Mrs Diana Jaffri

Gobowen

Inspection Report

3-4 Brook Buildings,
Gobowen,
Oswestry,
Shropshire SY11 3JP
Tel: 01691 662719
Website: www.talkingteeth.org

Date of inspection visit: 7 August 2019
Date of publication: 05/12/2019

Ratings

Overall rating for this service

Are services safe?	Requirements notice ✖
Are services well-led?	Requirements notice ✖

Overall summary

We carried out this unannounced focused inspection on 7 August 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 and an inspection manager.

To get to the heart of patients' experiences of care and treatment, we asked the following two questions:

• Is it safe?

• 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 well-led?

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

Background

Signature Smiles is in Gobowen, Shropshire and provides NHS treatment to adults and children.

There is ramp access for people who use wheelchairs and those with pushchairs. Car parking is not available on site, however there is a public car park across the road from the surgery. There are no dedicated parking spaces for blue badge holders.

Summary of findings

The dental team includes 3 dentists, 4 trainee dental nurses and 1 receptionist. The practice has 3 treatment rooms.

The practice is owned by an individual. 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.

During the inspection we spoke with two dentists, three trainee dental nurses, one company director and the area manager. The registered manager was unavailable on the day of inspection. We looked at practice policies and procedures and other records about how the service is managed.

The practice was open: Monday to Friday 8.30am to 5.30pm.

Our key findings were:

- The clinical staff provided patients' care and treatment in line with current guidelines.
- We saw that staff treated patients with dignity and respect.
- Staff worked well as a team.
- The practice did not appear clean and well maintained throughout.
- There were a lack of systems and processes to ensure staff had full awareness of their responsibilities in relation to the duty of candour which was not in compliance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider did not have adequate systems in place to help them manage risk to patients and staff.
- Governance arrangements required significant review and strengthening.

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.

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:

- Review the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.
- Review the security of NHS prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the practice's sharps procedures to ensure the practice is complying with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Review the practice's recruitment policy and procedures to ensure accurate, complete and detailed records are maintained for all staff

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe? We found that this practice was not providing safe care and treatment in accordance with the relevant regulations.	**Requirements notice** 
Are services well-led? We found that services at this practice were not well-led in accordance with the relevant regulations.	**Requirements notice** 

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)

The practice systems and processes to provide safe care and treatment were not always operating effectively.

Staff showed awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. However, the provider did not have all safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse.

On the day of inspection, we were not provided with evidence to show that all staff had received safeguarding training. Some staff records were held at Head Office and were sent to us after the inspection. Some staff had not completed safeguarding training to the appropriate level within the last three years. Within 48 hours of inspection, we received evidence that all staff had subsequently completed training in safeguarding to the appropriate level.

The staff we spoke with on the day of inspection knew about the signs and symptoms of abuse and neglect; however, they had not operated effectively regarding one specific safeguarding concern. We saw evidence of a vulnerable patient having been identified as a high risk safeguarding concern by staff, yet no external agencies had been informed. There was one other incident which had been referred to safeguarding services but not followed up by dental staff. Both these incidents demonstrated a clear absence of guidance for staff and lack of oversight from senior staff.

There was no clear signposting for staff on how to report concerns. The safeguarding policy contained out of date contact information for external agencies. Within 48 hours of inspection the policy had been updated with correct contact details.

There was no clear indication to staff of how to inform the CQC should a notification be required for safeguarding. The policy was updated after the inspection.

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

The provider had a whistleblowing policy; however, this was not readily accessible to staff and did not include information for external agencies to whom any concerns could be raised. We received evidence following inspection that this had been updated. Not all staff we spoke to were aware of how to raise concerns and some staff did not feel they could raise concerns without fear of recrimination.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice which involved referring patients to one of its sister practices.

The provider had a recruitment policy. We looked at three staff recruitment records which showed that the provider had not followed their recruitment procedure. In particular, one staff member had no references held on file and another staff member only had one reference noted. The three records we looked at did not contain the minimum of two ID checks, as identified in their policy.

We noted that dentists were qualified and registered with the General Dental Council (GDC). The provider could not provide proof of indemnity for all staff on the day of inspection. We received evidence that all staff had professional indemnity cover within 48 hours of inspection which was valid before the date of inspection. One trainee dental nurse had recently qualified and was awaiting GDC registration.

