Mrs. Helene Burns

Mrs H Burns Dental Surgeon

Inspection Report

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Overall summary

We carried out this announced inspection on 29 January 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 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 not 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

Mrs H Burns Dental Surgeon is located in a residential area and provides NHS and private dental care for adults and children.

There is level access to facilitate entrance to the practice for people who use wheelchairs and for people with pushchairs. Car parking is available outside the practice.

The dental team includes the principal dentist, two trainee dental nurses and a receptionist/dental nurse. The practice has one treatment room.

Summary of findings

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.

We received feedback from two people during the inspection about the services provided. The feedback provided was positive.

During the inspection we spoke to the dentist, the dental nurses and the receptionist/dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday 9.00am to 5.30pm.

The practice is closed for lunch between 12.00 and 2.00pm.

Our key findings were:

- The practice had infection control procedures in place. These did not reflect published guidance.
- The provider had safeguarding procedures in place and staff knew their responsibilities for safeguarding adults and children.
- Staff knew how to deal with medical emergencies. Not all the recommended medical emergency equipment was available or working satisfactorily.
- The provider had staff recruitment procedures in place. These were not operating effectively.
- The provider did not take account of current guidelines when assessing and delivering patients' care and treatment.
- Staff treated patients took care to protect patients' privacy and personal information.
- The appointment system took account of patients' needs.
- The provider had a procedure in place for dealing with complaints. This did not contain all the relevant information.
- The practice's leadership and management structure was unclear. Governance arrangements were ineffective and limited means were in place to encourage improvement.
- The provider had systems in place to manage risk. These were not operating effectively.
- Staff felt involved and supported and worked well as a team.
- The practice asked patients and staff for feedback about the services they provided.

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

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- Ensure care and treatment is provided in a safe way to patients.
- Ensure all premises and equipment used by the service provider is fit for use.
- 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 not meeting are at the end of this report.

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

- Review the security of NHS prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the practice's system for recording, investigating and reviewing incidents and significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review the practice's complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users. In particular, ensure sufficient information, including contact details for NHS England and the Dental Complaints Service is available for patients.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Enforcement action

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

The practice used learning from incidents to help them improve. Staff were not aware what could constitute a significant event.

Staff received training in safeguarding and knew how to report concerns.

Staff were qualified for their roles, where relevant.

The provider had recruitment procedures in place and completed some essential recruitment checks before employing staff. Not all the checks had been carried out for the two most recently employed staff.

Equipment used in the practice was not properly maintained.

The provider's infection prevention and control procedures did not follow current guidance for cleaning, sterilising and storing dental instruments.

The practice had arrangements for dealing with medical and other emergencies. Not all the recommended medical emergency equipment was available at the practice.

The practice had systems in place for the use of X-rays. These did not follow guidance or legislation.

Are services effective?

Enforcement action

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

The provider supported staff to complete some training relevant to their roles. Some of the recommended training had not been completed, for example, radiography refresher training.

The provider did not take account of recognised guidance when assessing patients' needs and providing care and treatment.

The practice had clear arrangements for referring patients to other dental or health care professionals.

The provider gave detailed toothbrushing guidance to patients to assist them in improving and maintaining good oral health.

Are services caring?

No action

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

Summary of findings

We received feedback about the practice from two people. Patients were positive about the service the practice provided. They told us staff were fantastic. They said they were given good explanations about dental treatment, and said their dentist listened to them.

Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

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 book an appointment quickly if in pain.

Staff considered patients' differing needs and put measures in place to help patients receive care and treatment. This included providing facilities for patients with disabilities and families with children.

The provider had arrangements to assist patients who had sight or hearing loss. Staff were unaware of whether they had access to interpreter services.

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

Information about alternative organisations patients could contact should they wish to complain were not available.

Are services well-led?

Enforcement action 

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 Enforcement Actions section at the end of this report).

The provider had ineffective systems for the practice team to monitor the quality and safety of the care and treatment provided, for example, in relation to the monitoring of staff training and receiving and acting on safety alerts.

Leadership and management responsibilities were not clearly defined.

The provider was visible and approachable and staff felt supported and appreciated.

The practice team stored dental care records securely.

Staff asked for and listened to the views of patients.

The provider had ineffective systems in place to manage and reduce risks. Risk assessments, including fire and Legionella, were not regularly reviewed.

