Burton Dental Lodge Ltd

Burton Dental Lodge

Inspection Report

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Overall summary

We carried out this announced inspection on 26 June 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

Burton Dental Lodge is in Boston in Lincolnshire. The practice provides private dental treatment to adults and children.

There is level access through the automatic sliding front door. The practice has two treatment rooms, both located on the ground floor.

The dental team includes one dentist, one dental hygienist, one part-time anaesthetist, and four dental nurses.

The practice is owned by a company and as a condition of registration must have a person registered with the

Summary of findings

Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Burton Dental Lodge is the principal dentist.

On the day of inspection, we collected 15 CQC comment cards filled in by patients.

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

The practice is open: Monday to Saturday: from 9am to 5.30pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance. Six-monthly audits of infection prevention and control had not been completed.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available. Records did not demonstrate that staff were checking these regularly to ensure they were available, within their expiry date, and in working order.
- The provider was not following guidelines issued by the British Endodontic Society in respect of the use of rubber dams.
- The provider did not have a system for receiving and responding to patient safety alerts, issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.
- The provider did not have risk assessments for the control of substances hazardous to health identified by the Control of Substances Hazardous to Health Regulations 2002
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider was not following national guidance when delivering domiciliary care.
- The provider had thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines. Records relating to sedation were not always fully completed.
- The provider had not registered with the Health and Safety Executive in respect of the Ionising Radiation Regulations (IRR17)
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider did not demonstrate effective leadership or a culture of continuous improvement.
- The provider dealt with complaints positively and efficiently.

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 was/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 policies and procedures for obtaining patient consent to care and treatment to ensure they are following legislation, take into account relevant guidance, and staff follow them. Particularly in respect of the Mental Capacity Act (2005) and best interest decisions, and Gillick competencies.
- Review the practice's registration with the health and safety executive in relation to radiography in line with the updated Ionising Radiation Regulations (IRR17) in 2017.
- Review the practice's protocols for medicines management and ensure antibiotic prescribing is audited annually in line with current guidelines.

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 

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 practice did not have systems and processes to provide safe care and treatment.

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

Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available with the exception of a paediatric bag valve mask as part of their emergency kit.

Records did not demonstrate that staff were checking the equipment regularly to ensure they were available, within their expiry date, and in working order.

The provider was not following guidelines issued by the British Endodontic Society in respect of the use of dental dams.

The provider did not have a system for receiving and responding to patient safety alerts, issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

Staff were qualified for their roles and the practice completed the essential recruitment checks.

In the period up to this inspection the practice had not been completing infection prevention and control audits on a six-monthly basis as identified in national guidance.

Substances held in the practice had product safety data sheets and some but not all had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The provider had not registered with the Health and Safety Executive in respect of the Ionising Radiation Regulations (IRR17)

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

Are services effective?

No action

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

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 painless, professional and thorough. The dentists discussed treatment with patients, so they could give informed consent and recorded this in their records.

The provider was not following national guidance when delivering domiciliary care.

The provider's consent policy did not contain sufficient detail for staff to fully understand their responsibilities.

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?

No action ✓

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

We received feedback about the practice from 15 people. Patients were positive about all aspects of the service the practice provided. Patients told us staff were friendly and put them at ease. They said that it was easy to get an appointment particularly in an emergency. Patients 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.

Are services responsive to people's needs?

No action ✓

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 a translation and interpreting service and had arrangements to help patients with sight or hearing loss.

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

Are services well-led?

Requirements notice ✗

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).

Summary of findings

The practice had arrangements to ensure the smooth running of the service. These included systems for the practice team to discuss the quality and safety of the care and treatment provided. There was a clearly defined management structure and staff felt supported and appreciated.

The practice team did not keep complete patient dental care records, particularly in respect of sedation.

The provider did not demonstrate effective leadership or a culture of continuous improvement. The provider did not have an effective system for audit with no records to show infection prevention and control, dental care records or radiography had been audited.

The provider did not have a duty of candour policy or guidance for staff.

Are services safe?

Our findings

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

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. There was a designated lead person for safeguarding alerts within the practice. They had completed safeguarding training, and arrangements were being made for them to complete training to a higher level.

The practice had a system to highlight vulnerable patients on records for example, 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. We saw examples of how this information was recorded within dental care records.

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

The dentist told us they did not always use dental dams when providing root canal treatment. This was not in line with guidance from the British Endodontic Society. The dentist told us there were no non-latex rubber alternative dams in the practice. We saw a box of latex dental dams in in the treatment room which had expired in February 2018.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. We noted this document was a template and had not been filled in.

The practice had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at six staff recruitment records. The files contained the information required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced. A fire risk assessment had been completed internally.