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.

On the day of inspection, we were not provided with evidence that the practice had suitable arrangements to ensure the safety of the X-ray equipment; in particular the

servicing of the X-Ray equipment was not available in the radiation protection file. We received this evidence within 48 hours of the inspection. There were no rectangular collimators fitted to X-ray equipment.

The provider had not carried out radiography audits every year which was not in line with current guidance and legislation.

We found that some clinical staff could not provide evidence of having completed continuing professional development (CPD) in respect of dental radiography on the day of inspection. Some staff subsequently completed radiography CPD after the inspection.

Risks to patients

The provider had current employer's liability insurance.

We were not assured that all health and safety policies, procedures and risk assessments were in place or reviewed to help manage potential risks.

We looked at the practice's arrangements for safe dental care and treatment. There was no sharps policy in place to guide staff on the safe use of sharps. A sharps risk assessment had not been undertaken. A sharps policy and risk assessment were subsequently completed and sent to us following inspection.

Some clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, however there were no systems in place to ensure the effectiveness of vaccination was checked for all staff. A risk assessment had not been completed for those staff who had not got appropriate levels of immunity recorded.

We did not see evidence on the day that all staff had completed training in emergency resuscitation and basic life support. Within 48 hours of inspection we received certificates for all staff confirming they had completed this training within the preceding 12 months.

Not all emergency equipment and medicines were available as described in recognised guidance. Missing equipment included a child self-inflating bag with reservoir, 5 clear face masks (sizes 0,1,2,3,4), adult oxygen face mask with tubing and child oxygen face mask with tubing. We saw these had been recorded as ordered on the 18th July 2019 but had not been received by the practice. The dispersible aspirin was the incorrect dose. Three members of staff we spoke to were unaware of where the emergency equipment was stored.

A trainee dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team.

There were suitable numbers of dental instruments available for the clinical staff.

The practice occasionally used staff from one of its sister practices in situations such a requiring cover for annual leave or sickness. The practice had an agency available for cover if required, although had not needed to use this for some time. We were told the agency used by the practice carried out legislative checks on staff prior to them carrying out work, however there was no service level agreement seen on the day of inspection to confirm this.

The provider had an infection prevention and control policy and procedures that required review. Staff were unsure who the infection prevention lead was, and we saw no designated person named on the policy. We saw cleaning schedules for the premises, however the practice was not visibly clean when we inspected and the toilet used by patients was unclean.

The practice was not following guidance in The Health Technical Memorandum 6.47 with the flooring outside the treatment rooms dirty and not fully adhered to the floor, coved or sealed on the day of inspection.

Infection prevention audits had been carried out but had not identified flooring issues or the dirt which appeared longstanding in the toilet.

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

The practice did not always follow 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.

The provider had mostly suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. There was no magnifying light for use during decontamination. This would ensure that items were thoroughly checked for their

suitability for use. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

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. There was no separate bath for impressions and returned lab work.

We were not assured that there were procedures in place to reduce the possibility of Legionella or other bacteria developing in the water systems. No risk assessment was available to mitigate risks. The water temperature was not checked or recorded for manual cleaning.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance however there was no pre-acceptance waste audit available on the day on inspection.

Information to deliver safe care and treatment

We were not assured that 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 complete and legible.

The storage of dental care records was not secure and did not comply with General Data Protection Regulation (GDPR) requirements. Paper dental records were stored on worktops in the unlocked staff kitchen area and in unlocked cupboards and were therefore accessible to others, not just staff members.

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 reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

We saw staff stored NHS prescriptions securely. However, the record log did not show that prescription numbers were being recorded as described in current guidance. This meant that staff would be unable to identify if a prescription was taken inappropriately.

The dentists we spoke to were aware of current guidance with regards to prescribing medicines.

Antimicrobial prescribing audits were not carried out annually so we were unable to see whether dentists were following current guidelines.

Track record on safety and Lessons learned and improvements

There were no comprehensive risk assessments in relation to safety issues. No incidents had been recorded or reviewed and hence staff were unable to understand risks, give a clear, accurate and current picture intended to lead to safety improvements.

There were no clear systems for reviewing and investigating when things went wrong.

We saw no evidence of MHRA alerts being monitored, reviewed, acted upon, reported or shared within the practice.

The COSHH folder had been updated seven months prior to inspection, however there were no safety data sheets or risk assessments for all substances used at the practice.

