Ter-Man Healthcare Limited

Grange Green Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 April 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive, and well-led?

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 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

Grange Green Dental Practice provides private dental treatment to patients of all ages. The principal dentist employs a dental nurse, two trainee dental nurses, and two receptionists. A hygienist provides services to the practice. In addition to an outside cleaner, the nurses and receptionists cover some of the cleaning duties.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice is located close to a GP practice and a variety of shops in Grange Road. It is operated from a converted bungalow making it accessible to wheelchair users. The practice has three treatment rooms, a reception and waiting area. There is a decontamination room for cleaning, sterilising, and packing dental instruments, a room for developing X-rays, and a toilet suitable for disabled patients. There is an annex situated in the garden, providing facilities for a staff kitchen and rest area with, storage for materials and files. There is a small car park at the front of the building and on street parking is available.

We received feedback from 43 patients during the inspection process. We received 42 positive comments about the cleanliness of the premises, the empathy and responsiveness of staff, and the quality of treatment

Summary of findings

provided. We received one negative comment about the services provided. Patients told us that staff explained treatment plans to them well. Patients reported that the practice had seen them on the same day for emergency treatment. We did not have the opportunity to speak with patients on the day.

Our key findings were:

- The practice did not have robust systems in place to help ensure patient safety. These included responding to medical emergencies and maintaining equipment.
- The practice did not meet the standards required to ensure compliance with Health Technical Memorandum 07-01 (HTM 07-01) and Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Patients' care and treatment was not always planned and delivered in line with evidence-based guidelines, best practice and current legislation.
- All the staff were employed within the last eight months and did lack some of the skills, knowledge, and experience to deliver safe, effective care and treatment.
- Patients did not always receive clear explanations about their proposed treatment and but were actively involved in making decisions about it.
- Patients reported that they were treated in a way that they liked by staff.
- Appointments were easy to book and emergency slots were available each day for patients requiring urgent treatment.
- The practice did not record and collate feedback from patients to make improvements to the service provided.
- Staff had a limited understanding of the Mental Capacity Act and the importance of gaining patients' valid consent to their treatment.
- The practice did not have robust quality monitoring systems and did not undertake any audits to ensure quality and safety for patients, including infection control.
- The practice did not undertake appropriate pre-employment checks for all staff.
- Staff did not receive regular support of their training needs and working practices.
- We were concerned that during our inspection a range of evidence or documents that we need to inspect were not made available to us.

We identified regulations that were not being met and the provider must:

- Ensure staff training and availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure the training, learning and development needs of staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff employed.
- Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD)
- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices, The Health, and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Ensure the practice's sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Ensure audits of various aspects of the service, such as radiography, infection control and dental care records are undertaken at intervals in accordance with published guidance to help monitor safety and improve the quality of service. Ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

- Ensure the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure that systems and processes are established and operated effectively to safeguard patients from abuse.
- Ensure systems are put in place for the proper and safe management of medicines.
- Ensure an effective system is established to assess, monitor, and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure that a system is implemented for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).

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

- Regularly seek and collate feedback from patients and use it to monitor and improve the service provided.
- Review guidance such as that provided by the National Institute for Health and Care Excellence (NICE), the Better Oral Healthcare Toolkit and the Faculty of General Dental Practice record keeping guidance to support the dentist to maintain appropriate dental care records.

You can see full details of the regulations not being met at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was 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 Enforcement Action section at the end of this report).

There was a lack of systems and processes in place to help ensure the safety of staff and patients. There was no evidence that equipment was maintained and safe to use.

The practice was not meeting the standards as required by the Ionising Regulations for Medical Exposure Regulations (IR(ME)R 2000.

The infection control procedures did not meet the national guidance.

The practice had not completed robust risk assessments to identify and manage risk for example; several containers filled with toxic waste had been stored for over 12 months in area that was not secure and could be access by members of the public. The practice had not undertaken a sharps risk assessment.

Staff were not clear about reporting incidents, near misses, and concerns and there was no evidence of learning and communication with staff from them.

Recruitment procedures were not robust, and DBS checks had not been undertaken for all dental staff.

Regular professional registration checks were not undertaken for dentists to ensure they were still fit to practise.

There were quantities of materials and medicines found that had expired.

Are services effective?

