Belford Dental Practice Limited

Belford Dental Practice

Inspection Report

54B High Street
Belford
Northumberland
NE70 7NJ
Tel: 01668 213744
Website: www.thedentalroombelford.co.uk

Date of inspection visit: 28 March 2018
Date of publication: 30/05/2018

Overall summary

We carried out this announced inspection on 28 March 2018 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.

We carried out this inspection in response to information that was shared with us from the NHS England area team.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was 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

Belford Dental Practice is in Belford, Northumberland and provides private treatment to adults and children.

A portable ramp is available for people who use wheelchairs and pushchairs. On street parking is available near the practice.

The dental team includes one dentist, one dental nurse and one receptionist. The practice has one treatment room.

Summary of findings

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 17 CQC comment cards filled in by patients. This information gave us a positive view of the practice.

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

The practice is open:

Monday 9am to 6:30pm

Tuesday 9am to 4pm

Wednesday 9am to 5pm

Thursday 9am to 5pm

Friday 9am to 1pm

Our key findings were:

- The practice was clean and well maintained.
- The practice had infection control procedures which reflected published guidance.
- Improvements were needed to the medicines and life-saving equipment were available in accordance to national guidance. The practice did not have appropriate access to an Automated External Defibrillator.
- The practice did not have effective systems to help them manage risk.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice did not have thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- The practice asked staff and patients for feedback about the services they provided.
- The practice had systems to deal with complaints positively and efficiently.

We identified regulations that were not being met and the provider 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 was not meeting are at the end of this report.

There were areas where the provider could make improvements and should:

- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review the protocols and procedures for use of X-ray equipment giving due regard to guidance notes on the Safe use of X-ray Equipment.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act assessment is undertaken for the premises.
- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Review staff awareness of the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

The practice did not have effective policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. A recent incident involving the failure of a medical device had not been recorded as an incident, risk assessed or reported appropriately.

The practice did not have a system to receive national patient safety and medicines alerts from the MHRA.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Systems were not in place to ensure the correct storage and disposal of dental materials and medicines. Dental medicines and materials including local anaesthetics had expired.

Staff were qualified and registered for their roles. The practice did not have a recruitment process and had not completed essential recruitment checks.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments. Evidence of appropriate servicing was not available for the dental compressor.

The arrangements for responding to medical and other emergencies had not been effectively risk assessed or reviewed. Training had been completed on the three-yearly basis and key staff were not familiar with the correct operation of equipment. The practice did not have access to an Automated External Defibrilator (AED), a risk assessment of this was not in place.

The practice did not have access to a Radiation Protection Advisor (RPA) and were not familiar with the need to seek advice from a suitable RPA for advice on complying with Ionising Radiations Regulations 1999. Local rules on the correct use of the equipment were not in place; the dentist confirmed this would be addressed.

Risks relating to fire safety, COSHH and radiographic were not appropriately assessed.

Are services effective?

No action 

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

Summary of findings

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as relaxed and reassuring. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

The practice's consent policy included information about the Mental Capacity Act 2005. The team had not received training and did not fully understand their responsibilities under the act when treating adults who may not be able to make informed decisions.

Are services caring?

No action ✓

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

We received feedback about the practice from 17 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, caring and professional. They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them.

Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action ✓

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff told us they made courtesy calls to remind patients of upcoming appointments and telephoned patients after complex treatment to check on their well-being and recovery.

Staff considered patients' different needs. This included providing some facilities for disabled patients and families with children. A disability access assessment had not been carried out and we discussed other reasonable adjustments that could be considered by the practice.

The practice staff were unsure as to whether they had access to interpreter services.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Summary of findings

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 at the end of this report).

The practice had policies and procedures to support the management of the service and to protect patients and staff.

The arrangements to risk assess and monitor the quality and safety of the service required improvement. For example, in relation to MHRA alerts, fire safety, risk assessing and reporting faulty devices, fire safety, disposal of out of date medicines and dental materials and the arrangements to provide medical emergency care had not been risk assessed appropriately.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.

Systems were not in place to ensure the team were aware of forthcoming changes in legislation and guidance. Staff were not aware of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competency.

Evidence of up to date audits were not available on the day of the inspection. The provider was asked to supply evidence of this after the inspection but this was not received.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. They did not have clear records of the results of these audits, clinician reflections or action plans and improvements made as a result.

Enforcement action 

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have effective policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events.