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 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

We did not see or find evidence that leaders had the capacity and skills to deliver high-quality, sustainable care. Leaders did not demonstrate they were able to deliver the practice strategy and address risks to it.

We were unable to speak to the registered manager on the day of inspection. Staff we spoke with were not knowledgeable about issues and priorities relating to the quality and future of services. The newly appointed area manger did however, understand the challenges and were making some attempts to address them.

Leaders at all levels were not visible or approachable. Staff told us they did not work closely with leaders.

Effective processes to develop leadership capacity and skills were not in place on the day of inspection. We saw no evidence of any planning for the future leadership of the practice.

There was no evidence of clear vision or set of values.

Culture

Some staff stated they felt respected, supported and valued and were proud to work in the practice. Some staff we spoke to said they felt under-supported.

We did not see evidence of how the provider had taken or would take action to deal with staff poor performance.

There had been no significant events or incidents recorded at the practice and therefore no learning was apparent.

The provider was aware of but did not have systems in place to ensure compliance with the requirements of the Duty of Candour.

Not all staff felt they knew how to or could raise concerns.

Governance and management

There were no clear responsibilities, roles and systems of accountability which are required to support good governance and management.

The registered manager had overall responsibility for the management and clinical leadership of the practice. There was no dedicated practice manager. The day to day running of the service was carried out by the trainee dental nurses and receptionist. A spreadsheet allocating roles and responsibilities was produced on a weekly basis for staff.

The provider did not have a robust system of clinical governance in place. The recruitment policy had not been adhered to. The sepsis policy had not been signed by all staff however we received evidence of this post inspection. The whistleblowing and safeguarding policy did not contain all relevant information or contact information for external agencies to whom concerns should be raised, but was updated after inspection. All policies were digital although not all staff said they were familiar with how to access them. The policies we saw had not all been reviewed on a regular basis.

The practice was part of a group which had a centre where teams including human resources, and finance were based.

We saw there were inadequate processes for managing risks, issues and performance.

Appropriate and accurate information

The provider was aware of information governance arrangements but not all staff were aware of the importance of these in protecting patients' personal information. For example, patient records not stored securely.

Engagement with patients, the public, staff and external partners

The provider stated they used patient surveys and comment cards to obtain staff and patients' views about the service. We did not see any examples of suggestions from patients/staff the practice had acted on.

Some staff meetings had occurred however not on a frequent basis.

Continuous improvement and innovation

There were inadequate systems and processes for learning, continuous improvement and innovation.

Are services well-led?

The provider did not have quality assurance processes to encourage learning and continuous improvement. There was a lack of audits including dental care records and radiographs. Infection control audit was ineffective as it had failed to address cleanliness issues we identified on the day of our visit.

Some of the team had annual appraisals during which some records were seen of learning needs, general wellbeing and aims for future professional development. Not all dental nurses had received appraisals.

Some staff had completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

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 **Action we have told the provider to take** The table below shows the regulations that were not being met. The provider must send CQC a report that says what action they are going to take to meet these regulations. Ensure that all 'must do's' cover the regulatory breaches identified Use the term 'registered person' **Regulated activity** **Regulation** Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12** **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: • Not all emergency equipment required was available. • There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

This section is primarily information for the provider

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)
- Staff did not feel they could raise concerns without fear of recrimination

Regulation 12 (2)

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** **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. 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: • There no comprehensive risk assessments in relation to safety issues. No incidents had been recorded or reviewed and hence staff were unable to understand risks, give a clear, accurate and current picture intended to lead to safety improvements. • Not all staff had received appraisals. • There were limited systems for monitoring and improving quality. For example, radiography audit and infection prevention and control. There were no systems or processes that enabled 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:

This section is primarily information for the provider

Requirement notices

- Clear absence of guidance for staff in reporting safeguarding with a lack of oversight from the Registered Manger regarding one referral having not been followed up, and one referral not having been made to external agencies.
- The COSHH folder had been updated seven months prior to inspection however there were no safety data sheets or risk assessments for all substances used at the practice.
- Hep B status had not been checked on all staff nor risk assessments carried out for those who were non-converter.

There were no systems or processes that ensured the registered person maintained securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular:

- Patient records were kept on the side in the staff kitchen and in unlocked cupboard.

Regulation 17 (2)