Mr Roopesh Singh

Mr Roopesh Singh

Inspection report

10 The Crescent
Spalding
PE11 1AE
Tel: 01775760364

Date of inspection visit: 11 November 2021
Date of publication: 22/12/2021

Overall summary

We carried out this announced inspection on 11 November 2021 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 questions:

• Is it safe?

• Is it effective?

• 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 this practice not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services well-led?

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

Summary of findings

Background

Roopesh Singh (known as Crescent Dental Practice) is in Spalding, Lincolnshire and provides private dental care and treatment for adults and children.

The practice is not accessible to people with reduced mobility as access is via a set of stone steps. The practice is located on a narrow road so parking is not available although there are several car parks a short walk away.

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

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.

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

The practice is open:

Monday, Tuesday and Friday 9.15am to 5.30pm

Thursday 9.15am to 1pm

Our key findings were:

- The practice appeared to be visibly clean.
- The provider had infection control procedures, although we found these were not applied effectively or consistently.
- Life-saving equipment was missing from the medical emergency kit and we could not confirm if staff had completed relevant training.
- Systems were not operated effectively to help manage risk to patients and staff.
- Staff had not completed relevant safeguarding training.
- Staff recruitment procedures did not reflect current legislation.
- Patients' care and treatment was not always provided in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Preventive care and advice to support patients to maintain better oral health was not given consistently or recorded in patient records.
- Leadership was not effective and did not promote or enable continuous improvement.
- Processes were not in place to enable staff or patients to give feedback about the service.
- The provider's information governance arrangements did not reflect current guidance.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

- Ensure care and treatment is provided in a safe way to patients.

Summary of findings

- Improve the practice's arrangements for ensuring good governance and leadership are sustained in the longer term.

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:

- Implement practice protocols and procedures to ensure staff are up to date with their mandatory training and their continuing professional development.
- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment .
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the College of General Dentistry.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services effective?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

We found 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 Actions 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)

Clear systems were not in place to keep patients safe.

Staff did not demonstrate an understanding of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider's safeguarding policies and procedures lacked detail and did not provide staff with clear guidance on identifying, reporting or dealing with suspected abuse. Evidence we saw showed safeguarding training was not completed at recommended intervals with the last date of completion recorded as September 2017.

We did not see evidence, within dental care records, that the provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication. This might expose people to the risk of receiving care that did not meet their needs.

The provider had an infection prevention and control policy and procedures. We found these did not always follow guidance set out in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care, and were not applied consistently.

The provider's arrangements for transporting, cleaning, checking, sterilising and storing instruments were not in line with HTM 01-05. Staff did not have access to the correct levels of personal protective equipment (PPE) such as heavy duty gloves, visors or aprons. The records showed that not all equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. For example, we saw the autoclave had been validated in April 2021, but the ultrasonic cleaner had not been validated or serviced. The provider had suitable numbers of dental instruments available for the clinical staff. We found that measures to ensure they were decontaminated and sterilised appropriately were not in place. For example, in addition to the above; staff did not use a magnifying examination light, the cleaning brush was worn and required replacement and the recommended non foaming cleaning solution was not available.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

The provider was failing to assess and mitigate the risks associated with Covid 19 infection as advised in UK Health Security Agency (UKHSA) guidance 'COVID-19: infection prevention and control dental appendix'. We observed, and the provider confirmed, that staff did not wear the recommended level of PPE when carrying out Aerosol Generating Procedures (AGP). We noted staff wore disposable cloth surgical masks and the provider told us they were unaware of the need to wear FFP3 face masks or undertake fit testing for individual members of staff. Following our inspection the provider submitted evidence that they had purchased the recommended level of PPE and had arranged fit testing of masks for all staff.

Evidence was not available or submitted to show how the provider calculated and monitored the fallow time, a period when a treatment room is not in use to minimise the spread of airborne particles. The provider was unaware of the need for processes to ensure air flow or exchange between patients to help minimise the risk and spread of Covid 19.

Are services safe?

Procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, were not in place. A risk assessment was carried out by an external company in 2014. Recommendations in the assessment for remedial action had been completed. Staff and the practice manager informed us they carried out water safety checks. We did not see, and were not supplied with, evidence that records of water testing and dental unit water line management were maintained.

The provider did not keep cleaning schedules which would enable monitoring and oversight of cleanliness of the practice. When we inspected we saw the practice was visibly clean. We noted that surgery flooring was not sealed as recommended in national guidance.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We advised the provider of the need to ensure clinical waste bags were marked to enable identification of the practice if required.

We did not see, and were not supplied with, evidence that the provider had carried out infection prevention and control audits. The provider confirmed these had not been carried out.

The provider had whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentist's use of dental dam when providing root canal treatment was not always in line with guidance from the British Endodontic Society. The dentist informed us they did not always use latex free rubber dam and in instances where dental dam could not be used, such as for example allergy or refusal by the patient, they did not use any other methods were to protect the airway.

