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Waters Green Dental and Implant Clinic

Inspection Report

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Date of inspection visit: 12/02/2020
Date of publication: 05/06/2020

Overall summary

We carried out this announced inspection on 12 February 2020 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 provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

Waters Green Dental and Implant Clinic is near the centre of Macclesfield. The practice provides private dental care for adults and children.

There is level access to the practice for people who use wheelchairs and for people with pushchairs.

Car parking is available near the practice.

Summary of findings

The dental team includes two dentists, a dental hygiene therapist, and three dental nurses. Two locum dental hygienists and a locum dental nurse also work at the practice. The practice has three treatment rooms.

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 to both the dentists and the dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday and Friday 9.00am to 5.00pm

Tuesday 11.00am to 8.00pm

Wednesday 9.00am to 7.00pm

Thursday 9.00am to 8.00pm.

Our key findings were:

- The practice was visibly clean.
- The practice had infection control procedures in place which took account of some of the recognised guidance. The routine testing of the practice's instrument sterilisers did not take account of the guidance.
- The provider had safeguarding procedures in place. Staff knowledge of their responsibilities for safeguarding adults and children was inconsistent.
- Appropriate medical emergency medicines were available. Some of the recommended medical emergency equipment was not available in the practice.
- The provider had staff recruitment procedures in place but was not following them to ensure suitable staff were recruited.
- Staff did not consistently take into account current guidelines when providing patients' care and treatment.
- The dental team provided preventive care and supported patients to achieve better oral health.
- The provider did not ensure staff had completed recommended training, including in medical emergencies, in line with their professional regulator's guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider had a procedure in place for handling complaints. No information was provided to patients about how to make a complaint.
- The practice had a leadership and management structure in place. There was little evidence of clinical or managerial leadership in the practice.
- The provider's systems for identifying and managing risk were ineffective.
- Staff roles and responsibilities were unclear and staff lacked support for their responsibilities.
- The provider had systems to support the management and delivery of the service, to support governance and to guide staff. These were not operating effectively.
- Changes made as a result of previous inspections were not embedded or sustained. There were no mechanisms to help the practice continually improve.
- The provider had limited means for asking patients and staff for feedback about the service.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- 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 as is necessary to enable them to carry out their duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

Summary of findings

- Ensure specified information is available regarding each person employed.

Full details of the regulations the provider is not meeting are at the end of this report.

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

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This means we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

There were areas where the provider could make improvements. They should:

- Improve the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.
- Improve and develop staff awareness of the requirements of the Mental Capacity Act 2005 and Gillick competence and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Take action to ensure all clinicians are aware and take account of current relevant nationally recognised evidence-based guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Enforcement action** 
Are services effective?	**No action** 
Are services caring?	**No action** 
Are services responsive to people's needs?	**No action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

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

We will report further when any enforcement action is concluded.

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

The practice had safeguarding policies and procedures in place. We found staff had limited knowledge and understanding of their responsibilities should they have concerns about the safety of children, young people or adults who were at risk due to their circumstances. The provider could not demonstrate whether six of the staff had received safeguarding training within the currently recommended time period. After the inspection the provider told us that all clinical staff had completed the recommended safeguarding training and would complete training for an annual review of competencies in safeguarding. The provider did not send us evidence to confirm this.

We found the provider did not have means to identify vulnerable adults or children to alert staff should safeguarding concerns arise. After the inspection the provider told us they were implementing the recommended system to alert staff to children in vulnerable circumstances. The provider did not send us evidence to confirm this.

We saw that the qualified clinical staff were registered with the General Dental Council and had professional indemnity in place to ensure means for redress were available for patients should the need arise.

We reviewed the provider's arrangements to ensure standards of cleanliness and hygiene were maintained in the practice.

The practice had an infection prevention and control policy and associated procedures in place to guide staff. The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments in accordance with the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), guidance published by the Department of Health.

The practice's records showed equipment used by staff for cleaning and sterilising instruments had not been validated and maintained in accordance with HTM 01-05 guidance. The provider arranged for servicing and testing to be carried out on this equipment the following day and sent CQC copies of the test certificates to confirm this had been done.

We were not provided with evidence as to when or whether the recommended disinfection and decontamination had been completed for seven of the staff.

The provider had had a Legionella risk assessment carried out at the practice in accordance with current guidance. We saw evidence of measures taken by the provider to reduce the possibility of Legionella or other bacteria developing in the water systems, for example, water temperature testing and the management of dental unit water lines.

