

Dr. Damian Allen

D B Allen - Rawtenstall

Inspection Report

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Overall summary

We carried out this announced inspection on 23 April 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 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

D B Allen Rawtenstall is in Rossendale, Lancashire and provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs. There is no car parking immediately outside the surgery. A long stay car park is located approximately two minutes' walk from the practice.

Summary of findings

The dental team includes 2 dentists, two dental nurses, two dental hygienists, and one receptionist. The practice has three treatment rooms, two at ground floor level and one at first floor level.

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 26 CQC comment cards filled in by patients. All feedback provided was positive.

During the inspection we spoke with two dentists, one 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 on Monday and Thursday from 8.30am to 5.45pm; on Tuesday from 8.30am to 7pm; on Wednesday from 8.30am to 1pm; and on Friday from 8.30am to 5pm. The practice closes each day for lunch between 1pm and 2pm.

Our key findings were:

- The practice appeared clean and tidy. Clinical areas appeared to be well maintained.
- The provider had infection control procedures in place; these did not fully reflect published guidance. Our observations of staff showed that these were not routinely followed by all.
- Staff knew how to deal with emergencies.
- All appropriate medicines and life-saving equipment was not available, as described in recognised guidance.
- The practice's systems to help them manage risk to patients and staff required review.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- Staff recruitment procedures in place did not reflect recognised guidance and legislation.

- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership was present but required improvement.
- Staff felt involved and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- Information governance arrangements required improvement.

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:

- Review the practice's systems for assessing, monitoring and mitigating the various risks arising from the undertaking of the regulated activities. In particular, a risk assessment should be conducted in respect of the dental hygienist who routinely works without dental nurse support.
- Introduce protocols regarding the prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice. This should include annual audit to ensure adherence to protocol.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low. We will be following up on our concerns to ensure they have been put right by the provider.

The practice had systems and processes to provide safe care and treatment; not all of these were routinely followed by all staff. The practice learned from any incidents and complaints to help them improve.

Staff received training in safeguarding people and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles in the practice. Recruitment checks were completed for permanent staff but records of these were not complete. In respect of agency and locum staff, assurance that recruitment checks had been completed had not been obtained, before locum staff began working at the practice.

The clinical areas of the premises were clean and maintained. Other areas of the practice required attention to maintenance; there was no suitable fire risk assessment in place. Actions required by the Legionella risk assessment had not been addressed. Water temperature testing was not in place.

Where there was identifiable risk, the provider had not sought to mitigate this by use of risk assessments. For example, in the case of dental hygienists who routinely worked alone. The sharps risk assessment had not been adapted to take into account the needs of individual staff members.

Equipment within the practice was clean and properly maintained.

The practice was not following national guidance for cleaning, sterilising and storing dental instruments.

The practice had suitable arrangements for dealing with medical and other emergencies. Some items of emergency equipment were missing, for example oropharyngeal airways in all sizes, and adult and child oxygen masks.

Requirements notice



Are services effective?

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

No action



Summary of findings

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as excellent, efficient and professional. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The provider supported staff to complete training relevant to their roles and had systems to help them monitor this.

Are services caring?

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

We received feedback about the practice from 26 people. Patients were positive about all aspects of the service the practice provided. They told us staff were helpful, kind and courteous.

They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

No action



Are services responsive to people's needs?

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

The practice's appointment system took account of patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for patients with a disability and families with children. The practice had access to telephone interpreter services and had arrangements to help patients with hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

No action



Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

The practice had arrangements to ensure the smooth running of the service. There was a clearly defined management structure. Staff felt appreciated and were happy in their work.

Requirements notice



Summary of findings

Management of the building and some areas of governance required improvement. There was no clearly defined way of receiving alerts and updates into the practice, for example, from the Medicines and Healthcare Products Regulatory Agency (MHRA), or updates to National Institute of Health and Care Excellence (NICE). These were not routinely shared amongst staff at practice meetings.