Summary of findings

The provider had ineffective systems and processes in place to encourage learning, continuous improvement and innovation, for example, no auditing was carried out to identify where improvements could be made to the service.

On the day of the inspection the provider acted immediately on some of the most serious issues identified and demonstrated a willingness to continue to take appropriate action to comply after the inspection.

We are liaising with our colleagues at NHS England in supporting and monitoring the provider.

Are services safe?

Our findings

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

The provider had limited systems in place at the practice to keep patients safe.

The provider had safeguarding policies and procedures in place to provide staff with information about identifying and reporting suspected abuse. Staff knew their responsibilities should they have concerns about the safety of children, young people or adults who were at risk due to their circumstances.

Staff told us they felt confident to raise whistleblowing concerns with the provider but were unaware of any external organisations they could raise concerns with.

We reviewed the procedures the provider followed when providing root canal treatment. The provider did not use dental dam or alternative methods to protect the patient's airway during root canal treatment in accordance with current guidance from the British Endodontic Society, and had not assessed the risks inherent in this.

The provider had staff recruitment procedures in place to help the practice employ suitable staff. We looked at two staff recruitment records. We saw that some recruitment checks were carried out and the required documentation was available. No Disclosure and Barring Service, (DBS), checks had been carried out, and no references obtained at the appropriate time for the most recently recruited staff. The provider said they had recently applied for the DBS checks to be carried out for these staff. The provider was unaware whether these were required or not, but had not risk assessed this..

We saw that clinical staff were registered with the General Dental Council, where relevant, and had professional indemnity cover.

The provider had limited arrangements in place to ensure that the practice's facilities and equipment were safe and maintained according to manufacturers' instructions.

We saw that the written scheme of examination for the air compressor recommended pressure vessel testing to be carried out every two years. The practice's records showed the last test as having been carried out in 2006. The provider did not know if it had been tested since.

Records showed that firefighting equipment, such as fire extinguishers, was regularly serviced. We saw that a fixed electrical installation test and gas safety test had been carried out recently.

We observed that a PAT test label on the X-ray machine stated '12 May 2006'. Staff said portable electrical appliance testing, (PAT), had last been carried out in 2016. No records of test were available to confirm this.

The provider did not have all the required radiation protection information. We saw the provider had not registered the use of X-ray equipment on the premises with the Health and Safety Executive. The provider carried this out after the inspection and sent CQC evidence to confirm this.

The X-ray unit test certificates stated that the X-ray machine was installed in 1979. The provider did not know how often the recommended routine testing should be carried out. We saw certificates indicating routine testing was last carried out in 2010. We were unable to confirm whether any specific recommendations had been made in relation to the safe use of the equipment, as the provider did not have any relevant information about this and had not sought advice from the practice's Radiation Protection Adviser. During the inspection the provider made a booking for the service and test of the X-ray machine at a later date.

The provider had not put in place reasonable measures to ensure X-rays were carried out safely and that patient exposure to X-rays was as low as possible. For example, the provider did not have radiograph film holders for use when taking X-rays, and did not have rectangular collimation for the X-ray tube.

We saw that the provider justified and reported on the X-rays they took. We saw the X-rays were graded as to their quality but this was in reverse of the recommended protocol in recognised guidance. The provider did not carry out radiography audits regularly in accordance with current guidance and legislation.

The provider had not completed the General Dental Council's highly recommended radiography and radiation

protection continuing professional development training within the recommended time interval. Three days after the inspection the provider sent evidence to the inspector that a training course had been booked for a later date.

Risks to patients

The provider did not sufficiently monitor and act on risks to patients.

We saw that the provider had put in place measures to reduce the risks identified in the assessments.

The provider had current employer's liability insurance.

Staff followed relevant safety regulations when using needles and other sharp dental items. A sharps risk assessment had been undertaken. Staff confirmed that only the provider was permitted to dismantle and dispose of needles and other sharp items in order to minimise the risk of inoculation injuries to staff. Staff were aware of the importance of reporting inoculation injuries. We saw the provider had not made information readily accessible and available for staff about action to take should they sustain an injury from a used sharp.

The provider ensured clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. The provider had not checked the result of the vaccination for two of the clinical staff and did not have a risk assessment in place in relation to these staff working in a clinical environment when the effectiveness of the vaccination was unknown.