We found that this practice was not providing effective 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 were concerned that explanations were not given to patients in a way they understood and risks, benefits and options available to them. We were not shown sufficient evidence to be assured that staff were supported through training, and opportunities for development.

Patients were referred to other services in a timely manner. Staff had received training in the Mental Capacity Act 2005 however; they had limited understanding and knowledge of its relevance in practice.

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially.

Patients with urgent dental needs or pain were responded to in a timely manner, usually on the same day.

The majority of comments from patients who completed the comment cards reflected that patients were happy with the service provided.

Summary of findings

Are services responsive to people's needs?

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

Comments from patients reflected that appointments were easy to book. The practice offered appointment slots each day enabling responsive and efficient treatment of patients with urgent dental needs. The practice was accessible to all patients including wheelchair users.

There was a clear complaints procedure and information about how to make a complaint was displayed in the waiting area.

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 Enforcement Actions at the end of this report).

We found a number of shortfalls in the practice's governance and leadership. Robust policies and procedures to govern the practice's activities were not in place.

Risk assessments to ensure patient and staff safety were not undertaken.

Staff did not receive regular reviews of their performance and did not have personal development plans in place.

Staff training was not actively monitored and staff had not received training such as basic life support and dealing with medical emergencies.

The practice had failed to address all the actions identified in a report following an advisory visit by the radiation protection advisor.

The practice failed to monitor water temperatures in the building as a precaution against the development of legionella.

No regular audits were undertaken ensure standards were maintained.

Grange Green Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

The inspection took place on 28 April 2016 and was conducted by a CQC inspector and a specialist dental advisor.

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?

Prior to the inspection, we asked the practice to send us some information, which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications, and proof of registration with their professional bodies. We also reviewed the information we held about the practice.

During the inspection, we spoke with the principal dentist, a trainee dental nurse and two receptionists. We reviewed policies, procedures and other documents. We received feedback from 43 patients who used the service.

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Practice staff we spoke with had a limited understanding of what might constitute a significant incident, whether there was a policy, how they should record information and share learning from any. The practice staff had all been employed within the last eight months and told us that there had not been any reported incidents. They told us that if anything went wrong, they discussed it as a team, and found a solution. For example, they identified that there was a potential loss of important information when a patient cancelled their appointment, as they did not record this; a system was put into place to record this information. The practice did not have a log of any incidents or near misses.

We asked to view the practice's current accident book; we were shown a notebook, which only contained the basic details of two incidents, and these both involved members of staff. The last entry detailed an accident involving a staff member: the floor in the treatment room was not of a non-slip material, water had splashed onto the floor, and the staff member slipped. All staff we spoke with were aware of this incident and that water spillages must be cleared up immediately and that they must wear appropriate foot wear.

At the time of the inspection we were not shown any evidence either that the practice receive communication from the Medicines and Healthcare products Regulatory Agency (MHRA) or that any action had been taken if needed.

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Reliable safety systems and processes (including safeguarding)

The practice was unable to provide robust information about how to raise safeguarding concerns for vulnerable adults or children. The dentist was the safeguarding lead and staff had received training in January 2016, however, they had a limited knowledge of procedures. Staff also had a limited knowledge of the external agencies they could report to if they wanted to raise concerns out with the practice.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The dentist we spoke with told us that he did not use rubber dams because patients did not like them and used gauze instead.

We noted that there was clear signage throughout the premises clearly indicating fire exits, medical emergency equipment, and X-ray warning signs to ensure that patients and staff were protected.

Medical emergencies

Staff did not have a clear understanding of where the emergency equipment was held. The practice did not have access to an automated external defibrillator (AED) in line with current guidance and had not undertaken, and documented a risk assessment as regards its absence. An AED is a portable electronic device that analyses life-threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

The practice did have emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. There were no systems in place to ensure that these were checked. All emergency medicines were within their expiry date, having been purchased as a kit in Nov 15, however the Glucagon injection was stored out of the fridge, and had not had the expiry date reduced to ensure it was safe to use. Glucagon is a medicine used to increase a patient's blood sugar level quickly in an emergency. The oxygen cylinder had expired in June 2014.

The dentist told us that he was not up to date with basic life support training and had last received training in 2012. The staff we spoke with had not received any training in basic life support or how to deal with medical emergencies should one happen.