Staff ensured clinical waste was segregated and stored securely in accordance with guidance.

The practice was visibly clean when we inspected.

Staff carried out infection prevention and control audits sporadically. We saw one had been completed in August 2017 then no further auditing until June 2019. Current guidance recommends these audits to be carried out six-monthly. We found that some information recorded in the audits contradicted the processes which were actually taking place in the practice.

We reviewed the procedures the dentists followed when providing root canal treatment and found these were in accordance with recognised guidance.

The provider had staff recruitment procedures in place to help the practice employ suitable staff. These reflected the relevant legislation.

We looked at four staff recruitment records. These showed the provider did not follow their recruitment procedure. We saw the provider did not have evidence, including of the required documentation, to demonstrate that they had carried out all the relevant pre-employment checks for these staff.

- The provider had not carried out Disclosure and Barring Service, (DBS), checks for two of these staff prior to them commencing work at the practice. We saw the provider had relied on a DBS check carried out by a previous employer for a further member of staff. This check was

not within the current recommended time period for which previous DBS checks can be accepted by new employers. After the inspection the provider told us they would arrange for a new DBS check to be carried out. The provider did not send us evidence to confirm this. The provider had not considered the risks inherent in allowing these staff to start work without DBS checks.

- The provider had not obtained references for three of these staff prior to them commencing work at the practice. After the inspection the provider told us they had requested references for one of these staff. The provider did not send us evidence to confirm this.
- The provider had not carried out identification checks for one of these staff, or employment history checks for two of these staff. After the inspection the provider told us that an identity check had been carried out for this member of staff. The provider did not send us evidence to confirm this.

We reviewed the provider's arrangements for ensuring that the practice's facilities and equipment were safe. We saw that equipment, including the practice's instrument sterilisers and air compressor, had not been maintained at the appropriate recommended time intervals. The provider arranged for this testing to be carried out the following day and sent CQC copies of the test certificates to confirm this had been done.

The provider had carried out a fire risk assessment in line with the legal requirements. We saw they had not reviewed the fire risk assessment following the addition of a new treatment room in November 2018 to identify whether additional risks were associated with this.

We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear. Records showed that firefighting equipment, such as fire extinguishers, was regularly serviced.

We saw that not all risks relating to fire safety had been reduced sufficiently, for example, we saw that cardboard boxes had been stored in the boiler room, and the fire exit was not adequately signposted. After the inspection the provider told us they had removed the boxes from the boiler room, displayed further fire exit signs and provided fire evacuation training for all staff. The provider did not send us evidence to confirm this.

The provider could not confirm whether a fixed electrical installation inspection had been carried out at the practice. After the inspection the provider told us a fixed electrical inspection had been carried out. The provider did not send us evidence to confirm this.

The provider had arrangements in place at the practice for carrying out X-ray procedures and had most of the required radiation protection information available.

We found the provider had not registered the use of X-ray equipment on the premises with the Health and Safety Executive. The provider acted on this after the inspection and sent us evidence to confirm this.

We saw that routine testing had been carried out on the X-ray machines. One of the X-ray machines was due for the next routine test four days after the inspection. The provider sent us evidence after the inspection to confirm this testing had been carried out.

We saw that the dentists justified, graded, and reported on the X-rays they took.

Where appropriate, clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The practice had an overarching health and safety policy in place, underpinned by some specific policies and risk assessments to help manage potential risk.

The provider had current employer's liability insurance.

We found that the provider had taken insufficient action in some areas to assess and prevent the spread of infection.

- We observed that only the clinicians were permitted to dismantle and dispose of used needles and other sharp items in order to minimise the risk of inoculation injuries to staff. The dentists re-sheathed needles after use however no protective devices were available to help prevent injuries to the clinicians when doing this. After the inspection the provider told us that needle re-sheathing devices were now available. The provider did not send us evidence to confirm this.

Staff were aware of the importance of reporting inoculation injuries. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a 'sharps' injury.

Are services safe?

- We found that the provider had not checked whether two staff had received the Hepatitis B vaccination, and had not checked the result of the vaccination in another member of staff. The provider had not assessed the risks associated with these staff working in a clinical environment. After the inspection the provider told us they had Hepatitis B antibody levels for all staff. The provider did not send us evidence to confirm this.
- We found the clinical staff did not have sufficient awareness of the recognition, diagnosis and early management of sepsis. After the inspection the provider told us staff had received training in sepsis in October 2019 but did not send us evidence to confirm this.

