Primrose Dental Ltd

Primrose Dental Practice

Inspection Report

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Overall summary

We carried out an unannounced follow- up inspection at Primrose Dental Practice on the 10 March 2017.

This followed inspections on 3 August 2016 and 21 March 2016 carried out as part of our regulatory functions where breaches of legal requirements were found. Following our last inspection we had imposed conditions on the provider in regards to undertaking of dental implant surgery.

Our findings were:

Are services safe?

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

Are services effective?

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

Are services responsive?

We found that this practice was not 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

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

You can read the reports from our previous inspection by selecting the 'all reports' link for Primrose Dental Ltd on our website at www.cqc.org.uk.

Our key findings were:

• The practice did not have arrangements in place to ensure the safety of products used.

• There was a lack of an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.

• There was a lack of effective processes for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

• There was a lack of systems in place to ensure staff were appropriately trained.

• Governance arrangements in place were not effective to facilitate the smooth running of the service.

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?

Enforcement action 

At our previous inspection we had found that the practice was not identifying and mitigating risks to service users. Risks that were identified in risk assessments were not always acted upon.

At our follow-up review on the 10 March 2017 we found that action had still not been taken to ensure that identified risks in risk assessments were acted upon. There were out of date products in the treatment rooms and staff recruitment checks were not being consistently carried out.

Are services effective?

Enforcement action 

At our previous inspection we found that this practice had not taken sufficient action to ensure that the practice was effective because the provider had not provided relevant training and supervision in line with published guidance, such as from the Faculty of General Dental Practice (FGDP) for procedures such as dental implant surgery that were undertaken at the practice.

At our follow-up review on the 10 March 2017 we found that this practice was still not providing effective care in accordance with the relevant regulations. The principal dentist and staff at the practice had not undertaken relevant training.

Are services responsive to people's needs?

Enforcement action 

At our previous inspection we found that this practice had not established an accessible system

for identifying, receiving, recording, handling and responding to complaints by service users.

At our follow-up review on the 10 March 2017 we found that sufficient action had still not been taken to ensure that appropriate systems were in place to manage complaints.

Are services well-led?

Enforcement action 

At our previous inspection we had found that there was lack of effective governance systems at the practice.

At our follow-up review on the 10 March 2017 we found that this practice had still not taken action to ensure that the practice was well-led. There was lack of governance arrangements and risk management. Leadership at the practice was lacking and responsibilities were not being undertaken in a cohesive manner. Staff were not confident of raising concerns with the principal dentist.

Primrose Dental Practice

Detailed findings

Background to this inspection

This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out an inspection of this service on 10 March 2017. The inspection was led by a CQC inspector who was accompanied by a dental specialist advisor.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after inspection on the 3 August 2016 and the 21 March 2016 had been made. We reviewed the practice against four of the five questions we ask about services: is the service safe, effective, responsive and well-led?

During our inspection visit, we checked whether the provider's action plan had been implemented by looking at a range of documents such as risk assessments, audits, staff records, maintenance records and policies.

We carried out a tour of the premises. We also spoke with all the staff working on the day of the inspection. We spoke with one member of staff on the phone after the day of the inspection as they were not available on the day of the visit.

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Are services safe?

Our findings

Reliable safety systems and processes (including safeguarding)

During the last inspection we found that records were not being made available to all staff who needed this information. One member of staff told us that the principal routinely locked up the practice computer to deny them access to the records. The staff we spoke with at this inspection confirmed they were given appropriate access to records.

Staff recruitment

The majority of staff had worked at the practice for a number of years and the practice had recently recruited two members of staff. The practice had carried out some employment checks for one of these new staff members. For example they had an identity check and immunisation record for one member of staff. However we found that there was no evidence that Disclosure and Barring Service (DBS) checks or references had been taken for this member of staff. There were no employment checks for another member of staff.

We spoke to the principal about this. They told us that they had the records for these staff but did not know where they were located.

Monitoring health & safety and responding to risks

During the last inspection we found that action was not always taken to respond to risks that were identified. For example a May 2016 fire risk assessment had identified nine actions that were required to be carried out within a month of the assessment. None of the actions had been completed by the practice at the time of the inspection.

We found these actions were still outstanding at this inspection. For example the assessment stated that fire safety instruction/training should be given to staff by a competent person and recorded. We found no evidence that this training had taken place. Staff we spoke with told us this training had not taken place. We asked the principal about this and they stated that a nurse, who was not on duty on the day of the inspection, was responsible for actioning the points identified in the assessment.

We checked the practice fire safety procedures and it stated that the principal was the person to contact in relation to fire precaution issues.

Equipment and medicines

At the last inspection we found that the practice did not have appropriate equipment. This was still the case at this inspection. There was insufficient equipment to undertake implant surgery in a safe and effective manner. We found numerous examples of implant surgery related equipment and dental products that were past their use by date, some dating as far back to 2011.

We also found out of date local **anaesthetic** In the treatment rooms. In one room the anesthetic was loaded into a syringe ready to be used. The principal stated that the anesthetics were not used but could not explain why it was in the surgery or why one had been loaded into a syringe.

Are services effective?

(for example, treatment is effective)

Our findings

Staffing

At the last inspection the principal dentist was unable to provide evidence of their up-to-date training in dental implants or any training on implants staff had undertaken. At this inspection they were still not able to provide evidence of having undertaken up to date training.

The principal told us they were currently undertaking a Diploma in Implant Dentistry. When we asked for further details of this it was found the principal had not studied on the course they stated they were currently undertaking since 2008.

The principal stated that they checked with the college they studied at and were informed that they could still complete the course, as long as they sent case studies to be assessed.

We checked with the college and were advised that the students studying on the course were required to send case studies within two years of completing studies on a course.

It had been over eight years since the principal had studied on the course.

The principal stated that they had provided in house training on implants but staff we spoke with said they had not received implant training.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At the last inspection we noted that the practice complaints policy advised patients that they could escalate complaints to NHS England despite the practice being wholly private. The name of the person given responsibility for complaints at the practice was someone who did not work at the practice.

At this inspection the policy had been updated to include appropriate organisations to escalate complaints too, including the General Dental Council. The policy had now also been updated to include the name of the principal dentist as the person to contact in relation to complaints. However, there were still improvements required to the complaints system.

We reviewed the complaints log and noted there were no complaints in the log. Records of staff appraisals however showed that there had been at least one complaint discussed. We asked the principal dentist about this and they told us that a nurse who was not on duty at the time of the inspection was responsible for keeping the complaints log.

Are services well-led?

Our findings

Governance arrangements

During the last inspection we found that the management at the practice was weak. The principal dentist was the identified lead for key work areas such as on infection control and safeguarding but staff told us they were not clear about their areas of responsibility.

We found that things had not improved at this inspection.

When asked about areas identified as their responsibility in the practice policies the principal had no knowledge of these issues and was unable to provide any information about these topics. This included complaints, fire and recruitment records. They advised us that they could not provide us with any information on these issues because they were the responsibility of a nurse who was not on duty on the day of the inspection.

Leadership, openness and transparency

During the last inspection staff said they felt the practice owner was not open and transparent. Staff told us they would not be comfortable raising concerns with the owner. During this inspection we found that there was a mixed view as to whether this had improved. One staff member said they felt the principal dentist was open and transparent, another said the principal was not open and transparent, and it was not always clear what was happening at the practice.