Although infection control audits were in place, these were not fully effective as they did not highlight the issues we had found during our inspection.

The understanding and management of risk assessments overall, required improvement.

The practice team kept complete patient dental care records which were clearly written and typed and stored securely.

There was some monitoring of clinical and non-clinical areas of work to help the practice improve and learn. This could be further developed and improved to provide a focus on continuous improvement.

Are services safe?

Our findings

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

The practice had several systems in place 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 practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff 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 practice had a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

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

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record and a risk assessment completed.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The practice had a recruitment policy and procedure to help them employ suitable staff. We looked at two staff recruitment records. These showed the practice did not consistently follow their recruitment procedure. For one of the staff files, there was no record of references in place, or that verbal references had been sought; there was no evidence of immunity to Hepatitis B, or an associated risk assessment. In the case of another staff member, where there was no evidence of immunity to Hepatitis B, risk

assessments had not been carried out, and steps to mitigate risk had not been implemented. In the case of agency locum staff, no assurances were sought from the agency, that all required recruitment checks had been carried out before agency staff commenced work at the practice.

We noted that permanent clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. The provider could show us a current gas safety certificate for the premises. There was no electrical safety certificate for the premises, and no evidence that electricians in the building had been checked within the last five years.

Records showed that fire detection equipment, such as smoke detectors were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced.

The fire risk assessment in place had been completed in-house and not by a competent person. This did not fully consider the layout of the building and the challenges it presented. For example, there was no fire alarm and no emergency lighting in place; one of the surgeries and the waiting area for this surgery, was located on the first floor, which was accessed via a steep staircase. The staff kitchen was on the second floor which was accessed via a door and a further staircase from the first floor. We have recommended the provider seek advice and guidance from the local Community Fire Safety Officer.

Although clinical areas of the practice appeared well maintained, other areas of the practice required maintenance. We saw that the roof of the practice had been leaking and caused part of the ceiling to fall in on the second floor of the property. This was in a room where staff would normally take their rest breaks. This was now cordoned off and staff were not allowed to enter. We were told that repairs had been made to the roof but did not see any paperwork to support this. Staff access to this area was still restricted.

Following our inspection, the provider submitted copies of invoices for some initial roof repairs, which had been carried out in December 2018.

Are services safe?

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

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

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were insufficient systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies and procedures took account of some areas, for example, managing needle stick injuries, and helped to manage potential risk. Other risk assessments required review, to take account of the needs of individual staff and working practices, for example, the lone working of the dental hygienists. In other examples, we saw the sharps risk assessment did not take account of any staff who did not have immunity to Hepatitis B. The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. However, the effectiveness of the vaccination was not checked for all clinical staff. The practice had current employer's liability insurance.

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

Emergency equipment and medicines were broadly available as described in recognised guidance. Items we identified as missing were adult and child face masks as recommended and oropharyngeal airways in all sizes as recommended by the Resuscitation Council UK. Staff kept records of their checks of these items but had not identified items as being missing. We noted that items were within their expiry date, and in working order. Glucagon was available but had not been date adjusted due to being kept out of the fridge.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team. No risk assessment was in place for the dental hygienists who routinely worked without chairside support.

There was no COSHH risk assessment in place to minimise the risk that can be caused from substances that are hazardous to health.

The practice had an infection prevention and control policy and procedures. Observations of staff on the day of inspection showed they did not routinely follow 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. We made checks inside the dental surgeries; we noted that these rooms were clean, well maintained and generally well managed. We found local anaesthetic cartridges were stored in drawers, out of their blister packs. We also found some out of date temporary tooth filling agent in use. We saw used dental instruments had been placed in a hand washing sink. These were not kept moist, as is required to enable effective cleaning.

When we reviewed processes in the decontamination room, we found staff were not following manufacturer's instructions for the use of detergent when manually cleaning instruments, and staff were not monitoring the temperature of the water used for cleaning instruments. When setting up equipment and surgeries at the start of each session, staff did not check information stored on the autoclave data-logger, to ensure it was reaching the correct temperature and pressure, for the required time, to sterilise dental instruments effectively. We saw that helix testing was in place.