Staff knew how to respond to medical emergencies and completed training in medical emergencies and life support annually.

The practice did not have all the recommended medical emergency equipment and medicines available. Only one of the five recommended sizes of clear face mask for the self-inflating bag was available, and no oxygen masks with reservoir were available. We were not provided with evidence that these had been obtained. The practice's automated external defibrillator, (AED), was not working; the battery had fully discharged and the pads were past their expiry date of 2011. The provider ordered the relevant parts for the AED during the inspection and arranged for a service to be carried out on it for a later date. The provider had not carried out an assessment of the risks whilst waiting for the AED to be restored to full function. The provider told us there were two AEDs near to the practice and immediate arrangements would be put in place to request to use the nearby AEDs should one be needed in an emergency. We were not provided with evidence this had been done.

Staff carried out, and kept records of, checks to make sure the medicines and equipment were available, within their expiry dates and in working order. We saw that these checks did not include the recommended minimum weekly checks on the medical emergency oxygen and on the AED. A label on the practice's medical emergency oxygen cylinder indicated it had last been maintained and serviced in 2013. Staff said it had not been serviced since. Staff were unaware the AED was not working.

A dental nurse worked with the provider when they treated patients.

The practice had an infection prevention and control policy and associated procedures in place to guide staff, and arrangements for transporting, cleaning, checking, sterilising and storing instruments. These did not take full account of The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), guidance published by the Department of Health.

We found a number of deviations from the guidance, including: -

- the provider did not carry out infection prevention and control audits,
- the practice did not have a magnifying inspection light for examining instruments to ensure they were clean. The provider obtained one after the inspection,
- several scaler tips and numerous dental burs were contained in uncovered racks in drawers in the treatment room. Staff did not know when they were last sterilised,
- uncovered dental equipment items were stored on top of the units in the treatment room exposing them to aerosol contamination,
- debris was observed on wrapped, dated instruments which staff confirmed had been through the sterilisation process, including a flat plastic instrument, a matrix band, a set of tweezers, and a pair of forceps,
- we observed several matrix bands in their carriers. The single-use bands were damaged and bent at the edges. Staff confirmed they were re-used following sterilisation. After the inspection the provider replaced these with disposable matrix bands,

Are services safe?

- no detergent was available for the manual cleaning of instruments,
- the clinical staff wore long-sleeved clothing under their work tunics,
- staff were not recording every sterilisation cycle and the steriliser was not fitted with a means of doing this. Staff did not record remedial action taken when the steriliser faulted,
- the provider had not clearly identified dirty and clean zones in the decontamination room,
- the extractor fan in the decontamination room was covered with black dust.

The provider had had a Legionella risk assessment carried out at the practice in 2011. Actions to reduce the possibility of Legionella or other bacteria developing in the water systems were identified in the assessment, including monitoring of the temperature of the water from the sentinel outlets, and microbiological testing of the dental unit water lines. Staff said they carried out the temperature monitoring weekly but did not record the water temperatures. None of the staff had received any training in Legionella awareness and they were unaware of the guideline temperatures to be used for monitoring. The provider did not carry out microbiological testing. The day after the inspection the provider arranged for a Legionella risk assessment to be carried out at the practice for a later date and sent CQC confirmation of this arrangement.

Staff ensured clinical waste was segregated and stored securely in accordance 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 provider how information to deliver safe care and treatment was handled and recorded. We looked at several dental care records to confirm what was discussed and observed that individual records were managed in a way that kept patients safe. Dental care records we saw were stored securely.

We saw that when patients were referred to other healthcare providers information was shared appropriately and in a timely way.

Safe and appropriate use of medicines

The provider had limited systems for the appropriate and safe handling of medicines at the practice to ensure that medicines did not exceed their expiry dates and enough medicines were available when required.

We observed several dental materials in the treatment room drawers were past their expiry dates, including a pot of topical anaesthetic which expired in November 2016, and a tub of material to treat infected extraction sockets, expired August 2018.

Staff stored blank NHS prescription pads as recommended in current guidance. The provider did not keep records of NHS prescriptions to ensure they could be tracked if necessary.

The provider was not aware of current guidance with regards to prescribing antibiotics to treat dental infections.

Track record on safety

We saw that the practice monitored and reviewed incidents to minimise recurrence and improve systems.