The dentist told us that a medical device had failed a week before the inspection, this had not been recorded as an incident. Staff were not familiar with the system to report medical device failures through the Medicines and Healthcare Products Regulatory Authority (MHRA) 'yellow card' system. They had not risk assessed whether the remaining devices should be used or not.

We found staff were not fully aware of what should be reported under the Reporting of Injuries, Diseases and. Dangerous Occurrences Regulations 2013 (RIDDOR). We were told this would be addressed immediately.

The practice did not have a system to receive national patient safety and medicines alerts from the MHRA since May 2017. The dentist gave assurance that future alerts would be received, discussed with staff, acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

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 practice 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. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. A documented risk assessment was in place. Safe re-sheathing devices were not available and this had not been risk assessed. The dental nurse confirmed that only the dentist was permitted to assemble, handle and dispose of needles and matrix bands. The dentist used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Medical emergencies

We saw evidence that staff had completed hands-on training in emergency resuscitation and basic life support in May 2015. Staff told us training was completed on a three-yearly basis. We saw evidence that refresher training was booked for 13 April 2018. They had completed an hour of additional online training in addition to this. We found that a key member of staff was not familiar with the correct operation of the emergency medical oxygen cylinder.

Emergency equipment and medicines were not as described in recognised guidance. For example, oropharyngeal airways and self-inflating bag oxygen bags and masks were not available. The aspirin was not dispersible, diazepam was present as an alternative to buccal midazolam and the glucagon was refrigerated but the temperature of the fridge was not monitored. A portable suction device was not available, a child-sized oxygen mask was not available and the adult sized oxygen mask had passed its expiry date. Staff took immediate action to order the missing items on the day of the inspection and we saw evidence of this.

The emergency kit was checked monthly by the receptionist. Staff kept records of their checks to make sure these were available. This system was not working effectively.

The practice did not have an Automated External Defibrillator (AED) and a risk assessment was not in place. We were told community AEDs were available but staff were not aware how long it would take to obtain this in the event of an emergency. On the day of the inspection, the dentist confirmed that they would obtain an AED in the forthcoming months. We discussed the need to risk assess the existing arrangements until an AED is available.

Staff recruitment

The practice did not have a staff recruitment policy and procedure to help them employ suitable staff. They had recently recruited a new staff member a month prior to the inspection. We looked at staff recruitment files. We saw evidence that they had obtained photographic identification and ensured the new staff member read the practice policies and procedures. An up to date CV had been provided which included the contact details for two references. The practice had not contacted the referees to obtain a reference for the individual. The CV showed a significant gap in employment and this had not been

Are services safe?

explored by the practice. The dentist told us they were in the process of completing a Disclosure and Barring Service (DBS) check. This process is used to prevent unsuitable people from working with vulnerable groups, including children. A risk assessment was not carried out until this was in place.

We saw evidence that clinical staff were qualified and registered with the General Dental Council (GDC) and had appropriate professional indemnity cover in place.

Monitoring health & safety and responding to risks

The practice's health and safety policies and risk assessments were up to date and reviewed to help manage potential risk. These covered general workplace and specific dental topics. Staff had carried out a fire safety self-assessment. There were no fire detection systems on-site; staff told us that they had been informed by the fire service that due to the small size of the premises that these were not required, there was no evidence to support this. Fire extinguishers were available and serviced appropriately. We noted that the fire exit from the treatment room at the rear of the premises was partially blocked by materials discarded by a building contractor. We were told that these had been discarded on the evening before the inspection. Staff told us they would clear this exit. Staff carried out and documented six-monthly fire drills. The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

Staff had carried out Control of Substances Hazardous to Health (COSHH) risk assessments. Product safety data sheets were not accessible to ensure that the manufacturer's advice was followed appropriately. The dental nurse told us these would be obtained. We also noted that the mercury spillage kit had expired.

The dental nurse always worked with the dentist when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Staff completed infection prevention and control training every year.

The practice mostly had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. We noted that dental syringes and handpieces were not bagged after sterilisation as advised in guidance. This was discussed with the dental nurse who confirmed they would ensure these items are bagged in future. Decontamination was carried out in the treatment room. The dental nurse was aware of, and followed guidance to carry out these processes when patients were not present in the room. The practice had manual cleaning protocols in place and described the processes used. Records showed equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance.

The practice carried out infection prevention and control audits twice a year. There was no evidence that the results of audits were analysed to ensure any resulting actions were taken.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Staff were aware of the need to flush the dental unit water lines before commencing treatment but not at the end of the day or between patients.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed this was usual.

