Dr Mohammed Bala and Dr Saira Khan

Peel Green Dental

Inspection report

419 Liverpool Road
Eccles
Manchester
M30 7HD
Tel:

Date of inspection visit: 25 October 2022
Date of publication: 15/12/2022

Overall summary

We carried out this announced comprehensive inspection on 25 October 2022 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 practice 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 dental adviser.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 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:

- The dental clinic appeared to be visibly clean and well-maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with medical emergencies. Improvements were needed to ensure appropriate medicines and life-saving equipment were available. This was immediately addressed.
- The practice did not have effective systems to identify and manage risks to patients and staff.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.

Summary of findings

- The practice staff recruitment procedures did not reflect current legislation.
- The clinical staff provided patients' care and treatment in line with current guidelines. Systems to audit clinical protocols and record keeping were not effective.
- Patients were treated with dignity and respect and staff took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- There was a lack of effective leadership. A new manager was in post, but systems of governance and oversight had yet to be established.
- Staff felt involved and supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with efficiently. We highlighted areas for improvement in relation to how these are responded to.

Background

The provider has 3 practices and this report is about Peel Green Dental.

Peel Green Dental is in Eccles, Manchester and provides private dental care and treatment for adults and children.

A portable ramp is available to provide access to the practice for people who use wheelchairs and those with pushchairs. On street parking is available near the practice.

The dental team includes 3 dentists, 3 dental nurses who also have reception and administrative duties (one of whom is training to be the practice manager) and 1 dental hygienist. An area manager provides additional management support. The practice has 2 treatment rooms.

During the inspection we spoke with 2 dentists, the practice manager and the area manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday 8am to 5pm

Tuesday 8.30am to 5pm

Wednesday 10am to 6.30pm

Thursday 8.30am to 5pm

Friday 8am to 1.30pm

The practice also provides an emergency private dental service

Monday to Friday 6pm to 9pm

Saturday and Sunday 11am to 8pm

Summary of findings

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed and ensure specified information is available regarding each person employed

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

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

- Improve the practice's complaint handling procedures when responding to complaints by service users.

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?	**No action** ✓
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 providing safe care in accordance with the relevant regulations.

We found this practice was not providing well led care. 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.

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

The practice had processes for safeguarding vulnerable adults and children. Safeguarding leads were identified in the displayed procedures. The practice did not have a system to ensure all staff undertook appropriate training in safeguarding vulnerable adults and children. The area manager was in the process of obtaining evidence of training from staff.

The practice had infection control procedures which reflected published guidance. We observed damaged equipment and surfaces in clinical areas had not been highlighted by the recent infection control audit, and there was no evidence the findings of the audit had been analysed to ensure improvements were made. After the inspection the area manager confirmed the action plan had been updated in response to our feedback.

The practice had introduced procedures to reduce the risk of Legionella or other bacteria developing in water systems on 18 October 2022, in line with a risk assessment. There was no evidence control measures were in place prior to this date. The provider was in the process of actioning the recommendations in the report. Training should be provided for the Legionella lead to support them in this role. Dental unit water line management was in place and manufacturer's instructions were followed.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We saw some waste bags were stored uncovered in the back yard. After the inspection, the area manager confirmed these were removed and waste would be stored inside the practice.

We saw the practice was visibly clean and there was a cleaning schedule to ensure the practice was kept clean.

The practice had recently introduced a procedure to help them employ suitable staff. This reflected the relevant legislation. We reviewed some staff files. We saw recruitment checks had not been carried out in accordance with relevant legislation to employ suitable staff. There was no evidence that any checks of identity, qualifications, professional registration, employment history, indemnity or immunity had been carried out on a dentist who worked at the practice.

A Disclosure and Barring Service (DBS) check was not carried out and references were not requested for another staff member. After the inspection the area manager confirmed these had been applied for.

Clinical staff were registered with the General Dental Council and had professional indemnity cover. The practice did not have a system to obtain evidence of immunity for blood borne diseases. Evidence of immunity was not in place for 2 clinical staff members.

The practice ensured equipment was safe to use and maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

A fire risk assessment was carried out in line with the legal requirements, but this had not been completed by a competent person. Not all areas of the premises had been risk assessed. For example, the cellar was inaccessible due to

Are services safe?

the quantity of old equipment and combustible items stored. Fire safety checks were not documented, and staff were not aware of the presence of emergency lighting or the requirement to have this serviced. After the inspection, the area manager confirmed the risk assessment would be reviewed, arrangements had been made to clear the cellar and a system was introduced to log checks of smoke detectors.

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

Risks to patients

The practice had implemented systems to assess, monitor and manage risks to patient and staff safety. This included sharps safety, sepsis awareness and lone working.

Emergency equipment and medicines were available. The checking processes should be reviewed to ensure these are in accordance with national guidance. For example:

- an adult oxygen face mask was unpouched and degraded and no child-sized mask was available.
- Midazolam was available but not in buccal format described in Resuscitation UK guidance.
- The automated electronic defibrillator included a child setting, but no child-sized pads were available and this had not been risk assessed.

After the inspection the manager confirmed these had been obtained apart from buccal Midazolam due to supply issues.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. Evidence of up to date training had not been obtained for 2 dentists. We were shown evidence that face to face training was booked for the whole team on 4 November 2022.

The area manager had identified that risk assessments to minimise the risk that could be caused from substances that are hazardous to health were not in place. Staff were in the process of obtaining the relevant safety data sheets to enable them to complete risk assessments. We observed hazardous waste was stored in the cellar and staff were unaware of this.