The practice had the medical emergency equipment and medicines available as recommended in recognised guidance, with the exception of three sizes of airway.

The provider told us staff carried out, and kept records of, checks to make sure the recommended medicines and equipment were available, within their expiry dates and in working order. We found the checks had not identified that the practice's child-sized pads for the automated external defibrillator, (AED), were past their March 2018 expiry date, the two sizes of airway were past their 2017 expiry date, and one of the medicines used in anaphylaxis was past it's expiry date of November 2019.

After the inspection the provider told us they had the five recommended sizes of airway, that the child-sized pads for the AED had been replaced and that the medicine used in anaphylaxis had been replaced. The provider did not send us evidence to confirm this.

We observed that staff checked the practice's AED annually and the other items of medical emergency equipment monthly instead of weekly as currently recommended.

After the inspection the provider told us they check the AED weekly but did not send us evidence to confirm this.

We saw that staff training in medical emergencies was not updated annually, which is the recommended time frequency. Four staff had last completed the training in November 2018 and a further member of staff in June 2017. The provider did not know when or whether three further members of staff had completed this training.

A dental nurse worked with each of the clinicians when they treated patients.

The provider told us that staff new to the practice, including locum staff, completed a period of induction. The provider could not demonstrate that new staff or locum staff had received an induction to ensure that they were familiar with the practice's procedures, including fire safety procedures, infection prevention and control protocols and equipment operating procedures. After the inspection the provider told us that all of these topics would be part of the induction for new staff and temporary staff. The provider did not send us evidence to confirm this.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentists how information to deliver safe care and treatment was handled and recorded. We observed that where patients were referred to other healthcare providers staff drafted the referrals. These were not then consistently checked for accuracy by the dentists.

Safe and appropriate use of medicines

The practice had systems for prescribing and storing medicines.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety and lessons learned and improvements

The practice had procedures in place for reporting, investigating, responding to and learning from accidents, incidents and significant events. Staff knew about these and understood their role in the process. We saw one significant event had been reported and investigated.

The provider had a system for receiving and acting on safety alerts, for example, from the Medicines and Healthcare products Regulatory Agency. We saw that relevant alerts were shared with staff, acted on and stored for future reference.

Staff reviewed Coronavirus advisory information and updates.

The practice had a whistleblowing policy in place to guide staff should they wish to raise concerns. The policy included details of external organisations staff could raise concerns with.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We looked at several dental care records with the clinicians. We found inconsistency between clinicians in their assessment of patients' care and treatment needs and in the level of detail recorded in patients' dental care records. We saw that not all the clinicians took into account current legislation, standards and guidance when delivering care and treatment, for example, the record-keeping guidance from the Faculty of General Dental Practitioners (UK) had not been followed by all clinicians.

The practice provided dental implants. These were placed by the principal dentist who had completed relevant post-graduate training.

Helping patients to live healthier lives

The practice supported patients to achieve better oral health in accordance with the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. The dentists told us they prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them. The clinicians discussed smoking, alcohol consumption and provided dietary advice to patients during appointments.

Consent to care and treatment

The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions.

The practice's consent policy included information about the Mental Capacity Act 2005. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves in certain circumstances. We found staff knowledge of consent was insufficient.

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

Monitoring care and treatment

The provider had limited means in place for monitoring treatment outcomes to assess the quality of care and treatment provided at the practice.

Effective staffing

Staff had the experience to carry out their roles. We found their skills and knowledge were not updated in accordance with current recognised guidelines.

The provider offered limited training opportunities to assist staff in updating their skills and knowledge, including meeting the medical emergencies and safeguarding continuing professional development, (CPD), requirements of their professional registration with the General Dental Council.

The provider told us a staff appraisal system was in place. We saw documented records of one appraisal; no evidence was provided to confirm that any other appraisals had been carried out.

Co-ordinating care and treatment

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

The dentists confirmed they referred patients to specialists in primary and secondary care where necessary or where a patient chose treatment options the practice did not provide. This included referring patients with suspected oral cancer under current guidelines to help make sure patients were seen quickly by a specialist.

Staff tracked the progress of all referrals to ensure they were dealt with promptly.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

We saw that staff treated patients appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Privacy and dignity

The practice team respected and promoted patients' privacy and dignity.