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

Staff completed infection prevention and control training and received updates as required. However, as the decontamination lead demonstrated, further refresher training was required.

The practice had taken some steps to reduce the possibility of Legionella or other bacteria developing in the water systems. To enable this, the practice had carried out a risk assessment. We found that not all recommendations had been actioned. There were no records of water temperature testing from identified sentinel taps. Dental unit water line management in the dental surgeries was in place, but this was not in accordance manufacturer's instructions for the system used.

Are services safe?

We saw cleaning schedules for the premises. The practice was visibly clean in all clinical areas.

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

The practice carried out infection prevention and control audits twice a year. These required review as the latest audit had not identified the issues we raised during our inspection.

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 dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

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

Safe and appropriate use of medicines

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

There was a suitable 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.

The practice stored and kept records of NHS prescriptions as described in current guidance.

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

Antimicrobial prescribing audits were not carried out annually. We discussed how this should be introduced to support microbial stewardship.

Track record on safety and lessons learned and improvements

There was a lack of comprehensive risk assessments in relation to safety issues. The practice was able to demonstrate that they monitored and reviewed any incidents that did occur. This helped it to understand risks and provide a clearer picture that led to safety improvements, but risk assessments that had been carried out, for example, for the control of Legionella, required review to ensure all actions had been addressed. Risk assessments on the building and in relation to safe use of sharps were required.

In the previous 12 months, when there had been safety incidents these were investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice dentists and dental hygienists had systems to keep themselves up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice offered dental implants on referral. The principal dentist restored implants after placement and had undergone appropriate post-graduate training in this speciality.

The provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay.

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

The practice was aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition

Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

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

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

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. Staff could also refer to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

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

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 line with recognised guidance.

We saw the practice audited patients' dental care records to check that the dentists and hygienists recorded the necessary information.

Effective staffing

Overall, staff had the skills, knowledge and experience to carry out their roles. Some areas of training required refreshing for some staff.

Staff new to the practice had a period of induction based on a structured programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs at annual appraisals and within practice meetings which we saw were held regularly. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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

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

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

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were friendly, approachable and professional. We saw that 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 could choose whether they saw a male or female dentist.

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

The practice 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, staff would take them into another room. 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 and were aware of the

Accessible Information Standards and the requirements under 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.

- Interpreter services were available for patients who did not use English as a first language. We saw notices in the reception areas, informing patient's translation service were available.
- Staff communicated with patients in a way that they could understand, and communication aids and easy read materials were available.
- Staff helped patients and their carers find further information. They helped them ask questions about their care and treatment.

The practice gave patients clear information to help them make informed choices about their 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 website provided patients with information about the range of treatments available at the practice.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

The practice met the needs of more vulnerable members of society such as patients with dental phobia, and any children with a learning difficulty.

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

The practice had made reasonable adjustments for patients with disabilities. This included step free access to the ground floor and a hearing loop in reception which was portable. Staff telephoned some patients on the morning of their appointment to make sure they could get to the practice.

The practice had not carried out a disability access audit in order to continually improve access for patients.

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 on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen 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 staff took part in an emergency on-call arrangement with other local practices in the area. This was on a rota basis and contact details for the practice providing cover each weekend were included in the practice answerphone message. The practice's website also provided advice for patients needing emergency dental treatment 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

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The practice displayed the complaints procedure in the practice which explained how to make a complaint.

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

We looked at comments, compliments and complaints the practice received in the past 12 months. We were able to confirm that any concerns were addressed in accordance with the practice policy.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders demonstrated they had the experience, capacity and skills to deliver a quality service to patients, and were patient focussed in the delivery of care. They were knowledgeable about issues and priorities relating to the quality and future of services. In relation to the challenges facing the practice in terms of the premises, maintenance of these and addressing of risks, more focus was required.

Leaders were visible and approachable.