We noted the Landlord's Gas Safety certificate was dated 1 December 2015. It is a requirement that this is reviewed annually. The provider told us he did not have a more up-to-date gas safety certificate.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file. The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file. Local rules for the X-ray unit were available in line with the current regulations. The provider used digital X-rays and had rectangular collimation fitted to enhance patient safety. The provider said they had not registered with the Health and Safety Executive as required by the Ionising Radiation Regulations 2017.

The practice had a cone beam computed tomography machine (CBCT). Staff had received training and appropriate safeguards were in place for patients and staff.

We saw evidence that the dentist justified, graded and reported on the radiographs they took. We asked if any radiography audits or audits of the use of the CBCT had been carried out. The provider told us that there had not been any completed.

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

Risks to patients

There were 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 practice had current employer's liability insurance.

Are services safe?

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items.

Equipment used for sedation was stored in an open compartment on a trolley. We saw that there as cluttered equipment including needles and syringes stored in the bottom of the trolley at a height that would be accessible for young children. The medical oxygen tank in the treatment room had tubing and masks still attached from its last use. This should be retained in its packaging until being placed just prior to the sedation procedure.

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, and that the effectiveness of the vaccination was checked.

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

Emergency equipment and medicines were available as described in recognised guidance. There were no clear records to show staff were regularly checking to make sure equipment and medicines were available, within their expiry date, and in working order. One particular emergency medicine called Glucagon which is used to treat severe hypoglycaemia (low blood sugar) needed to be stored in the refrigerator to preserve its use by date. This medicine was not in the refrigerator and the use by date had not been altered accordingly. The records did show a significant gap between expiry dates of medicines and the date they were re-ordered.

A dental nurse worked with the dentist and dental hygienist when they treated patients in line with GDC Standards for the Dental Team.

The provider had product safety data sheets but did not have suitable risk assessments, to minimise the risk that can be caused from substances that are hazardous to health.

Infection prevention and control processes including the process for decontamination followed guidance as laid out in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. We were unable to locate an infection prevention and control audit had been carried out. Staff told us that no such audits had been completed.

There was a lead for infection control as recommended by the published guidance. The lead had undertaken infection control training in line with their continuing professional development.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.

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.

The provider had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The risk assessment had been reviewed by an external company in October 2017.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

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

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 not always written and managed in a way that kept patients safe. For example, we saw records for patients who had received sedation at the practice. These were missing important information, in some examples the patient's name had not been recorded, their date of birth, height, weight and body mass index were not recorded. We saw some examples where the sedationist had not signed the records and their name was not recorded.

Are services safe?

Patients updated their medical histories and the information was scanned directly into their electronic dental care records.

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 practice's systems for the appropriate and safe handling of medicines were not effective. We saw medicines that were out of date but still available for use. For example, Flumazenil 0.1 mg/ml for injection to be used by February 2017. Flumazenil is a reversal agent used to counter the effects of the medicine midazolam which is used in sedation to cause drowsiness and decrease anxiety.

The records showed a significant gap between the expiry date and re-order date for some medicines in the practice. We noted one particular medicine where the provider had not followed the manufacturers advice regarding storage.

Track record on safety and lessons learned and improvements

There were risk assessments in relation to safety issues. The practice monitored and reviewed incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

In the 12 months up to this inspection there had been no accidents recorded, and staff told us that no accidents had occurred since the practice opened. There was a system for recording and analysing critical incidents, and the records showed three such incidents had occurred in the year up to this inspection. The records demonstrated the critical incidents had been analysed and learning points identified.

There were systems for reviewing and investigating when things went wrong. The practice learnt, and shared lessons identified themes and acted to improve safety in the practice.

The provider did not have a system for receiving and acting on safety alerts. We signposted the provider to the website to receive alerts but did not receive confirmation this had been done.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We saw that in respect of general dentistry clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. With regard to sedation there were examples of guidance not being followed. Particularly in relation to record keeping.

The provider told us they occasionally carried out domiciliary visits to see and treat patients in their own home. The provider was unaware of the guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence.

The practice offered dental implants. These were placed by the principal dentist who 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 dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice provided health promotion leaflets to help patients with their oral health. We saw evidence of these discussions in dental care records.

Staff were 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 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 the dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act (MCA) 2005. The policy included brief information relating to best interest decisions and Gillick competence, by which a child under the age of 16 years of age may give consent for themselves.

Monitoring care and treatment

The practice kept 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.

The practice carried out intra-venous sedation. This included people who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The sedationist was from the local hospital and was qualified and experienced in sedation. We noted the records showed that staff recorded important checks at regular intervals. This included pulse, blood pressure and the oxygen saturation of the blood. We did however, see several examples where important details such as the patient's name, height, weight, Body Mass Index, and the chaperone's name were left blank on the form.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history; blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines.

Effective staffing

Are services effective?

(for example, treatment is effective)

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

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

Records showed all staff had received an annual appraisal and completed personal development plans where appropriate.