The layout of the reception and waiting areas provided limited privacy when reception staff were attending to patients but staff were aware of the importance of privacy and confidentiality. Staff described how they avoided discussing confidential information in front of other patients. Staff told us that if a patient requested further privacy they would respond appropriately. The reception computer screens were not visible to patients and staff did not leave patient information where people might see it.

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

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care.

They were aware of the requirements of the Equality Act. We saw that

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Interpreter services were available for patients whose first language was not English.

The dentists described to us the conversations they had with patients to help them understand their treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to take account of patients' needs and preferences.

A variety of dental services, including general dentistry, orthodontics, and dental implants was provided at the practice.

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

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service. No cards had been completed.

The entire practice was at ground floor level and accessible for wheelchairs.

Staff had access to interpreter and translation services for people who required them. The practice had arrangements in place to assist patients who had hearing impairment, for example, appointments could be arranged by email or text message.

Larger print forms were available on request, for example, patient medical history forms.

Timely access to services

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

The practice displayed its opening hours on the premises, and included this information on their website.

The practice's appointment system took account of patients' needs. Patients who required an urgent appointment were offered an appointment the same day. We saw that the clinicians tailored appointment lengths to patients' individual needs. Patients could choose from morning, afternoon and evening appointments. Staff made every effort to keep waiting times and cancellations to a minimum.

The practice had appointments available for dental emergencies and staff made every effort to see patients experiencing pain or dental emergencies on the same day.

The practice had emergency on-call arrangements for when the practice was closed.

Listening to and learning from concerns and complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. We saw it had last been reviewed in 2017.

The provider was responsible for dealing with complaints. Staff told us they would tell the provider about any formal or informal comments or concerns straight away so patients received a quick response.

Information on how to make a complaint was not displayed for patients, and no information was available about organisations patients could contact if they were not satisfied with the way the practice dealt with their concerns or should they not wish to approach the practice directly. After the inspection the provider told us they had displayed their complaints policy in the waiting room. The provider did not send us evidence to confirm this.

The provider told us no complaints had been received since 2015.

Are services well-led?

Our findings

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

We will report further when any enforcement action is concluded.

Leadership capacity and capability

We found the provider did not have the skills, knowledge, capability and experience to lead effectively and deliver sustainable care. There was little demonstration or evidence of clinical or managerial leadership in the practice.

The provider had limited knowledge of nationally recognised guidance and legislation, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, guidance from the General Dental Council, the Resuscitation Council (UK), and the Faculty of General Dental Practice (UK). After the inspection the provider told us they had updated their knowledge in these areas. The provider did not send us evidence to confirm this.

Vision and strategy

The provider had a strategy for delivering care and supporting business plans to achieve priorities.

The provider's strategy included the implementation of a dental team approach to deliver care and treatment at the practice. They did this by using a skill mix of dental care professionals, including a dentist with advanced skills, a dental hygiene therapist and dental nurses to deliver care for patients.

The practice planned its services to meet the needs of the practice population.

Culture

We saw that staff were not actively engaged or empowered by the provider to make decisions.

Staff did not have clear objectives to follow. We found staff were unclear what was expected of them. We observed there were some barriers to open communication between the provider and staff.

Staff development was managed inconsistently. No evidence was provided to demonstrate that all staff had been appraised or to demonstrate that clinicians had participated in peer review.

Staff were aware of the Duty of Candour requirements to be open, honest and to offer an apology to patients should anything go wrong.

Governance and management

The provider had systems in place at the practice to support the management and delivery of the service. Systems included policies, procedures and risk assessments to support governance and to guide staff. We observed some policies and procedures had not been reviewed since 2017.

We found that several of these systems for monitoring the quality and safety of the service were operating ineffectively, including: -

- The system for checking the medical emergency equipment and medicines. We identified several failings in this, including some of the equipment was not being checked within the recommended time, and checks had not identified that one of the medical emergency medicines was not in the recommended format until two days before the inspection.
- The system for monitoring staff training. The provider could not identify when or whether staff had completed their professional regulator's recommended continuing professional development training, including in medical emergencies, and other recommended training. The provider had limited means for identifying staff training needs. Their training policy indicated that training needs would be identified at staff appraisals and practice meetings, however no staff meetings were held. No evidence was provided to confirm that appraisals were carried out for all staff. We found safeguarding, consent and sepsis had not been identified as staff training needs. We found there was limited support for staff with additional responsibilities, for example, responsibility for compliance. After the inspection the provider informed us they had introduced a staff appraisal system to identify training needs and support. The provider said they had also

Are services well-led?

introduced logs of continuing professional development to ensure staff were up-to-date with their professional regulator's recommended training. The provider did not send us evidence to confirm this.