The provider had informal procedures in place for reporting, investigating, responding to and learning from accidents, incidents and significant events. Staff knew about these and understood their role in the process. The practice manager explained these were discussed together as a team. Staff did not all fully understand what could constitute a significant event.

Staff told us in the previous 12 months there had been no significant events or accidents.

We discussed with staff examples of significant events which could occur in dental practices and we were assured that should one occur it would be reported and analysed in order to learn from it, and improvements would be put in place to prevent re-occurrence.

The provider was aware of some safety alerts, those forwarded by NHS England, and we saw these had been acted on. Staff were not aware of other safety monitoring organisations, for example, the Medicines and Healthcare Regulatory Agency, and had not subscribed to receive safety alerts from them. After the inspection the provider subscribed to receive these and sent us evidence of this.

Lessons learned and improvements

Are services safe?

Staff confirmed that learning from incidents, events and complaints was shared with them to help improve systems at the practice, to promote good teamwork and to prevent recurrences.

There were informal systems for reviewing and investigating when things went wrong. Staff learned and shared lessons, identified patterns and acted to improve safety in the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We found the provider did not take account of the current recognised guidance when assessing patients' care and treatment needs and delivering care and treatment, including the National Institute for Health and Care Excellence guidance "Dental checks: intervals between oral health reviews". We found the provider did not take account of The Faculty of General Dental Practitioners (UK) The Royal College of Surgeons of England FGDP (UK) Good Practice Guidelines "Selection Criteria for Dental Radiography" guidance. The provider made limited use of radiographs and took them mainly when patients presented with pain or for root canal treatment. The provider did not take radiographs where recommended, or at the recommended time intervals and, did not comply with the legislation in relation to X-rays as they did not record the justification for taking the X-rays, or the X-ray findings.

Helping patients to live healthier lives

The provider supported patients to achieve better oral health but was unaware of the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. The provider told us they applied high concentration fluoride products if a patient's risk of tooth decay indicated this would help them, and toothbrushing advice to patients including demonstrations of good brushing technique. The provider did not discuss smoking with patients or provide smoking cessation advice.

The provider described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice. We found the provider was unaware of current British Society of Periodontology guidance about the diagnosis and charting of periodontal disease which advises taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. We observed the provider had not carried out further examination, charting and treatment where screening indicated this should be done.

The practice had a selection of dental products for sale to help patients with their oral health.

Consent to care and treatment

Staff 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 provider told us they gave patients information about treatment options so they could make informed decisions. Patients confirmed the provider listened to them and gave them 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. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves in certain circumstances. 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 where appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The provider kept dental care records containing information about patients' current dental needs, past treatment and medical histories. We found the information was not sufficiently detailed.

Effective staffing

Staff were not sufficiently equipped with the appropriate skills, knowledge and experience to carry out their roles.

None of the staff had received training in Legionella awareness and were not familiar with tasks they were requested to carry out. The provider was the lead for safeguarding vulnerable adults and children and young people, and infection prevention and control. They could not demonstrate whether they had completed relevant recommended training within the recommended time limit.

Staff new to the practice completed a period of induction based on a structured induction programme.

Two of the staff were trainees and we saw they received training from one of the more experienced practice staff as well as attending a recognised training course.

Are services effective?

(for example, treatment is effective)

The provider offered support and training opportunities to assist staff in meeting the requirements of their registration, and with their career development. The provider did not monitor training to ensure staff completed the recommended training, for example, in safeguarding vulnerable adults and children, and in infection prevention and control.

The provider told us staff discussed training needs at annual appraisals and one to one meetings. We saw evidence that appraisals had taken place for some staff but not all.

Co-ordinating care and treatment

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

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

The practice had systems and processes to identify, manage, follow up, and, where required, refer patients for specialist care where they presented with dental infections.

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

Are services caring?

Our findings

Kindness, respect and compassion

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

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

Staff understood the importance of providing emotional support for patients who were nervous of dental treatment. Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Privacy and dignity

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

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

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

Involving people in decisions about care and treatment

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

They were aware of the requirements of the Accessible Information Standard, (a requirement to make sure that patients and their carers can access and understand the information they are given), and the Equality Act.

- Staff were unsure if interpreter services were available for patients whose first language was not English. Patients were told about multi-lingual staff who may be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.

