

Mr. John Russell

Haughton Green Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 19 November 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 this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Haughton Green Dental Practice is based in Denton, Manchester, Greater Manchester and provides NHS care and treatment for adults and children.

The practice is not suitable for those patients who use wheelchairs due to the dental treatment rooms being located on the first floor, which is accessed via a staircase. The practice is accessible at ground floor level for those with pushchairs. Car parking spaces are available at the rear of the practice.

Summary of findings

The dental team includes three dentists, four dental nurses, two of whom are trainees, one dental hygiene therapist and a practice receptionist. The practice is supported by a practice manager and has two 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.

On the day of inspection, we collected 36 CQC comment cards filled in by patients. All views expressed were positive.

During the inspection we spoke with the principal dentist, two dental nurses, the dental hygiene therapist 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 and Thursday from 9am to 5pm; Tuesday and Wednesday from 8.30am to 4pm, and on Friday from 8.30am to 4pm.

Our key findings were:

- The practice appeared to be visibly clean and well-maintained.
- The provider had some infection control procedures which reflected published guidance. Guidance in relation to the processing of dental instruments was not always adhered to.
- Staff knew how to deal with emergencies.
- Not all appropriate life-saving equipment was available as described in recognised guidance.
- The provider had systems to help them manage risk to patients and staff. Some of these required review and advice from suitably qualified persons.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures which reflected current legislation.

- Some care and treatment provided to patients was not in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health. We found some care and treatment provided was not in line with recognised guidance.
- The appointment system took account of patients' needs.
- Clinical leadership was present and recognisable. More use of audit and peer review was required to support a culture of continuous improvement.
- Staff felt involved and supported and worked as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with any complaints positively and efficiently.
- The provider had information governance arrangements.

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

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

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

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

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

Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of dental dam for root canal treatment.

Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

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 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)

Staff had systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures in place. These did not fully reflect guidance 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.

From training records, we could see staff completed infection prevention and control training and received updates as required. However, our review of working practices demonstrated that guidance to support the safe management of the decontamination process and storage of dental instruments, was not always followed.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments. This was not fully in line with HTM 01-05. We found large numbers of dental instruments loose in the drawers in the dental treatment rooms. There was no system in place that could

confirm how long the instruments had been there. We advised the practice that processing instruments and distributing for use in this way does not comply with guidance provided in HT01-05.

We also observed that staff did not allow dental instruments to dry following removal from the autoclave. They were placed into plastic boxes for transfer to the dental treatment room, straight from the autoclave. As a result, the boxes contained condensation and the instruments were damp.

Records we reviewed showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

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.

We saw staff had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. The practice did not have a Legionella risk assessment, carried out by a suitably qualified person. Records of water temperature testing and dental unit water line management were maintained. However, water temperature testing was only being carried out six-monthly.

We saw effective cleaning schedules to ensure the practice was kept clean. When we inspected we saw the practice was visibly clean.

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

The infection control lead carried out infection prevention and control audits. These did not follow a recognised standard. The audit in place was basic and did not cover all areas of the practice. The audit that had been carried out had not identified any of the issues we raised regarding re-processing of dental instruments and the handling and storage of these post decontamination process.

The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. Staff felt confident they could raise concerns without fear of recrimination.

Are services safe?

One of the dentists used a dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed. The principal dentist confirmed they did not routinely use a dental dam but did use other methods to protect the patient airway. They did not record this in patient dental records.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at three staff recruitment records. These showed the provider followed their recruitment procedure.

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

Staff ensured facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical appliances and the fixed electrical wiring for the premises. There was no gas safety certificate for the premises. The provider acted immediately, and engineer was booked to service the boiler for the premises.

A fire risk assessment had been carried out. We saw there were fire extinguishers and fire detection systems throughout the building and fire exits were kept clear.

The practice had arrangements to ensure the safety of the X-ray equipment. Servicing documents were available for each X-ray set. Paperwork to confirm critical acceptance testing for the X-ray sets at the practice was sent to us in the days following the inspection.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The grading of the X-ray images varied in accuracy. We found inconsistencies with grading and reports on X-ray images. The lack of effective radiograph audit, across the dentists at the practice, showed this issue had not been addressed.

Clinical staff completed continuing professional development in respect of dental radiography. Although the required number of hours of continuing professional

development in respect of radiography had been completed for all dentists, evidence from inspection suggested further instruction on the correct grading and reporting on X-ray images was required.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety.

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 and was updated annually.

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.

Staff had completed sepsis awareness training. However, the awareness training did not cover the receptionist who managed the booking of patient appointments. This could affect how staff made triage appointments effectively to manage patients who present with dental infection. The provider was responsive to this observation and acted immediately to arrange overview of sepsis training for the receptionist.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were not available as described in recognised guidance. Items not present on the inspection day were: child oxygen masks and self-inflating bag, and adult clear oxygen face masks and reservoir. We found staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order. This process was not effective as the list being used to conduct these checks was not from recognised guidance, for example, Resuscitation Council UK guidance.

Are services safe?