Staff recruitment

We reviewed staff recruitment files and found that some recruitment checks had not been undertaken for staff prior to their employment. For example, there was evidence that only one member of staff had obtained a disclosure and barring check (DBS) to ensure that they were suitable to

work with children and vulnerable adults. There was no evidence of references, an interview record, or a job description for any staff member. We requested but were not shown the practice's recruitment policy.

Monitoring health & safety and responding to risks

The practice did not have a robust health and safety policy or risk assessment in place. This would identify risks to staff and patients who attended the practice. The staff had received training in health and safety in January 2016.

Fire detection and firefighting equipment such as fire alarms and fire extinguishers had not been regularly tested; for example, the fire extinguishers were last checked in October 2012 and staff did not test the alarms or conduct a fire drill**.** Staff had received fire refresher training in January 2016 as part of health and safety training**.**

There was not a comprehensive Control of Substances Hazardous to Health (COSHH) folder in place that contained chemical safety data sheets for products used within the practice. Employers are required by law to control substances that are hazardous to health.

Electrical equipment had been checked in June 2015.

Hazardous waste was not well managed. On the day of the inspection, we found quantities of spent chemicals stored alongside the garden annexe. Specialist waste contractors had not been engaged to remove these toxic chemicals. The provider told us that these containers had been there for over 12 months and were left by the previous provider. However, our records show that the provider has owned the business and been operating from this location since 2013. The hazardous waste posed a risk to members of the public who had access to the area.

A legionella risk assessment had been carried out on 24 April 2015 with no identified actions; however, staff did not carry out regular checks of water temperatures in the building as a precaution against the development of legionella. Legionella is a term for a particular bacterium, which can contaminate water systems in buildings.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The dentist was the named lead for infection control however he had not nor had the staff received appropriate training in infection prevention and control. The dentist was aware that this training was required and that he had planned for it to take place in the future. He did not provide us with a date.

The practice was generally clean, tidy, and uncluttered. However, we found areas that were not for example, in the treatment room, drawers where equipment was available for use were cluttered and dirty; the inner side of handles were smeared with cement residue. We noted that the chair used by the dentist was damaged and the soft filling was exposed. The dentist covered this with a cloth towel, which was not changed between patients. This did not meet the standards for infection prevention and posed a risk to patients.

There was an infection control policy, however, this was not dated, and there was no evidence that staff had read it. The dentist was responsible for infection prevention and control, and the dental nurse and trainee dental nurses were responsible for the decontamination processes. The practice team were responsible for the cleaning of the practice two days of the week and a contractor cleaner was engaged for the rest of the week. The practice did not have systems for testing and auditing the infection control procedures; there was no evidence that any audits had been undertaken, this did not meet the requirements as recommended in The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05). This document is published by the Department of Health and sets out in detail the essential processes and practices to prevent the transmission of infections.

Decontamination of dental instruments took place in a dedicated room in the practice. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments; there were no policies or procedures available for us to view to ensure that guidelines were being met.

We noted that the hygienist used the ultrasonic cleaning bath, whilst the trainee dental nurses manually cleaned the equipment. This posed a greater risk of harm for the trainee nurses from sharps injuries. Not all the equipment was correctly packaged, sealed, stored, and dated with an expiry date. Staff did not check the water temperature before manually cleaning instruments to ensure it was kept below 45 degrees Celsius.

Are services safe?

We found equipment that was sterilised was not always bagged and labelled with the expiry date correctly. In the treatment room, we found some equipment in the drawers and available for use that had not been bagged, we asked staff how often this equipment was removed and re sterilised, they told us that it was changed every two weeks. We found equipment that was recommended for single use, for example, matrix bands (which are used to isolate a tooth during treatment) had been through the sterilising process, were available for use in the treatment room and had not been bagged. The bands were damaged through use and they had not been cleaned thoroughly as we saw residues of cement on them. We were concerned that this posed a risk to patients.

We found a large quantity of used rotary (and some hand) endodontic files. The dentist told that these would not be re used but he had hoped to sell them for scrap. Although he had said they had been decontaminated (by hand scrubbing and sterilisation,) we found dentine chippings were evident on a number.

Regular flushing of the water lines was carried out in accordance with current guidelines.

We found that the practice was not meeting the HTM01- 05 essential requirements for decontamination.

We saw that some sharps bins were not signed and dated and that some sharps bins were overfilled.

The practice did not have a robust sharps management policy, staff we spoke with were not confident in the steps to take should an injury occur.