The practice provided patients with information to help them make informed choices. Patients confirmed that staff listened to them, discussed options for treatment with them and did not rush them. The provider described to us the conversations they had with patients to help them understand their treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had considered the needs of different groups of people, for example, people with disabilities, wheelchair users and people with pushchairs, and put in place reasonable adjustments, for example, handrails to assist with mobility and step free access. Part of the reception desk was at a suitable height for wheelchair users. The toilet facilities were not accessible for wheelchairs. Parking was available outside the practice.

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

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

Timely access to services

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

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

The practice's appointment system took account of patients' needs. We saw that the provider tailored appointment lengths to patients' individual needs. Patients could choose from morning and afternoon appointments. Staff made every effort to keep waiting times and cancellations to a minimum.

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

The practice took part in an emergency on-call arrangement with the NHS 111 out of hours' service.

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

Listening and learning from concerns and complaints

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

The practice had a complaints policy providing guidance to staff on how to handle a complaint.

The provider was responsible for dealing with complaints. Staff told us they would tell the provider about any formal or informal comments or concerns straight away so patients received a quick response. Information was available about organisations patients could contact if they were not satisfied with the way the practice dealt with their concerns or should they not wish to approach the practice initially. We saw this did not include contact details for NHS England and the Dental Complaints Service.

We looked at comments, compliments and complaints the practice received within the previous 12 months. These showed the practice responded to concerns and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

Leadership responsibilities were not clearly defined. The provider was aware of issues and challenges relating to the future of the service.

The provider had considered the future leadership and management of the practice and one of the staff was currently studying for a dental practice management qualification.

Vision and strategy

The provider had a strategy for delivering care, and supporting business plans to achieve priorities. The strategy had taken account of some of the health and social priorities across the region.

Culture

The provider and staff demonstrated openness, honesty and transparency when responding to incidents and complaints. Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients should anything go wrong.

Staff said they were respected, supported and valued.

Staff told us there was an open, transparent culture in the practice. They said they were encouraged to raise issues and they were confident to do this. They told us the provider was approachable and would listen to their concerns.

The practice held regular meetings where staff could communicate information and exchange ideas. Where appropriate meetings were arranged to share urgent information.

Governance and management

The provider had ineffective systems in place at the practice to support the management and delivery of the service.

We found that the provider had insufficient systems and processes to ensure good governance in accordance with the fundamental standards of care. There was inadequate guidance for staff, for example, limited policies and procedures. Some policies and procedures were documented but these did not refer to the specific circumstances in the practice.

We saw the practice had ineffective and inadequate systems in place to monitor the quality and safety of the service and make improvements where required, including: -

- checks on the medical emergency kit had not identified that some of the recommended medical emergency equipment was not available or not working,
- there was a limited system in place for receiving and acting on patient safety alerts,
- there was an ineffective system for monitoring training, and for ensuring staff were completing the General Dental Council's, (GDC), highly recommended continuing professional development, (CPD), in disinfection and decontamination, radiography and radiation protection, where appropriate, and the GDC's recommended CPD in safeguarding vulnerable adults and children and young people, to the GDC's recommendations,
- the job roles and responsibilities of staff were unclear. Staff were unclear who the practice's lead for infection prevention and control was. Staff were not assigned responsibilities for monitoring the quality and safety of the service by carrying out checks, for example, on the expiry dates of dental materials,
- there were ineffective recruitment procedures in place. These had not identified that references, and Disclosure and Barring Service checks had not been obtained for recently employed staff prior to employing them.

The provider had ineffective systems in place to ensure risks were identified and managed, and measures put in place to reduce risks, including: -

- no assessment had been carried out in relation to staff working in a clinical environment where their Hepatitis B status was unknown,
- risk assessments were not regularly reviewed, including, the fire risk assessment and the Legionella risk assessment,
- no system was in place to identify when the testing and maintenance of equipment were due. Various items of

Are services well-led?

equipment including the X-ray machine, the medical emergency oxygen cylinder, the automated external defibrillator, and the compressor had not been tested at the recommended intervals,

- dental treatment options, associated risks and decisions taken, were not recorded in the patients' dental care records.

The provider had overall responsibility for the management and clinical leadership of the practice. One of the staff had recently started studying for a dental practice management qualification. We saw this was beginning to impact positively on governance at the practice.

The provider was not fully aware of what needed to be done to comply with the fundamental standards and took a minor role in monitoring compliance. One of the staff assisted with compliance at the practice. The provider placed significant reliance on this member of staff.