Information to deliver safe care and treatment

Dental care records we saw were legible, were kept securely and complied with General Data Protection Regulation requirements.

The practice had systems for referring patients with suspected oral cancer under the national two-week wait arrangements.

Safe and appropriate use of medicines

The practice had some systems for appropriate and safe handling of medicines. A log of private prescriptions was maintained but there were no security measures to prevent fraudulent use of these. After the inspection, confirmation was sent that this had been addressed.

Track record on safety, and lessons learned and improvements

The systems for investigating when things went wrong should be reviewed. We identified 2 significant events which had not been documented to ensure that timely action was taken, appropriate discussions were held, learning and improvement occurred, or consideration was given to notifying external organisations. After the inspection significant event reports were completed and sent to us.

The practice had a system for receiving and acting on safety alerts.

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 had some systems to keep dental professionals up to date with current evidence-based practice. The documentation of this should be reviewed. The practice did not always keep detailed dental care records in line with recognised guidance and systems to audit this were not effective. We saw diagnoses were not consistently documented, there was a lack of radiographic assessment and we saw 2 dental care records where patients had attended but no clinical records were documented for those visits.

The orthodontist carried out a patient assessment in line with recognised guidance from the British Orthodontic Society.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health.

Consent to care and treatment

Staff told us they obtained patients' consent to care and treatment. The dental care records we looked at showed there was a lack of consistency in the documentation of this. In particular, the lack of risks, options and benefits of treatment options explained to the patients.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).

Monitoring care and treatment

Staff conveyed an understanding of supporting more vulnerable members of society such as patients with dementia, and adults and children with a learning difficulty.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits, but these were not effective as they did not reflect the findings on the inspection day.

Effective staffing

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

Newly appointed staff did not have a structured induction. The area manager was in the process of establishing systems to ensure that staff employed in the future would receive a role-specific induction. They were also reviewing their systems to obtain evidence that clinical staff completed continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

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

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

We saw patient feedback that confirmed staff were compassionate, understanding and helpful when they were in pain, distress or discomfort.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality.

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.

The practice's website and information folder 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 study models and X-ray images.

Are services responsive to people's needs?

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.

The practice had made reasonable adjustments for patients with disabilities. Staff had carried out a disability access audit and had formulated an action plan 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 had an appointment system to respond to patients' needs. A private 24-hour emergency telephone triage service was offered by the provider. Appointments were available to carry out any necessary face to face assessments and treatment during working hours during the week and at weekends.

Listening and learning from concerns and complaints

The practice responded to concerns and complaints appropriately and discussed outcomes with staff to share learning and improve the service. We discussed that when responding to clinical complaints, the clinician should be involved, and consideration should be given to seeking input from their indemnity provider.

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 there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the management of services for which the practice is registered. An application was in process for the practice manager to undertake this role.

Leadership capacity and capability

The practice demonstrated a transparent and open culture in relation to people's safety. An area manager had recently been employed. They had reviewed the provider's systems and was in the process of setting up new oversight processes. These were yet to be established. During the inspection the provider and managers were open to discussion and feedback to make further improvements. After the inspection, the area manager sent evidence they were prioritising and addressing the concerns highlighted by the inspection process.

The managers were establishing systems to support and develop staff with additional roles and responsibilities. In particular, the new practice manager was undertaking a practice management qualification to support them in this role.

Culture

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

The area manager was establishing a new system to obtain evidence that staff completed up-to-date training at the required intervals and to discuss staff training needs during annual appraisals and one to one meetings.

Governance and management

Systems of accountability to support good governance and management were not yet established and embedded.

The clinical governance system which included policies, protocols and procedures was in the process of being reviewed to ensure these were up to date and accessible to all members of staff.

We saw the processes for identifying and managing risks, issues and performance were not yet effective. As a result, the inspection highlighted areas of risk relating to oversight of infection prevention and control, medical emergency arrangements, staff recruitment, fire safety, prescription security and significant events.

Appropriate and accurate information

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

Staff gathered feedback from patients, the public and external partners and a demonstrated commitment to acting on feedback.

The practice gathered feedback from staff through meetings and informal discussions.

Continuous improvement and innovation

The practice did not have systems and processes in place for learning, continuous improvement and innovation.

Appropriate quality assurance processes to encourage learning and continuous improvement were not effective.

Are services well-led?

Audits of radiographs, infection prevention and control and record keeping did not highlight the issues identified by the inspection and clinicians did not take into account the guidance provided by the College of General Dentistry when completing dental care records. Audits did not have conclusions, learning points or action plans to demonstrate any learning and improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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: • Clinical audits were not undertaken at required intervals to improve the quality of the service. Audits did not have documented learning points and improvements could not be demonstrated. Oversight and auditing of infection prevention and control was not maintained effectively. • Fire safety risks were not assessed by a competent person and ongoing fire safety management was ineffective. • Oversight of systems to ensure the provision and checking of medical emergency equipment and medicines was not effective. • The provider did not implement an effective system for recording, investigating and reviewing incidents or significant events. Consideration was not given to preventing further occurrences, sharing information with external organisations and ensuring that improvements were made as a result. • There were no security measures to prevent fraudulent use of private prescriptions. • Systems were not in place to ensure evidence of up-to-date training was obtained from all staff. Regulation 17(1)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not have processes for assessing and checking that people have the competence, skills and experience required to undertake their roles. • The registered person had not ensured that essential checks were carried out for staff as specified in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Schedule 3). • New staff members had not been subject to a suitable role-specific induction. Regulation 19(1)(3)