Mr. Wai Yeap

West Norwood Dental Surgery

Inspection Report

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Overall summary

We carried out this unannounced inspection on 30 October 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

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

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

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

Our findings were:

Are services safe?

We found 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

West Norwood Dental Surgery is in West Norwood and provides NHS and private treatment to adults and children.

Car parking spaces, including some for blue badge holders, are available near the practice.

The dental team includes a dentist, a dental nurse and a trainee dental nurse. The practice has one treatment room and decontamination area.

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 received feedback from four patients.

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

Our key findings were:

- Improvements were required in the appearance and cleanliness of the practice, including attending to the rip in the waiting room carpet.
- The dentist generally provided patients' care and treatment in line with current guidelines.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The dentist had some understanding of how to deal with medical emergencies. Some medicines and life-saving equipment were available on the premises. However, there were some improvements required including replacing out of date adrenaline.
- Improvements were required to the provider's infection control procedures.
- The practice had some systems in place to help them manage risk to patients and staff.
- The dentist was not up to date with key training such as safeguarding children and vulnerable adults and improvements were required to their safeguarding policy.
- The provider did not carry out all the required recruitment checks for staff employed
- The provider did not have systems in place to audit their non-clinical and clinical processes.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- 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.

They should:

- Take action to ensure the clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records. In particular in regard to recording patients consent .
- Review the practice protocols regarding audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Review the practice protocols regarding auditing patient dental care records to check that necessary information is recorded.
- Improve and develop the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation, take into account relevant guidance, and staff follow them.
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.

Following our inspection the provider informed us that their trainee nurse who provided chairside assistance had resigned and the practice would stop undertaking regulated activities while they undertook a process to recruit a new dental nurse.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

We found 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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

The dentist knew some of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. However, the practice did not have localised safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. They had some details of the local authorities safeguarding policy. Neither the dentist or the nurses had undertaken safeguarding training. We spoke with the dentist about this and they told us they would review their safeguarding arrangements.

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

The provider had a staff recruitment procedure in place. The provider employed two members of staff one had worked with him for a number of years, the other had been recruited in the last two years. They had undertaken some employment checks for these staff, including criminal records checks and identification checks. However, there were gaps in these records. For example, there were no references or evidence of checks on employment history. We spoke to the provider about this and they told us they would make improvements to their recruitment process.

Portable appliance testing (PAT) had been undertaken in June 2019.There was no evidence of pressure vessel checks. There was no evidence of an electrical installation safety check. There was no evidence of gas safety checks. The provider was not able to give us any assurances as to whether the check and testing had ever been completed.

The provider was also unable to give any assurances as to whether fire detection equipment, such as fire extinguishers were regularly serviced.

The provider had completed their own fire risk assessment in June 2017. They told us that one had been completed by a fire specialist some years ago, but they were unable to find it on the day of the inspection.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and we saw the required information was in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation.

However, the dentist was not able to give us assurances that they had completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

We looked at the practice's arrangements for safe dental care and treatment.

The practice had some health and safety policies and procedures in place including a Control of Substances Hazardous to Health (COSHH) file. The dentist generally followed relevant safety regulation when using needles and other sharp dental items. However, a sharps risk assessment had not been undertaken. Following the inspections we were set a copy of a sharps risk assessment by the provider.

The practice had employer's liability insurance.

The provider did not have a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. The provider was not able to give assurances that these checks had been undertaken for the staff they employed on the day of the inspection. Following the inspection the provider sent us details of Hepatitis B checks that had been carried out.

Most emergency equipment and medicines were available as described in recognised guidance. However, improvements were required. For example the syringes and Adrenaline had expired. We spoke with the dentist about this and they told us they would replace the expired items.

The dentist told us that they worked with a dental nurse when they treated patients, in line with GDC's Standards for

Are services safe?

the Dental Team. There was no dental nurse on the day of the inspection. The dentist told us this was because they had come in to do consultations with patients and had no planned chairside treatments.

The practice had an infection prevention and control policy and procedures. They had some understanding of guidance in regard to the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. However, some improvements were required. For example, there was a rip in the lino in the surgery and dental instruments that were sterilised and packaged were not date stamped. We spoke to the provider about these deficiencies and they told us they would make improvements to the process.

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

The practice had systems in place to ensure that dental work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment that had been undertaken in October 2018. Water lines were regularly flushed; however the practice was not recording the temperature of water. We spoke with the provider about this and they told us they would start to test the temperature.

The practice appeared generally clean when we inspected it. However, there was a rip in the carpet in the waiting room.

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

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We checked a sample of dental care records. We noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were, kept securely, and complied with General Data Protection Regulation requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The provider had some systems for appropriate and safe handling of medicines.

The dentist was aware of and following guidance in relation to prescribing medicines. Improvements were needed in regard to tracking medicines dispensed and ensuring that antimicrobial prescribing audits were carried out annually to demonstrate that the dentist was following current guidelines.

Track record on safety, lessons learned and improvements

There were adequate systems for reviewing and investigating when things went wrong. There had been no incidents recorded in the last twelve months.

There was a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dentist assessed patients' needs and delivered dental care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The provider was not aware of guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence. For example, they did not ensure that they had risk assessed whether emergency equipment needed to be taken with them while undertaking the visit and did not attend the visits with someone to offer chairside assistance.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health.

The dentist, where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice; they could also be referred to a specialist if needed.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions.

The dentist had a general understanding of their responsibilities under the Mental Capacity Act 2005 when treating adults who may not be able to make informed decisions. Similarly, they had a general understanding of the circumstances by which a child under the age of 16 years of age may give consent for themselves and were aware of the need to consider this when treating them. However, some improvements were required in regard to the understanding of the Mental Capacity Act 2005. For example, the dentist was not able to fully explain all the groups of people the Act would apply to and the practice did not have a consent policy. The provider told us they would familiarise themselves with the act.