Waste was segregated and disposed of appropriately. Gypsum waste was not being disposed of in line with current waste management regulations. The dentist assured us that an appropriate process would be put in place.

The staff records we reviewed with the practice manager provided evidence to support the relevant staff had received inoculations against Hepatitis B. It is recommended that people who are likely to come into contact with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections.

Equipment and medicines

We saw servicing documentation for the equipment used. We saw evidence that staff carried out the daily test cycle

on the autoclave. Staff were not aware of the need to review and record the results of this for the automatic control test. Staff carried out checks in line with the manufacturers' recommendations.

Evidence was not available that the dental compressor had been serviced since 2013. Staff were not sure whether the equipment for carrying out dental implants required servicing or calibration.

The practice had suitable systems for prescribing and dispensing medicines. Systems were not in place to ensure the correct storage and disposal of dental materials and medicines. For example, several dental medicines, materials and dental instruments, including local anaesthetics and endodontic files, had expired. These items were still available for use in the surgery drawers. The local anaesthetic had expired in June 2016, endodontic files and dental materials had expired between 2009 and 2016.

Private prescriptions were written when required following assessment of the patient.

Radiography (X-rays)

There were suitable arrangements in place to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection information. The practice did not have access to a Radiation Protection Advisor (RPA) and were not familiar with the need to seek advice from a suitable RPA for advice on complying with Ionising Radiations Regulations 1999.

We saw evidence that the practice had acted on recommendations made in the critical examinations of the X-ray equipment. Evidence was provided after the inspection that the practice had registered with the Health and Safety Executive (HSE). Local rules on the correct use of the equipment were not in place, the dentist confirmed this would be addressed.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiograph audits every year following current guidance and legislation. We noted that these did not include the clinician's reflections or an action plan to improve.

We saw evidence that clinical staff completed continuous professional development in respect of dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist assessed patients' treatment needs in line with recognised guidance.

The dentist told us they audited patients' dental care records to check that they recorded the necessary information. Evidence of this was not available on the day of the inspection. The provider was asked to supply evidence of this after the inspection but this was not received.

The practice also provided dental implants. The dentist explained the process which patients underwent prior to undertaking implant treatment. This included using X-rays to assess the quality and volume of the bone and whether there were any important structures close to where the implant was being placed. We saw evidence these X-rays were analysed to ensure the implant work was undertaken safely and effectively. We also saw that patients gum health was thoroughly assessed prior to any implants being placed. If the patient had any sign of gum disease then they underwent a course of periodontal treatment.

After the dental implant placement the patient would be followed up at regular intervals to ensure the implant was healing and integrating well and a direct contact number for the dentist was provided if they had any questions or concerns. We saw positive feedback from a dental implant patient who confirmed they were highly satisfied with the treatment and the outcome.

Health promotion & prevention

The practice provided preventative care and support to patients in line with the Delivering Better Oral Health toolkit. They displayed oral health education information throughout the practice and supported national oral health campaigns. Patient's comments confirmed that the dentists were very informative and gave them information to improve their oral health.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children as appropriate.

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

Staffing

We were told staff new to the practice had a period of induction, evidence of this was not available. We saw evidence that a recently recruited staff member had read and signed policies appropriate to their role. Staff told us they discussed training needs informally. We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council and the practice supported them to complete their training by offering in-house, external and online training.

Working with other services

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included 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. The practice did not have a system to monitor urgent or non-urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. 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 not received training and did not fully understand their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy did not refer to Gillick competence, the dentist and dental nurse were not fully aware of the need to consider this when treating young

Are services effective?

(for example, treatment is effective)

people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were friendly, caring and professional.

Anxious patients said staff were compassionate and understanding.

The layout of the reception and waiting area did not provide privacy when reception staff were dealing with patients but staff were aware of the importance of privacy and confidentiality. Staff described how they avoided discussing confidential information in front of other patients and if a patient asked for more privacy they would hold their discussion in the treatment room.

The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.

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

Music was played in the treatment room and there were magazines and children's books in the waiting room. Practice information was available for patients to read.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. Patients commented that the dentist took lots of time to talk and answer any questions fully.

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

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments for gum disease and more complex treatment such as implants.

Each treatment room had a screen so the dentists could show patients photographs, videos and X-ray images when they discussed treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was renovated and maintained to a high standard and staff aimed to provide a comfortable, relaxing environment. Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they 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.