A clinical waste disposal contract was in place and waste matter was stored within a designated area at the rear of the property prior to collection, this area was accessible to members of the public. We noted that clinical waste bags were not labelled with the practice postcode. This ensures that clinical waste can be traced back to source should there be any issues during transportation through to disposal. There were three full clinical waste bins, one of these was overfull and could not be locked. Staff told us that this was unusual and they were not sure where the additional waste had come from.

The practice did not have a record of all staff immunisation status in respect of Hepatitis B, and there were no clear instructions for staff about what they should do if they injured themselves with a contaminated needle or other sharp dental instrument.

Equipment and medicines

The practice had equipment to enable them to carry out the full range of dental procedures that they offered and staff told us they had the equipment they needed to enable them to carry out their work. We were not shown evidence to confirm that the equipment used for cleaning and sterilising instruments was checked, maintained, and serviced in line with the manufacturer's instructions. We asked to see records that showed that the equipment was in good working order and being effectively maintained but these were not made available to us.

We found large quantities of medicines and materials that had expired and were not safe for use stored in cupboards in the two treatment rooms; these included five boxes of Ibuprofen that expired in March 2015, and devices such as syringes, which expired in May 2006. Staff told us that these would not be used and that they were awaiting disposal. We also found some materials that were available for use that had expired, including temporary filling material, which expired in February 2015.

Radiography (X-rays)

The practice was registered with the Health and Safety Executive as required under Ionising Radiations Regulations 1999 (IRR99).

The practice had a radiation protection file; however, this did not show a record of all X-ray equipment including service and maintenance history.

A radiation protection advisor had been appointed as required by the Ionising Regulations for Medical Exposure Regulations (IR(ME)R 2000), the dentist was listed as the radiation protection supervisor and should ensure that the equipment was operated safely and by qualified staff only. We noted that not all actions identified in the report of an advisory visit carried out in 2015 had been completed and that some actions had been taken immediately prior to our visit, for example staff told us that they had recently added the local rules to the radiation protection file.

We did not find that there were suitable arrangements in place to ensure the safety of the equipment. Local rules

Are services safe?

were available in the radiation protection folder. Those authorised to carry out X-ray procedures were named in all documentation, however, there were no records available to show they had attended the relevant training. We asked the dentist if he followed the Faculty of General Dental Practice guidelines, he told us that he had not read them. We provided the practice with a link to this information. We were concerned that patients who required X-rays as part of their treatment were not protected.

The dentist did not monitor the quality of the X-ray images on a regular basis and did not undertake any audits. We did not see evidence that ensured they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice did not have robust policies and procedures in place for assessing and treating patients. This posed a risk to patients as radiographs could be taken at inappropriate intervals and not in accordance with the patient's risk of oral disease.

The dentist told us that he discussed each patient's diagnosis and treatment options and although he provided options, there was no evidence that he had discussed risks, benefits, advantages and disadvantages of each therefore valid consent could not be assumed.

The dentist told us, that when necessary, the practice staff would explain his advice and suggestions to the patient; he told us that this ensured that the patient understood what he was saying. The staff told us that they usually relayed the patient's conversation back to the dentist. We were concerned that staff did not have the qualifications to relay the clinical information and that this did not show clear communication with patients and could lead to misinterpretation and understanding. The practice staff told us that they did this, as the patient's did not always understand what the dentist was telling them.

Dental care records that the dentist showed us did not include a record of discussions of the options for treatment, risks and benefits. Whilst not mandatory for a practice which provides care for private patients only, the National Institute for Health and Care Excellence (NICE) guidance, the Better Oral Healthcare Toolkit and the Faculty of General Dental Practice record keeping guidance would support the dentist in maintaining appropriate dental care records.

The dentist told us that he did not prescribe fluoride varnish and higher concentration fluoride toothpaste for patients at high risk of developing tooth decay as he had read conflicting advice. The dentist did offer some preventative dental information in order to improve the outcome for the patient, for example dietary and smoking cessation advice.

We received feedback from 43 patients through CQC comment cards; the practice did not collate their own feedback from patients. 42 of the comments received reflected that patients were very satisfied with the staff, assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

The waiting room and reception area at the practice contained literature that explained the services offered at the practice.

Staff told us that they advised patients on how to maintain good oral hygiene for children and adults and the impact of diet, tobacco and alcohol consumption on oral health.

Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health.