Planning for the future leadership of the practice was in place. The process of transition from being an individual provider to the formation of a partnership was underway. We found during our inspection that some delays to this may be due to areas of work required to bring other parts of the building up to standard. There was no action plan in place to address this, or to timetable works required on the building.

Culture

The practice had a culture of high-quality sustainable care. The practice planned its services to meet the needs of the practice population.

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

The practice focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to any incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

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

Governance and management

There were responsibilities, roles and systems of accountability to support governance and management. When we reviewed these, we saw that the knowledge and awareness of systems and processes was insufficient to identify and address areas that required improvement. There was no clearly defined way for safety alerts and

clinical practice updates to be received and shared within the practice, for example, MHRA alerts and NICE guidance updates. Whilst there was a lead for decontamination processes, there was no oversight of this work.

There was a lack of follow-through on actions required following risk assessments, for example, in relation to Legionella, water temperature testing and records of this. Staff were not using the Alpron system correctly to manage water bottles in dental chairs. Infection control audits were not fully effective as staff had not identified the issues raised by our inspection. Where risk had been identified, risk assessments in place did not address how this could be mitigated.

There was a lack of understanding of the risks posed by the building, for example, in relation to fire safety and ease of exit in emergency. There was no fire alarm fitted and no emergency lighting in place. Access to and exit from the building was via the front door only. The only other point of exit in an emergency could not be negotiated due to furniture stacked in the basement and a car parked up against the exit on the outside of the building. There was no electrical safety certificate for the building. All required recruitment checks were not place for all permanent staff, for example evidence of immunity to Hepatitis B and records of verbal references taken. No assurance of checks on locum staff had been obtained.

Staff were managing the stock of emergency medicines and equipment, with no reference guide of what should be held, in accordance with recognised guidance, for example the Resuscitation Council UK.

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. We saw evidence that these were re-visited in practice meetings with staff to refresh and maintain understanding. As described above, in some areas, the lack of oversight meant some procedures and policies were not routinely followed.

Appropriate and accurate information

Are services well-led?

The practice acted on appropriate and accurate information.

Operational information was used to ensure performance. Performance information was combined with the views of patients.

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 practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from patients the practice had acted on.

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

Continuous improvement and innovation

There were systems and processes for learning, and continuous improvement.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records and radiographs. They had clear records of the results of these audits and the resulting action plans and improvements.

The practice manager showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The reception and dental nursing staff had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. The provider supported and encouraged staff to complete CPD.

Requirement notices

Action we have told the provider to take

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

| Regulated activity | Regulation |
|--|--|
| Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>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:</p> <p>There was no suitable fire risk assessment in place, or emergency lighting available within the building.</p> <p>There was no electrical safety certificate for the building.</p> <p>Individual COSHH risk assessments were not available for hazardous substances.</p> <p>Actions required by a Legionella assessment had not been followed.</p> <p>Risk assessments were not in place for staff who did not show immunity to Hepatitis B.</p> <p>Staff were not following recognised guidance in the decontamination of dental instruments.</p> <p>Validation checks on sterilising equipment were not being reviewed or checked.</p> |

This section is primarily information for the provider

Requirement notices

Medical emergency equipment was not available as described in recognised guidance.

Regulation 12(1)(2)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

There was no effective system to ensure MHRA alerts and NICE guidance updates were received, shared and actioned within the practice.

The system in place for ensuring medical equipment reflected nationally recognised guidance was not effective.

Management of risk assessments and actions required following these was insufficient.

Requirement notices

The infection prevention and control audit had not highlighted the issues we identified on the day of inspection with regards to the decontamination of used instruments.

Understanding of risks posed by the building was insufficient, for example, in relation to fire risk. Areas of the building required improved levels of maintenance.

The system to ensure Hepatitis B titre levels were available for all clinical staff was not effective.

Records of all required recruitment checks were not in place for permanent staff. For locum staff, no assurance of checks carried out was in place.

Regulation 17(1)