A dental nurse worked with the dentists and the dental hygiene therapists when they treated patients in line with General Dental Council Standards for the Dental Team. All dental clinicians worked with chairside support.

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

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings. We observed the patient dental records for one of the dentists was of a very high standard. Other records we reviewed were not in line with Royal College of Dental Practitioner and General Dental Council guidelines and requirements.

Records were legible, were kept securely and complied with General Data Protection Regulation requirements.

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 had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

Antimicrobial prescribing audits were not carried out. Review of records provided mixed results, which indicated insufficient familiarity with current antimicrobial prescribing guidance.

Track record on safety, and lessons learned and improvements

The provider had a system for reviewing and investigating when things went wrong. When we reviewed some examples, we found that the incidents were initially managed and responded to well. However, follow-up action to prevent such incidents happening again, was not in place.

There were risk assessments in relation to safety issues. Staff monitored and reviewed incidents, for example, accidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements in the working environment, for example, in response to any trips, falls or sharps injuries.

Where there had been a safety incident we saw this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again.

The provider had a system for receiving and acting on safety alerts. When we reviewed this, we found the system in place meant alerts were not automatically shared with all staff, including dental nurses and the dental hygiene therapist. Also, evidence collected at this inspection indicated that updates to treatment guidelines, for example, from the National Institute of Health and Care Excellence (NICE) were not routinely received and shared amongst clinicians, nurses and the dental hygiene therapist. Records of these alerts with confirmation that all staff had received and seen these, were not kept by the practice.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice did not have effective systems to keep dental professionals up to date with current evidence-based practice. We saw two of the three clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. For one of the dentists, we saw that treatments delivered did not align with current standards and guidance provided by clinical pathways and protocols. We also saw that lack of documented explanation of treatment required, meant some patients had presented again following treatment, when this could have been avoided.

Helping patients to live healthier lives

We saw evidence that the practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. However, some of the information and records we reviewed of one of the dentists, indicated that preventative work could have been improved through more clear diagnosis and presentation of correct treatment pathways to patients.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists and dental hygiene therapist, where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

The principal dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and

recording detailed charts of the patient's gum condition. Patient dental records of one of the dentists that we reviewed, lacked this depth of information and evidence of preventative advice discussed with patients.

The practice was selected to take part in the government's Dental Prototype Agreement Scheme to trial a new NHS dental contract which aims to offer a new way of providing dental care with an increased focus on disease prevention.

As part of this the practice carried out detailed oral health assessments which identified patient's individual risks. Patients were provided with detailed self-care treatment plans which included dates for ongoing oral health reviews based upon their individual need and in line with recognised guidance. In some cases, we found that even though a template was in use to prompt the dentist to comment in each area, providing diagnosis and ongoing treatment plans and options, these were not always followed. In some cases, information was missing from this template, or lacked sufficient detail.

Consent to care and treatment

Staff could not always demonstrate that they 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. Staff did not display a full understanding of the need to obtain proof of Power of Attorney for patients who lacked capacity. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We did not always see this documented in patients' records.

Feedback we received from patients in CQC comment cards, confirmed their dentist listened to them.

The practice's consent policy included information about the Mental Capacity Act 2005. The dentist we spoke with said they understood their responsibilities under the act when treating adults who might not be able to make informed decisions but could not explain these to us. The consent policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age. Staff we spoke with displayed a good understanding of Gillick competence.

Are services effective?

(for example, treatment is effective)

Staff described how they involved patients' relatives or carers when appropriate to do so.

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 dentists assessed patients' treatment needs. In some examples we reviewed, this was not always in line with recognised guidance.

The provider had processes to encourage learning and continuous improvement. We found that greater use of audit could assist this process. For example, in antibiotic prescribing audit and patient dental care record audit.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. In some examples we inspected, there was a lack of reflective exercises to ensure learning had been effective.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. We saw good examples of the practice working with school nurses, to ensure that children attended dental appointments.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services caring?

Our findings

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

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 approachable, caring and professional. We saw staff treated patients respectfully and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding.

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

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, the practice would respond appropriately. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

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

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care. They were aware of the Accessible Information Standard and the requirements of the Equality Act.

The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given. We saw:

- Interpreter services were available for patients who did not speak or understand English. Patients were also told about multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way they could understand, and communication aids and easy-read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information leaflet provided patients with information about the range of treatments available at the practice.

The principal dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, study models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found 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 meet patients' needs. It took account of patient needs and preferences.

Staff were clear about the importance of emotional support needed by patients when delivering care. They conveyed a good understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

The practice worked hard to meet the needs of people with drug and/or alcohol dependence. Where for example, the principal dentist knew patients would not attend a referral to secondary care for some oral health procedures, they tried where possible, to carry these out at the practice. This work was above and beyond what the practice was contracted to provide.

Patients described very high levels of satisfaction with the responsive service provided by the practice.

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.

36 cards were completed, giving a patient response rate of 72%

36 cards, or 100% of views expressed by patients were positive.

