sharps injury. After the inspection the provider ensured that re-sheathing devices were available.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We saw evidence that a member of staff had received a Hepatitis B booster in response to a low response to this vaccine. Evidence of immunity for the visiting clinician and

Are services safe?

their nurse was obtained and sent to us after the inspection. One member of staff required a booster dose five years after their initial course. This had not been actioned.

Clinical staff were aware of sepsis. A sepsis patient information poster was displayed in the waiting room. We highlighted that reception staff should be made aware of sepsis and provided with resources to ensure they triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. There was no evidence obtained to ensure staff providing treatment under sedation had completed Immediate Life Support training with airway management. After the inspection the provider told us they were looking into the availability of training.

Emergency equipment and medicines were not available as described in recognised guidance. Oropharyngeal airways had passed their expiry date and self-inflating oxygen bags and masks were not available. Sufficient amounts of adrenaline were not available to administer repeat doses as necessary. The provider took immediate action to obtain oropharyngeal airways, additional doses and appropriate needles and syringes from their supplier and we were sent evidence of this. We found staff did not keep appropriate records to make sure medicines and equipment were available, within their expiry date, and in working order. The checklist did not reflect Resuscitation Council UK guidance, and checks on this equipment were infrequent. The most recent checks were November 2019 and March 2019.

A dental nurse worked with the dentists and the dental hygienist when they treated patients in line with General Dental Council Standards for the Dental Team.

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

Information to deliver safe care and treatment

Systems to ensure staff have the information they needed to deliver safe care and treatment to patients should be reviewed.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were not consistently written and managed in a way that kept patients safe. Dental care records were not always legible and lacked detail of assessments and explanations provided to patients. Dental care records were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider did not have systems for appropriate and safe handling of medicines.

The stock control system of medicines held on site was ineffective. Systems were not in place to remove medicines that had passed their expiry date from the treatment rooms. A quantity of local anaesthetic which had a 'use before date' of January 2019 was removed from one of the rooms. This was disposed of immediately.

We saw staff stored NHS prescriptions as described in current guidance. No logs were kept of prescriptions issued. There was no system to identify if a prescription was missing.

The dentists were not familiar with current guidance with regards to prescribing medicines. No antimicrobial prescribing audits were carried out. We highlighted the availability of nationally agreed antimicrobial prescribing guidance and audit tools.

Track record on safety, and lessons learned and improvements

The provider had not implemented systems for reviewing and investigating when things went wrong. An accident book was available but staff struggled to locate this. There was no policy or process in place to ensure that in the event of an incident, a full investigation would be carried out and documented and appropriate external organisations involved as required. Staff confirmed there had been no incidents or accidents for several years.

Are services safe?

The provider did not have a system for receiving and acting on safety alerts. We identified an adrenaline auto-injection device that was affected by a patient safety alert first issued in July 2019 and updated to a recall of this device on 29 November 2019. Immediate action was taken to obtain adrenaline and this device was removed from the emergency medicines kit.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The documentation of this was not consistently in line with recognised standards.

The practice offered conscious sedation for patients. This included patients who were very anxious about dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice's systems included checks before and after treatment, medicines management and sedation equipment checks. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions. The system did not include medical emergency arrangement checks or evidence of staff training and competence.

The staff assessed patients for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history' blood pressure checks and an assessment of health using the guidance.

The records also showed that staff recorded details of the concentrations of the sedation gases used.

The operator-sedationist was supported by a trained second individual. The name of this individual was recorded in the patients' dental care record.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists did not consistently prescribe high concentration fluoride products if a patient's risk of tooth decay indicated this would help them. We highlighted the availability of local oral health improvement resources and toolkits.

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

The principal dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved referring to the dental hygienist, providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review. Patients confirmed they had received helpful home care preventative advice.

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 staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. Two patients we spoke to gave examples of treatment options, risks, benefits and costs that had been discussed with them. The dentists did not consistently document these, or justification and grading for X-rays in the dental care records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice did not have information about the Mental Capacity Act 2005 available. Not all members of the team understood their responsibilities under the act when treating adults who might not be able to make informed decisions and Gillick competence, by which a child under

Are services effective?