Monitoring care and treatment

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.

Effective staffing

The dentist had not completed safeguarding vulnerable adults and children, infection prevention and control, radiography and Mental Capacity Act, 2005 training. The practice employed two members of staff. A dental nurse and a trainee dental nurse. The nurse had not been on the General Dental Council (GDC) register since August 2018. The dentist said the nurse had not provided chairside assistance since this time and said they had been supported by the trainee nurse. The dentist told us that the trainee nurse was on a training course but they did not have any documentation about the course.

The dentist told us that told us they discussed development needs of staff during informal discussions but there was no formal clinical supervision or appraisals. We spoke to the dentist about these deficiencies. They told us that since the inspection took place the trainee dental nurse had resigned and they were in the process of recruited a new nurse.

Co-ordinating care and treatment

The practice had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The practice also had systems for referring patients with suspected oral cancer under the national two weeks wait arrangements. This was initiated by the National Institute for Health and Care Excellence in 2005 to help make sure patients were seen quickly by a specialist.

The practice could strengthen arrangements for monitoring all outgoing referrals such as by implementing a referral tracker.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were respectful, informative and warm. We saw that the dentist treated patients respectfully, appropriately and kindly and were friendly towards patients who visited the practice and over the telephone.

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

Privacy and dignity

The practice respected and promoted patients' privacy and dignity and were aware of the importance of patient confidentiality.

The dentist told us If a patient asked for more privacy they would take them into another room.

The practice stored paper records securely.

Involving people in decisions about care and treatment

The dentist helped patients to be involved in decisions about their care and were aware of the

Accessible Information Standards and the requirements under the Equality Act

or requirements under the Equality Act.

The provider told us that although they had never needed to in the past, they could arrange interpretation services for patients who did not speak or understand English as a first language. Staff communicated with patients in a way that they could understand.

The practice provided patients with information about the range of treatments available at the practice. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. The provider gave patients clear information to help them make informed choices about their treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Patients described satisfaction with the responsive service provided by the practice. They told us the practice had been accommodating with their needs.

The practice had not undertaken a Disability Access audit. We spoke to the dentist about this and they told us they would arrange for an audit to be carried out.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The provider displayed the opening hours in the premises.

The provider had an appointment system to respond to patients' needs. They told us patients who requested an urgent appointment were seen the same day. Patients told us the dental clinicians gave them enough time during their appointment and did not feel rushed.

The practice provided telephone numbers at the practice's entrance and on their answer phone for patients needing emergency dental treatment during the working day and when the practice was not open.

Listening and learning from concerns and complaints

The practice told us they had a written complaints policy providing guidance to staff on how to handle a complaint. However, the policy presented to us was from another organisation. There was no information available to patients about how to make a complaint.

The dentist said they were responsible for dealing with complaints. They aimed to settle complaints in-house. We spoke to the provider about these deficiencies and they told us they would ensure that a complaints procedure was put in place.

Are services well-led?

Our findings

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They also undertook responsibility for the day-to-day running of the service and worked closely with the dental nurse.

Governance and management

The provider had not established clear and effective processes for assessing, monitoring and managing risks, issues and performance. In particular they had not managed risks such as those arising from Legionella, electrical and portable appliances, use of pressure vessel and substances hazardous to health which could affect the safety of the practice.

Furthermore:

- They had not implemented effective systems to monitor staff training. We found the dentist had not completed training in safeguarding children and vulnerable adults, infection prevention and control and radiography.

Appropriate and accurate information

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

Engagement with patients, the public, staff and external partners

The provider used verbal and social media comments to obtain views from patients about the service. They sought feedback from staff through meetings and informal discussions.

Continuous improvement and innovation

The practice did not have quality assurance processes to encourage learning and continuous improvement. For example, there were no infection prevention and control antimicrobial and record keeping audits We spoke with the provider about this and they told us that arrangements would be made for audits to be undertaken.Following the inspection the provider sent us an infection control audit they had carried out.

The dentist had not completed all the 'highly recommended' training as per General Dental Council professional standards including for example safeguarding training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was breached** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: · The practice employs a nurse and a trainee nurse. The nurse had not been on the GDC register since August 2018. The dentist was not aware of this. · The practice was not recording water temperatures · The practice did not have details of the training course the trainee nurse was attending. · No servicing of pressure valves · No electrical condition report or Gas safety checks · No servicing of firefighting equipment · Out of date medicines in the medical emergency kit · Waiting room carpet ripped and is a trip hazard, also in poor condition · Domiciliary care carried out without bringing emergency equipment or assistance. · Lino in treatment room ripped

This section is primarily information for the provider

Requirement notices

· Lack of proper patient referral system in place.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was breached** The registered person had not ensured systems and processes had been established and operated effectively to prevent abuse of service users. **In particular:** · No practice specific safeguarding policy was in place. · The dentist or nurse had not undertaken safeguarding training.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was breached**

This section is primarily information for the provider

Requirement notices

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 mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

In particular:

- No consent policy or MCA training/understanding
- No Disability access audit
- The practice did not have a complaints policy

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was breached** The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: · There was a lack of evidence to show the dentist was up to date with their training including safeguarding children and vulnerable adults and radiography.

This section is primarily information for the provider

Requirement notices

· The provider had not ensured that persons employed had kept up to date with registration of relevant professional organisations including the General Dental Council (GDC)

Regulation 18 (2)

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 breached** The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • The registered person had not obtained references or check the employment history of persons employed. **Regulation 19 (3)**