Common themes within the positive feedback were continuity of care, the reassurance provided by practice dentists and staff, and the ease of access to appointments. Patients also commented that they would be seen on the day if in pain.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. For example, those patients who found it

unsettling to wait in the waiting room before an appointment. The team kept this in mind to make sure the dentist could see them as soon as possible after they arrived.

Staff telephoned some patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

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

The practice displayed its opening hours in the premises and included it in their information leaflet and in their telephone answer machine message.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice's information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

Staff told us the provider took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The provider had a policy providing guidance to staff about how to handle a complaint. The practice information leaflet explained how to make a complaint, and instructions on how to make a complaint were displayed in the reception and waiting area.

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

The principal dentist aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the principal dentist had dealt with their concerns.

Are services responsive to people's needs?

(for example, to feedback?)

We looked at comments and compliments practice received in the past 12 months. No complaints had been received by the practice in this time period.

The practice described how they would respond to concerns and discuss outcomes with staff to share learning and improve the service, wherever possible.

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 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.

At the time of inspection, the provider was not registered for all three regulated activities, as required for general dental practice. We brought this to the attention of the provider confirming they should update their registration immediately to show registration for surgical procedures, alongside their current registration which shows the regulated activities of treatment of disease, disorder and injury and diagnostic and screening procedures.

Leadership capacity and capability

Leaders were knowledgeable about issues and priorities relating to the quality and future of the service. They understood the challenges and were addressing them. Clinical leadership required improvement. The provider had effective processes to develop leadership capacity for the future, but issues that had been present for some time had not been fully addressed. As a result, some instances of dental care and treatment did not fully meet patients' needs, and dental record keeping in respect of some clinicians was below the standards expected by guidelines.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

Staff discussed their training needs at an annual appraisal and one to one meetings. They also discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

The staff focused on the needs of patients. Patients provided feedback that supported this.

We saw the provider had systems in place to deal with staff poor performance. In instances of poor care or practice that came to the attention of the principal dentist, this was addressed. However, the lack of consistent and ongoing peer review of dental work, and audit of dental care records against recognised standards, meant correct diagnoses for

patients was not always delivered. We found of radiograph images were not consistently graded; basic periodontal examinations were not scored and recorded consistently. Increased management and oversight could have assisted in identifying this.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, in instances where patients had presented in emergency appointments due to toothache or discomfort, and any treatment previously provided had failed to address a recognised problem, the provider explained this to the patient concerned. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour. However, effective steps to prevent this re-occurring had not been put in place.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Staff had clear responsibilities, roles and systems of accountability to support good governance and management.

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

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. Some of this required greater oversight, for example, in the management of processing of dental instruments, the oversight of management of Legionella risk, and gas safety.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

Quality and operational information, for example NHS BSA performance information and surveys. Was used to ensure and improve performance. Performance information was combined with the views of patients.

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

Are services well-led?

Engagement with patients, the public, staff and external partners

Staff involved patients and staff to support the service. The provider used patient surveys and verbal comments to obtain patients' views about the service. We saw examples of suggestions from patients the practice had acted on. For example, easy rise chairs had been provided for those patients who found it more difficult to rise from sitting.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and they said these were listened to and acted on.

Continuous improvement and innovation

The provider had systems and processes for learning and improvement and was also a member of a good practice certification scheme.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection

prevention and control. This required greater oversight; in relation to audit of dental care records and radiographs, these were not audited against recognised standards and guidelines. For example, we saw radiograph audit where grading of images was inconsistent with treatment offered. This meant audits were ineffective as they did not highlight the improvements required.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. However, greater oversight of training could have identified that the required reflective learning associated with some professional development activity, had not been completed, meaning there was some question over the validation of this professional development activity.

Staff completed 'highly recommended' training as per General Dental Council professional standards. The provider supported and encouraged staff to complete continuing professional development.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered persons 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: • Recognised guidance for the processing of dental instruments, for example, in HTM01-05 was not routinely followed by staff. • Not all recommended emergency equipment was available, as referred to in recognised guidance. • The Legionella risk assessment in place for the practice, had not been carried out by a competent, suitably qualified person. • There was no gas safety certificate for the premises. • Oversight of infection prevention and control required improvement. A full infection control audit had not been conducted for the practice or repeated at six monthly intervals. The audit in place did not identify the issues we raised regarding re-processing of dental instruments and the handling and storage of these. • Staff managing the booking of patient appointments had not received any sepsis awareness training. Regulation 12(1)
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Requirement notices

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:

- The provider had not provided a comprehensive Legionella risk assessment for staff to act on, that was completed by a competent person.
- There was no system in place to remind the practice to carry out servicing of the gas boiler, to enable the production of a gas safety certificate for the premises.
- Infection control audit was ineffective in that it had not identified the issues we found at this inspection, for example, in relation to the processing of dental instruments.
- There was no system in place to provide oversight of staff training, and validation of this.
- Systems in place to ensure all staff received, reviewed and understood patient safety alerts and updates on treatment guidance, from MHRA and NICE were ineffective.
- There was a lack of effective audit of radiographs,
- The provider was not correctly registered with CQC for providing surgical procedures.

Regulation 17(1)