The provider had a recruitment policy and procedure to help them employ suitable staff. We did not find evidence that this was always applied. We observed that staff did not always receive an induction to ensure they were familiar with the practice's procedures.

We looked at the recruitment record of the current staff member. This showed the provider had not followed their recruitment procedure with missing evidence including photographic proof of identification and references. We found that records of previous staff members' recruitment checks and personal information was included in the same file.

We observed that clinical staff were registered with the General Dental Council and had professional indemnity cover.

The provider could not confirm facilities were safe. The provider was unaware of the need for, and could not supply, an electrical safety certificate for the building. We found that not all equipment was maintained according to manufacturers' instructions.

A fire risk assessment had been carried out by the practice manager in line with the legal requirements on 3 March 2021. We found that fire extinguishers and fire detection systems were not adequate to ensure safety at the service. Exits were not clearly identified or illuminated, and fire evacuation drills were not carried out. We raised these concerns with Lincolnshire Fire and Rescue Service who have requested the provider make improvements.

The dentists arrangements to ensure the safety of the X-ray equipment were not The provider could not assure us they had undertaken continuing professional development requirement in respect of dental radiography.

We saw evidence the dentists justified, graded and reported on the radiographs they took.

The provider had not carried out a radiography audit since 2015. This does not adhere to current guidance and legislation in Ionising Radiation (Medical Exposure) Regulations 2017.

Risks to patients

The provider had implemented some systems to assess, monitor and manage risks to patient safety, however we found these were not always applied.

Are services safe?

We did not see evidence that the practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed the relevant safety regulation when using needles and other sharp dental items. A sharps' risk assessment had been undertaken in 2015. We did not see evidence this had been updated or reviewed.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Clinical staff had not received training in or had knowledge of how to recognise, diagnosis and respond to the early management of sepsis.

Emergency equipment and medicines were not available as described in recognised guidance. We found staff did not keep records of checks to make sure these were available, within their expiry date, and in working order. Essential equipment was missing from the emergency medicine kit including; all pads for use with the Automated External Defibrillator (AED), oxygen masks and tubing, size 0 and 4 airways, paediatric self-inflating bag and size 0-4 masks for this. Scissors, razor and gloves were also missing. The provider did not have a contract for supply and maintenance of the oxygen cylinder. Checks of this equipment had never been completed. The provider did not supply evidence that they had completed recent basic life support training and demonstrated a lack of knowledge regarding emergency medical situations. Following our inspection, the provider informed us they had purchased the missing equipment and booked all practice staff on medical emergency training.

A dental nurse worked with the dentist when they treated patients in line with General Dental Council Standards for the Dental Team. The provider told us that due to staff shortages, they could not always guarantee support from a nurse for all treatments. We noted that a risk assessment had not been completed for this.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with them to confirm our findings and observed that individual records were not always written and managed in a way that kept patients safe. We found records did not included the patients' medical history or treatment options. Records lacked detail of risk assessments for caries and oral cancer.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider's systems for handling of medicines were not always safe or appropriate.

The stock control system of medicines was not adequate and did not ensure that medicines did not pass their expiry date.

The provider issued private prescription forms for medicines. We found that the prescription forms were not stored securely and the system to monitor their use was not robust. Prescription forms we viewed were pre stamped with the provider's details and medicine to be prescribed. This meant prescriptions could be used to obtain medicines the person had not been prescribed.

The dentist was not aware of current guidance with regards to prescribing medicines.

Are services safe?

Antimicrobial prescribing audits were not carried out. The provider confirmed they were unaware of the recommendation to complete these audits and they had never done so.

Track record on safety, and lessons learned and improvements

The provider's system for reviewing and investigating when things went wrong was not robust or effective. Risk assessments in relation to safety issues were not regularly carried out. The process to record, monitor and review incidents was not effective.

In the previous 12 months one accident had been recorded. We did not see any investigation or learning from this incident had been recorded. The provider was unaware of the need to monitor and record serious incidents or near misses.

The provider did not have a system in place for receiving and acting on national patient safety alerts. The provider was not aware of, did not subscribe to or receive any safety alert notifications which would inform them of new risks from recalled equipment, medicines or procedures.

Are services effective?

(for example, treatment is effective)

Our findings

We found 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 Enforcement Actions 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.

Effective needs assessment, care and treatment

Systems to keep dental professionals up to date with current evidence-based practice were not effective or robust. Clinical assessments of patients' needs, and treatment were not always delivered in line with current legislation, standards and guidance. We noted that records of these assessments were not always recorded in detail in patient records. We advised the provider of the need to keep detailed records.

Staff had access to digital x-rays to enhance the delivery of care.

Helping patients to live healthier lives

Processes in place to provide preventive care and support patients to ensure better oral health, where not always in line with the Delivering Better Oral Health toolkit. The provider did not take part in any local or national oral health campaigns.

Care records we reviewed, and conversations held with the provider, indicated that the dentist did not discuss smoking, alcohol consumption and diet with patients during appointments. We did not see evidence that medical history was updated or recorded at each appointment, and we did not see evidence of advice given to promote and maintain better oral health. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

Records showed patients with severe gum disease were recalled at more frequent intervals for review.