Staffing

Dental staff were appropriately trained and registered with their professional body. We were not able to establish if staff were encouraged and supported to maintain their continuing professional development (CPD) to maintain their skill levels. We were concerned that the dentist did not maintain his CDP throughout the five-year cycle as recommended in the GDC guidance; he told us he would complete the requirements before the end of the current cycle. The GDC guidance states

- Medical Emergencies: at least 10 hours in every CPD cycle – and we recommend that you do at least two hours of CPD in this every year;
- Timing of CPD activity, you can choose when to do CPD within your five-year CPD cycle. We recommend that you participate in CPD activity regularly and take account of our recommendations about CPD topics Ideally you will divide your CPD evenly between each of the five years of the cycle. .

We were not shown any evidence of his training records except that he had completed safeguarding training, health, and safety (including fire refresher) in January 2016. CPD is a compulsory requirement of registration as a general dental professional and its activity contributes to their professional development.

The practice staff had all been employed within the last eight months and had not received an appraisal. There was no evidence that staff had undergone reviews or had a robust induction to the practice.

Are services effective?

(for example, treatment is effective)

Working with other services

The practice had a system in place for referring, recording, and monitoring patients for dental treatment and specialist procedures for example root canal treatment, impacted wisdom teeth and orthodontics. On the day of the inspection we were not shown a log of these referrals to ensure patients received care and treatment needed in a timely manner.

Consent to care and treatment

We saw evidence that patients were presented with treatment options and consent forms, which were signed by the patient.

Staff were aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Staff had not received Mental Capacity Act 2005 (MCA) training and were not fully conversant with the relevance to the dental practice. MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them.

The staff had limited knowledge of Gillick competency and we did not see the practice policy for obtaining consent from young patients. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity, respect, and maintained their privacy. The reception area was well laid out and conversations were managed to maintain patient confidentiality.

A data protection and confidentiality policy was not available for us to review; we observed the interaction between staff and patients and found that confidentiality was being maintained. We saw that dental care records were held securely.

Patients reported that they felt that practice staff were friendly, helpful, and caring and that they were treated with dignity and respect. We observed staff treating patients professionally, confidentially and with courtesy. They demonstrated a caring attitude about the patients and wanted to provide a good service.

Involvement in decisions about care and treatment

Feedback from patients included comments about how professional the staff were and several commented that staff were very sensitive to their anxieties and needs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided a range of services to meet patients' needs. It offered private treatment to children and adults.

There was information for patients about the practice, available both in the waiting area. This included details about the dental team, the services on offer, how to raise a complaint, and information for contacting the dentist in an emergency. There was information about costs on display in the waiting room.

Tackling inequity and promoting equality

The practice had three treatment rooms on the ground level, making good access for those in wheelchairs or with push chairs. There were toilet facilities that were suitable for disabled patients.

The practice had a low population of patients whose first language was not English but had access to translation services if required.

The practice did not have a hearing loop; practice staff described how they would communicate effectively with patients with hearing difficulties.

Access to the service

The practice was open Monday and Tuesday from 8.30am to 5.30pm, Wednesday 8.30am to 7pm, Thursday 8.30am to 5pm and Friday 8.30am to 4pm. Staff told us that on Thursday and Friday afternoons the practice did not routinely offer appointments and that staff conducted administrative tasks.

Appointments could be booked by phone or in person. Staff told us patients were seen as soon as possible for emergency care and this was normally on the same day. The comment cards patients completed reflected that the practice had responded quickly when they had a need for urgent treatment. They also reflected that were satisfied with the appointments system and said it was easy to use.

The practice's answer phone message detailed how to access out of hours emergency care if needed. Staff were sensitive to its use, for example, they would not play answerphone messages when patients were in earshot.

Concerns & complaints

There was information available for patients giving them details of how to complain. The practice had received one complaint in the past 12 months. The complaint had not been documented.

Practice staff told us they were aware of how to deal with a complaint should they need to.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was the registered manager and had responsibility for the running of the practice including its finances and personnel functions.