Staff told us they made courtesy calls to remind patients of upcoming appointments and telephoned patients after complex treatment to check on their well-being and recovery.

Tackling inequity and promoting equality

The practice was located in a ground floor premises. They made some reasonable adjustments for patients with disabilities. These included a portable ramp for wheelchair users. A disability access assessment had not been carried out and we discussed other reasonable adjustments that could be considered by the practice.

Staff told us they had previously had access to interpreter/ translation services but they had never had the need to use them. They were not sure whether this service was still available to them.

Access to the service

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

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept appointments free for same day care. Emergency care arrangements were in place with other local practices when the service was closed. The 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.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint. Staff told us they would discuss any formal or informal comments or concerns straight away so patients received a quick response.

Staff told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was not available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns. We discussed the need to make this information available to patients.

The practice had not received any complaints in the last 12 months. The practice had processes in place to respond appropriately to concerns and improve the service.

Are services well-led?

Our findings

Governance arrangements

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

Governance was unorganised and ineffective, on the day of the inspection, we found that staff had difficulty locating policies, procedures and other documentation when it was requested. The dentist and dental nurse often referred us to one another to locate policies and documents which should be readily accessible to all staff members. We discussed the need for the registered person to be fully aware and responsible for ensuring that appropriate governance arrangements are in place.

The practice had policies and procedures to support the management of the service and to protect patients and staff. The arrangements to risk assess and monitor the quality and safety of the service required improvement. For example, systems were not in place to receive and act on MHRA alerts, record, risk assess and report faulty devices, review the fire safety arrangements, or dispose of out of date medicines, dental materials and instruments. The arrangements to provide medical emergency care had not been risk assessed appropriately.

Systems were not in place to ensure the team were aware of forthcoming changes in legislation and guidance. For example, staff were not familiar with the requirements of the Control of Mercury (Enforcement) Regulations 2017 or the European General Data Protection Regulations (GDPR). Staff were not aware of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competency.

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

Leadership, openness and transparency

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They felt confident they could raise and discuss any issues.

Staff told us they held informal discussions where staff could raise any concerns and discuss clinical and non-clinical updates or share urgent information.

Learning and improvement

During the inspection we found staff were open and responsive to discussion and feedback to improve the practice. The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. Evidence of up to date audits were not available on the day of the inspection. The provider was asked to supply evidence of this after the inspection but this was not received.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. Appraisals had not been carried out due to the lack of team capacity. They discussed learning needs, general wellbeing and aims for future professional development.

Staff told us they completed highly recommended training each year. We noted that medical emergencies and basic life support training had been provided on a three-yearly basis and the dental nurse was not familiar with the correct operation of the emergency medical oxygen. The General Dental Council requires clinical staff to complete continuous professional development, including annual training in medical emergencies. Staff told us the practice provided support and encouragement for them to do so.

Practice seeks and acts on feedback from its patients, the public and staff

The practice used patient surveys and verbal comments to obtain patients' views about the service.

This section is primarily information for the provider

Enforcement actions

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 **Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular:** • Medicines including local anaesthetic and dental instruments available for use in the treatment room had expired between 2009 and 2016. • The practice did not ensure that medicines and equipment to manage medical emergencies were in line with guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. **There was additional evidence that safe care and treatment was not being provided. In particular:** • The provider had not recorded, risk assessed or reported a recent incident involving the failure of a medical device. • The provider did not ensure that appropriate fire safety systems were in place, including ensuring fire exits were kept clear.

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 operated 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:** **Appropriate governance systems were not in place to:** • Receive and act on patient safety alerts

This section is primarily information for the provider

Enforcement actions

- Record, risk assess and report faulty devices
- Ensure that appropriate fire safety arrangements were in place
- Ensure that out of date medicines, instruments and dental materials were identified and disposed of.
- Ensure appropriate, risk assessed arrangements and training to provide emergency medical care.

There was additional evidence of poor governance. In particular:

- Governance was ineffective, staff had difficulty locating policies, procedures and other documentation, which should be readily accessible to all staff members.
- The provider failed to asses the need to ensure the compressor was serviced.
- Evidence was not available to show the provider carried out clinical audits including radiography.
- Staff were not aware of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competency.
- The provider's staff recruitment procedures were not operating effectively. No evidence was available at the practice of pre-employment checks for one member of staff, namely, a Disclosure and Barring Service Check, (DBS) and references. The provider did not seek satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care, or children or vulnerable adults.