Consent to care and treatment

Records of patients' consent to care, and treatment was not recorded in line with legislation and guidance.

The provider did not demonstrate an understanding of the importance of obtaining and recording patients' consent to treatment. They told us they gained patients' consent verbally. None of the care records we reviewed contained evidence of patients' consent to care and treatment. We did not see evidence that the dentist gave patients information about treatment options and the risks and benefits of these enabling them to make informed decisions.

The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after.

The practice's consent policy was dated 2014 and did not show evidence of update or review. The policy included information about the Mental Capacity Act 2005 and referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances.

Monitoring care and treatment

Dental care records did not always contain detailed information about the patients' current dental needs, past treatment and medical histories.

The provider's quality assurance processes were not robust or effective. They did not encourage learning and continuous improvement. Audits were not carried out at recommended intervals and records were not always available.

Effective staffing

Are services effective?

(for example, treatment is effective)

We noted the provider did not have records confirming staff had completed all training identified as recommended by the General Dental Council. For example, we did not see evidence of completion of training in; fire safety, oral cancer, consent, mental capacity act or equality and diversity.

The provider had experienced a period of high staff turnover which meant they had struggled to establish a settled staff team and implement training and appraisal programmes. We noted that these programmes were not in place or available for the previous, long standing staff members.

Staff new to the practice did not receive a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentist confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide. We noted that the provider did not keep a record of acceptance of these referrals which may have led to patients experiencing delay in accessing treatment.

Are services well-led?

Our findings

We found 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 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 provider aimed to deliver a service in line with health and social priorities across the region, we noted this was not always achieved. It was not always clear that services were planned in a way that enabled the provider to meet the needs of the practice population.

Culture

The provider had a caring culture to provide general dental services to its patient community.

Staff stated they felt respected, supported and valued.

Procedures were not in place to enable to staff to discuss their training and development needs. The provider did not have a schedule of appraisal or supervision for staff.

Records indicated the provider had held one team meeting in 2021.

We saw the provider had systems in place to deal with staff poor performance.

The provider did not demonstrate and awareness of the requirements of the Duty of Candour. We were made aware of a complaint raised to the practice, but did not see a duty of candour policy or record of complaints or compliments received so were unable to assess the providers response to complaints and feedback.

Staff could raise concerns, and said they had confidence that these would be addressed.

Governance and management

The dentist had overall responsibility for the clinical leadership of the practice. The practice manager was responsible for the management and day to day running of the service. Staff knew the management arrangements.

We were not assured that the provider's system for clinical governance was effective. Policies, protocols and procedures were in place but not always readily available, implemented consistently or reviewed regularly.

Clear and effective processes for managing risks, issues and performance were not in place. For example, we noted shortfalls in appropriately assessing and mitigating risks in relation to electrical wiring testing, fire safety management, infection control processes, recruitment, prescribing, record keeping, appraisal, equipment maintenance, incident reporting and audit.

Appropriate and accurate information

The provider's information governance arrangements were not effective. Staff had not received training in the use and application of information governance guidelines.

Engagement with patients, the public, staff and external partners

We were not provided with evidence that staff involved patients, the public, staff and external partners to support the service.

The provider used online reviews to obtain staff and patients' views about the service.

Are services well-led?

Continuous improvement and innovation

The provider did not demonstrate or provide evidence to confirm that they had effective systems and processes for learning, continuous improvement or innovation. Processes for oversight of training, staff development or a schedule for appraisals were not in place.

Audits of radiographs, disability access, infection prevention and control, dental care records and anti-microbial prescribing were not completed within approved timescales.

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 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. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Systems or processes to enable governance and oversight of the service and to assess, monitor and mitigate risks were not operating effectively. • A system to monitor completion of CPD for the principal dentist was not in place, • There were limited systems for monitoring and improving quality. For example, audit activity was not always completed at reccomended intervals and did not result in improvement to the service. • Staff had not received training, to an appropriate level, in the safeguarding of children and vulnerable adults. • Systems to ensure premises and equipment were safe and maintained were not in place. **Regulation 17 (1)(2)**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 and the registered person had not done all that was reasonably practicable to mitigate these risks. In particular:

- Systems to ensure safe care and treatment was provided were not in place.
- Fire risk assessments and safety checks were not carried out. The registered person had not ensured equipment such as fire extinguishers and smoke alarms was properly maintained and regularly tested.
- Vital equipment missing from medical emergency kit including pads for the AED and Oxygen tubing. Staff had not received medical emergency training at appropriate intervals.
- Prescription pads were not stored securely or monitored.
- Decontamination processes did not follow guidance. Recommended cleaning equipment was not used or available and records of cleaning were not kept.
- Procedures to protect staff and patients from the risk and spread of Covid 19 were not adequate. Fallow time between patients was not assessed and recommended personal protective equipment was not used.

Regulation 12(1)(2)