We found a significant number of shortfalls in the practice's governance arrangements. Although there were a few basic policies in place to support the management of the service, these had not been dated or implemented. There was no system in place to show that staff had read, understood, and agreed to abide by the policies. There were not robust systems and processes in place to ensure that quality and safety was appropriately monitored and actions taken to address and issues. As a result, staff were not reporting and recording significant events; the practice was not monitoring water temperatures; there were no robust risk assessments and no systems in place to ensure that medicines were managed safely, or that routine checks were conducted on emergency drugs and equipment. We found large quantities of materials and medicines that had expired

The practice did not have robust team meetings to discuss the running of the practice, significant events, complaints, and share learning. The main form of communication between staff and the dentist was verbal and this did not appear to be effective at all times.

Recruitment procedures were not robust, and DBS checks had not been undertaken for all dental nurse or trainee nurses. Professional registration checks were not undertaken for dentists to ensure they were still fit to practise. Staff did not receive regular performance reviews and did not have clear objectives. The practice did not keep a record of training undertaken by staff.

Leadership, openness and transparency

We found there was a lack of leadership provided by the dentist. The dentist was the registered provider and responsible for the management of the practice. We were concerned that he did not have the skills or time to undertake this work. During our inspection, the dentist was not able or was unwilling to show us evidence or documents that we need to inspect. We found that the dentist was not open in our discussions and therefore we were not assured that he lead with openness and transparency.

There was not a whistleblowing policy and staff we spoke with had limited knowledge of whistle blowing and were not confident in what they would do.

Learning and improvement

The practice did not have a structured plan in place to audit quality and safety. There was no evidence of any audits. There was no evidence to show that learning was shared and that the dentist prioritised improvement.

There was no evidence to show that staff working at the practice were supported to maintain

their continuous professional development as required by the General Dental Council and that the practice would provide yearly training for staff in radiography, medical emergencies, and infection control. We requested but we were not shown any evidence to assure us that the dentist maintained his continuous professional development as required by the General Dental Council.

The practice did not actively monitor staff training or keep records of it to ensure it would be completed within the appropriate timescales.

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

Patients were given the opportunity to give verbal feedback and influence how the service was run at each appointment; however, the practice did not collate this nor did they collect written feedback.

All the staff had been employed within the last eight months; they told us that they did give feedback to the dentist.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** • The provider did not operate robust recruitment procedures to ensure that only fit and proper staff were employed. Only one of the four members of staff employed by the practice had obtained a disclosure and barring check (DBS) to ensure that they were suitable to work with children and vulnerable adults. There was no evidence of references, an interview record, or a job description for any staff member. **This was in breach of regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

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 **Safe care and treatment** **Why you are failing to comply with this regulation:** • The practice had not monitored the quality of the X-ray images on a regular basis and had not undertaken any audits. There was no assurance that X-rays were of the required standard or that the risk of patients being subjected to further unnecessary X-rays was reduced. • The practice had not undertaken assessment of the risk to patients regarding the decision not to hold an automatic external defibrillator (AED) in the practice. There were no written or formalised arrangements in place to access an AED in the event of an emergency. • The practice staff had not received training in basic life support or dealing with medical emergencies. The staff did not know how to access emergency equipment should the need arise. • The oxygen cylinder, which was available for use, had an expiry date of June 2014. • Fire detection and firefighting equipment such as fire alarms and fire extinguishers had not been regularly tested; the fire extinguishers were last checked in October 2012 and staff did not test the alarms or conduct a fire drill. • Staff authorised to carry out X-rays were identified in the radiation protection file. Dr Petrus Snyman was the named person but had delegated these duties to a trainee dental nurse who had not received the appropriate training to carry out the role. • Dental equipment that was being reused had not been appropriately cleaned and stored ready for use. • One of the three clinical waste bins at the rear of the property was over full and could not be locked. • Sharps bins inside the practice were overfilled.

This section is primarily information for the provider

Enforcement actions

- Hazardous waste in the form of spent chemicals was stored alongside the property which adjoined a residential dwelling.
- The practice had not ensured that clinical equipment available for use was within the expiry date.
- Forty four medicines and three cannulas were found that were not within the expiry date. The expiry date of a supply of Glucgon that was not stored in the fridge had not been amended to reflect its reduced validity.
- There was no system in place to check the expiry dates of emergency medicines and equipment and ensure appropriate disposal.

This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The practice had not implemented a programme of audits to manage and mitigate the risks associated with infection control and carrying out X-rays. • The practice did not follow decontamination processes and monitored dental equipment that was available for use • X-rays were not being monitored for quality and efficacy and there was no audit in place. • Dental care records did not follow the Faculty of General Dental Practice record keeping guidance. **This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**