(for example, treatment is effective)

the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance. The documentation of this could be improved. We discussed this with the principal dentist and made them aware of nationally agreed guidance and record keeping templates to support the process.

The provider did not have quality assurance processes to encourage learning and continuous improvement. No audits were carried out to review the quality of care.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a structured induction programme. There was no evidence that agency staff were provided with an adequate orientation process. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. The provider could not demonstrate that staff had up to date training in safeguarding and radiography. No evidence of training and competency was obtained for the sedation dentist or their dental nurse until after the inspection.

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 for treatment the practice did not provide.

The practice accepted patients referred by other practices, for procedures under inhalation sedation. The sedation dentist's nurse monitored these and ensured these were responded to in a timely way.

Other referrals were submitted through an electronic referral and tracking system. These were submitted from the provider's own home. The provider did not have sufficient oversight of this and was unable to demonstrate these were responded to and acted on promptly.

Are services caring?

Our findings

We found 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 welcoming, caring, and helpful. We saw staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

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

Patient and practice information was displayed in the waiting room for patients to read.

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 waiting area provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, the practice would respond appropriately. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it. We highlighted that post received during the inspection was not collected by staff. We discussed how a locked post box would keep any post received secure until staff were able to retrieve it.

Staff stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care. They were aware of the requirements of the Equality Act.

They were not aware of the Accessible Information Standard which is a requirement to make sure that patients and their carers can access and understand the information they are given.

Interpreter services were not available for patients who did not speak or understand English. Staff said these had never been required.

Staff communicated with patients in a way they could understand, and easy-read materials were available.

Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Staff gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, study models and X-ray images taken of the tooth being examined or treated and shown to the patient/relative to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found 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.

Staff were clear about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

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

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service.

45 cards were completed, giving a patient response rate of 90%

100% of views expressed by patients were positive.

Common themes within the positive feedback were the friendliness of staff, easy access to and flexibility of dental appointments and the information provided to improve oral health.

We shared this with the provider in our feedback.

We were able to talk to two patients on the day of inspection. Feedback they provided aligned with the views expressed in completed comment cards.

The practice was not accessible to wheelchair users. Staff ensured new patients were made aware of this.

The practice had made some reasonable adjustments for patients with disabilities. This included the installation of hand rails on the stairs and in the patient toilet.

Staff telephoned some patients before their appointment to make sure they could get to the practice.

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 and on their NHS Choices website.

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 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

Staff told us the provider took complaints and concerns seriously and had systems to respond to them appropriately to improve the quality of care.

The provider had a procedure providing guidance to staff about how to handle a complaint. The practice information leaflet explained how to make a complaint. This was not up to date. For example, the procedure stated that complaints would be acknowledged in 14 working days. These should be acknowledged within three working days.

The principal dentist was responsible for dealing with these. Staff told us they would tell them about any formal or informal comments or concerns straight away so patients received a quick response.

The principal dentist 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 had dealt with their concerns.

No complaints had been received by the practice.

Are services well-led?

Our findings

We found 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.

The provider could not demonstrate strong leadership or an emphasis on continually striving to improve. The inspection highlighted several issues and omissions. The information and evidence presented during the inspection process was not clear and well documented. Systems were not in place to monitor the quality of services and make demonstrate improvements as necessary.

Leadership capacity and capability

The principal dentist was not knowledgeable about issues and priorities relating to the quality and future of the service. They were open to discussion and feedback during the inspection and took immediate action on the day to address immediate concerns. The areas of concern were highlighted to the provider. They understood the challenges and showed a commitment to addressing them.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs informally. The provider was in the process of reviewing staff recruitment, induction and training systems. They showed us a new resource which was under development to provide staff with structured processes including annual appraisals, discussion of learning needs, general wellbeing and aims for future professional development.

The staff focused on the needs of patients.

The provider did not have systems in place to identify and deal with staff poor performance.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Systems to ensure staff had clear responsibilities, roles and systems of accountability to support good governance and management were not in place.

The principal dentist had overall responsibility for the management, clinical leadership and the day to day running of the service with support from staff.