- The provider maintained a schedule of when the maintenance and testing of items of equipment were due. We found that the recorded dates in the schedule did not match with currently recommended time periods for maintenance and testing to be carried out, including for one of the X-ray units, the instrument sterilisers and the air compressor.
- The provider did not have an effective safeguarding system, for example, there were no protocols to guide staff in acting appropriately when children were not brought to appointments. after the inspection the provider told us they had introduced a protocol. The provider did not send us evidence to confirm this.
- The provider had an ineffective system to communicate information and share learning with staff. No practice meetings were held. After the inspection the provider told us they did hold practice meetings but details were not always recorded. The provider told us monthly staff meetings were planned and minutes would be recorded.

We found the provider had ineffective systems to manage and monitor risk. The provider did not proactively identify risk, relying instead on external organisations, including CQC, to identify risks, before taking action to reduce the risk.

Where risks were identified, measures were not taken to reduce or remove the risks quickly. We found the provider had insufficiently assessed and acted on risks associated with staff recruitment, sepsis, staff induction, fire safety and staff Hepatitis B immunity.

The provider had overall responsibility for the management and day-to-day running of the practice. Some staff had additional responsibilities, for example, in relation to compliance and infection control, however we found staff responsibilities, roles and systems of accountability were unclear and staff lacked support in their roles. We observed there was a lack of clarity about authority to make decisions.

The practice had a business continuity plan describing how the practice would manage events which could disrupt the normal running of the practice.

Appropriate and accurate information

We found the provider did not seek and act on quality and operational information, for example, reviews by external organisations and patients' views, to improve performance.

The practice had 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 had a limited approach to obtaining the views of patients, staff and external partners to support high-quality sustainable services.

The provider did not encourage patients to provide feedback. We saw the practice had a 'comments box' available in reception. Staff told us this was rarely used. After the inspection the provider told us they actively encourage people to complete the comments forms. The provider did not send us evidence to confirm this.

We observed that information for patients on how to complain to the service or to other external organisations who could help them was not made available for patients. No records were kept of verbal complaints from people using the service. No CQC comment cards had been completed.

After the inspection the provider told us they had a system for managing verbal complaints. The provider did not send us evidence to confirm this.

The provider told us feedback was obtained from staff through informal discussions. We saw no evidence to confirm that staff suggestions for improvements to the service were acted on. After the inspection the provider told us they introduced an anonymous staff feedback form last year. The provider did not send us evidence to confirm this.

Continuous improvement and innovation

The provider had ineffective systems and processes to encourage learning and continuous improvement. Where improvements had been made to the service the impact on the sustainability of the service was not fully understood or monitored.

We found the provider had a limited understanding of ways to encourage improvement in the service, such as auditing.

Are services well-led?

Infection prevention and control audits were not carried out at the recommended time interval. The provider did not carry out any other audits to identify where improvements could be made in the practice. We identified some concerns with one clinician's dental record-keeping. As the provider had not carried out record-keeping audits this had not been highlighted. After the inspection the provider told us they planned to carry out infection control and radiography audits every six months, record-keeping, disability access and waiting times audits every 12 months and waste audits two-yearly. The provider did not send us any evidence to confirm this.

Sources of potential learning such as complaints, incidents, audits and feedback were not used to encourage improvement.

Changes made as a result of previous inspections were not embedded or sustained. At our previous comprehensive inspection in January 2017, we found

- The provider did not carry out audits to identify areas for improvement.
- The provider did not monitor staff training to identify whether staff were meeting their professional regulator's continuing professional development recommendations.
- The provider was not managing risk effectively. We saw that actions in the fire risk assessment had not been addressed and no assessment had been made as to the risks to staff working in a clinical environment where their immunity to the Hepatitis B virus was unknown.
- The provider was not carrying out pre-employment checks consistently.
- The provider did not actively seek the views of patients about the service to identify areas for improvement.
- The provider did not have an effective complaints system.
- The provider did not have effective systems for staff communication.

At our follow-up inspection in November 2017 we found the provider had improved these areas but at our comprehensive inspection in February 2020 we found these improvements had not been sustained.