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 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 received referrals from other dental professionals particularly in relation to treatment carried out under sedation.

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

The practice was a referral clinic for implants and procedures under sedation and we saw they monitored and ensured the dentists were aware of all incoming referrals daily.

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, courteous and welcoming. We saw that staff treated patients with respect, kindness and were polite. Staff were friendly towards patients at the reception desk and over the telephone.

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

The costs for private dental treatments were on display in the practice.

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. Staff told us that if a patient asked for more privacy they would take them into a private room within the practice. 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

requirements under the Equality Act. We saw:

- The practice had access to an Interpreting service, who could provide both face to face and telephone translations. There were staff at the practice who could speak and understand Arabic.
- Staff communicated with patients in a way that they could understand, and communication aids and easy read materials were available.

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

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example digital cameras, intra-oral cameras, digital X-rays, and an Orthopantomogram machine and cone beam computed tomography, used particularly when fitting implants which were used to enhance the delivery of care.

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.

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

The practice had some patients for whom they needed to make adjustments to enable them to receive treatment. These included having an induction hearing loop for patients who used a hearing aid; two ground floor treatment rooms; an adapted toilet with grab rails and an alarm; an automatic sliding front door to the practice and level access. There was car parking for blue badge holders outside the front door.

Staff sent text messages to remind patients who had agreed to receive them when they had an appointment.

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 practice information leaflet.

The practice had an efficient appointment system to respond to patients' needs. The practice had emergency appointments for patients who were in pain or who telephoned in an emergency. Patients told us they 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.

If patients required emergency out-of-hours treatment, they could access the practice website for details of the out-of-hours service.

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. This was displayed within the practice for the benefit of patients. The practice information leaflet explained how to make a complaint. The principal dentist was responsible for dealing with these. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

Staff told us they 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 and complaints the practice received in the year up to this inspection. The practice had not received any complaints during that year.

Are services well-led?

Our findings

Leadership capacity and capability

We identified issues in the governance and leadership of the practice which were impacting on the delivery of a quality service. We saw that policies were in many cases generic and not specific to the practice. For example, the infection control policy related to a different dental practice and identified two autoclaves which were not present in this dental practice.

Culture

Staff stated they felt supported and were proud to work in the practice. The practice focused on the needs of patients.

The practice held regular staff meetings to share information and support staff.

The provider was not aware of the duty of candour and did not have systems to ensure compliance with the requirements of the Duty of Candour.

Governance and management

There were 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 and the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

We noted that systems and processes within the practice were not always effective. For example:

- the system for checking medicines had failed to identify some medicines were out of date over a period of many months.
- records for the checking of emergency medicines showed significant gaps between the expiry date and the date when medicines were re-ordered.
- there had been no infection, prevention and control audits completed, and staff were unaware of the need to complete these on a six-monthly basis as identified in current guidance.
- there had been no audits of dental care records, radiography, the use of the cone beam computerised machine or patient satisfaction.
- the systems relating to the control of substances hazardous to health did not include risk assessments for every product.

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.

We saw there were clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

Staff acted on appropriate and accurate information.

The provider 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 patient surveys, comment cards and verbal comments to obtain staff and patients' views about the service.

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

In the year up to this inspection there had been 11 reviews by patients on-line, and 25 reviews overall. The feedback was all positive.

Continuous improvement and innovation

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

The principal dentist told us there was no system for formal audit at the practice. Therefore, there were no audits for infection prevention and control, radiographs, dental care records or antibiotic prescribing.

The whole staff team 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.

Are services well-led?

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

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users **How the regulation was not being met** Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. • In particular: Records for patients who had received sedation showed important information such as the patient's name, date of birth, height, weight, body mass index and the seditionist's details had not always been recorded. • There were medicines that were out of date including the reversal agent for intra-venous sedation. There was additional evidence that safe care and treatment was not being provided. In particular: • Risk assessments had not been completed for all hazardous substances. • The last annual gas safety test had been completed 1 December 2015. • The dentist was not using a dental dam or any other form of airway protection for root canal treatment in line with the guidelines issued by the British Endodontic Society. Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

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

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- There were no audits of infection prevention and control, radiography, the use of the cone beam computerised machine, sedation and dental care records.
- There were no systems for receiving and responding to patient safety alerts, recalls and rapid response reports issued by the Medicines and Healthcare products Regulatory Agency, the Central Alerting System and other relevant bodies, such as Public Health England.

There were no systems or processes that enabled 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 not an effective system for checking that emergency medicines were available, within their expiry date, and in working order.

There was additional evidence of poor governance. In particular:

- The registered person did not have a duty of candour policy or guidance for staff. Discussions with staff showed a lack of awareness of what the duty of candour was, and their responsibilities arising from it.
- Not all policies had been adapted to reflect the individual nature of the practice. For example: the infection control policy.

Regulation 17 (1)