A clinical governance system was not in place. In particular, up to date policies and procedures relating to managing medical emergencies, fire safety, incident reporting, complaints, raising concerns, business continuity and actions to be taken in the event of a sharps injury were not in place and staff were not aware of the processes to be followed.

Systems for identifying and managing risks, issues and performance were ineffective. In particular:

- Arrangements to respond to and check medical emergency equipment and medicines.
- The safe management of medicines and NHS prescriptions
- Processes were not in place to receive safety alerts
- Oversight and monitoring of referrals
- Obtaining evidence of indemnity, immunity, training and competency from all staff
- Radiological safety
- Assessing the risks from sharps.

The announcement of the inspection had prompted the provider to review risk management systems. As a result, they had identified that fire safety and Legionella risks had not been assessed for several years. They engaged an external company to carry out full risk assessments. At the time of the inspection the reports on these had not been received by the provider.

Appropriate and accurate information

Quality and operational information, for example NHS performance information was used to review performance. Performance information was combined with the views of patients.

Are services well-led?

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. We highlighted that security could be improved for handling post received by the practice.

Engagement with patients, the public, staff and external partners

Staff involved patients and the public to support the service. For example:

The provider encouraged verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from patients the practice had acted on. For example, providing an additional hand rail on the stairs.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used.

The provider gathered feedback from staff through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The provider did not have systems and processes for learning, continuous improvement and innovation.

No audits of dental care records, radiographs or infection prevention and control were carried out.

The principal dentist valued the contributions made to the team by individual members of staff.

The provider did not have a system to obtain up to date evidence that staff completed 'highly recommended' training as per General Dental Council professional standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Medical emergency arrangements were ineffective. Insufficient medicines were available and checks to review the arrangements were in line with Resuscitation Council UK guidelines and General Dental Council standards were ineffective. • Staff did not identify and dispose of medicines that were out of date. • Staff did not receive and respond to patient safety alerts, 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. As a result, one item affected by an alert had not been identified and removed from use. • Staff did not follow infection prevention and control guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices. Validation tests were not performed on autoclave operating cycles and single use devices were re-used. • Staff were not familiar with or following Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • Fire safety checks were not carried out to ensure fire detection systems were in working order.

This section is primarily information for the provider

Requirement notices

- The registered person could not evidence that staff received up to date training and competency in safeguarding, basic life support or immediate life support, radiation protection or infection prevention and control.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had systems or processes in place that 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:** • The registered person did not ensure arrangements for ensuring good governance were in place. Up to date operational policies and procedures were not in place for the delivery of care and treatment. • The registered person had not ensured that appropriate life-saving equipment was provided to enable staff to respond to a medical emergency or ensure appropriate checks on this equipment were in place. • Protocols for medicines management were not in place. Systems were not established to track and monitor the use of NHS prescriptions or for identifying, disposing and replenishing out-of-date stock. • Systems were not in place to receive and respond to patient safety alerts, 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. • A system was not in place to ensure patient referrals to other dental or health care professionals were centrally monitored to ensure they were received in a timely manner and not lost. • The registered person did not ensure the practice was in compliance with The Ionising Radiations Regulations

This section is primarily information for the provider

Requirement notices

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.

- The registered person did not have systems to ensure staff followed infection prevention and control guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- The registered person did not ensure the practice's sharps procedures were appropriately risk assessed or in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Quality assurance systems such as regular audits of radiography, infection prevention and control and dental care records, to assess, monitor and improve the quality and safety of the service were not in place. The registered person did not ensure all necessary information was recorded in dental care records.

There was additional evidence of poor governance. In particular:

- The registered person did not ensure all staff were provided with an appropriate role-specific induction. In particular, agency staff.
- Evidence of up to date training and competency in safeguarding, basic life support or immediate life support, radiation protection or infection prevention and control was not consistently obtained from all staff.
- The registered person did not ensure that evidence of immunity to vaccine-preventable diseases was obtained for all clinical members of staff.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed
Surgical procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Requirement notices

The registered person 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:

- The registered person did not ensure dental staff providing conscious sedation had the appropriate training and skills to carry out the role, taking into account guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'.
- The registered person did not ensure that evidence of professional indemnity was obtained for all clinical members of staff.

Regulation 19 (3)