Appropriate and accurate information

Staff acted appropriately on information.

The practice had information governance arrangements in place 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 used patient surveys, and welcomed verbal comments to obtain the views of patients about the service. We saw examples of suggestions from patients which the practice had acted on, for example, patients had suggested a change to the colour of staff uniforms from white, and the provider had acted on this.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used.

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

The provider had ineffective systems and processes in place to encourage learning, continuous improvement, and innovation.

We saw the provider did not audit the practice's systems and processes, for example, infection prevention and control, and radiography, to identify where improvements could be made.

Staff told us the team was committed to learning and improving. Staff described how they were open to new ideas and learned from each other. The provider had limited means in place to keep up to date with current evidence-based practice. For example, the provider completed continuing professional development primarily by reading journals, and did not participate in peer review meetings with other dental colleagues, or attend external courses or professional meetings. The provider was not a member of the dental professional organisation.

Some of the staff had regular appraisals, which helped identify their individual learning needs. The provider had not completed a personal development plan to assist in identifying their own training needs in line with the General Dental Council's recommendations.

This section is primarily information for the provider

Enforcement actions

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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment of service users must be appropriate, meet their needs and reflect their preferences. **How the regulation was not being met** 1. The registered person made limited use of radiographs and did not take account of The Faculty of General Dental Practitioners (UK) The Royal College of Surgeons of England FGDP (UK) Good Practice Guidelines "Selection Criteria for Dental Radiography". The registered person did not take radiographs where recommended, or at the recommended time intervals, taking them mainly when patients presented with pain or for endodontic treatment. The registered person did not record the justification for taking X-rays, or the X-ray findings. 2. The registered person was not familiar with, and did not take account of the Department of Health "Delivering Better Oral Health: an evidence-based toolkit for prevention" guidance in relation to smoking. 3. The registered person did not take account of the National Institute for Health and Care Excellence guidance "Dental checks: intervals between oral health reviews" when determining the interval between patient recalls. 4. The registered person was not aware of, and did not take account of current British Society of Periodontology guidance about the diagnosis and charting of periodontal disease. The registered person did not carry out further examination, charting and treatment where screening indicated this should be done.

This section is primarily information for the provider

Enforcement actions

Regulation 9 (1)

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

1. The practice's medical emergency equipment did not include all the equipment recommended by the Resuscitation Council UK. Only one of the five recommended sizes of clear face mask for the self-inflating bag was available, and no oxygen masks with reservoir were available. The practice's defibrillator was not working; the battery had fully discharged and the pads were past their expiry date. The registered person had not carried out an assessment of the risks whilst waiting for the defibrillator to be restored to full function.

2. The registered person did not use dental dam or alternative methods to protect the patient's airway during root canal treatment in accordance with current guidance from the British Endodontic Society.

3. The registered person had not completed the General Dental Council's highly recommended radiography and radiation protection continuing professional development training within the recommended time interval.

4. The registered person did not carry out checks on the image quality of the X-rays taken, or in relation to the quality of the X-ray developing process. No radiograph film holders for use when taking X-rays were available in the practice to assist in correct positioning. Rectangular collimation was not fitted to the X-ray tube to assist in reducing radiation exposures as far as possible.

This section is primarily information for the provider

Enforcement actions

5. Several dental materials in the treatment room drawers were past their expiry dates, including a pot of topical anaesthetic dated 'exp 11/2016', a tub of Alvogyl dated 2018 08, and two tubes of Tubli-seal 'exp 10 2015'. Endamethasone, which is no longer recommended for use in a dental setting, was also present in the drawer.

7. The registered person was aware of the Department of Health publication "Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices" but did not take account of the guidance as follows:

· A Legionella risk assessment had been carried out at the practice in 2011. Actions to be completed were identified in the assessment, including monitoring of the temperature of the water from the sentinel outlets and microbiological testing of the dental unit water lines to assist in controlling the development of Legionella. One of the staff carried the water temperature checks out weekly but did not record the temperatures and was unaware of the correct guideline temperatures to be used in monitoring. The water lines of the dental unit were flushed in the morning with distilled water and in the evening with the product "Milton". No other disinfectant was used. Microbiological testing was not carried out. None of the staff had received training in Legionella awareness.

· An uncovered box containing numerous disposable "3 in 1" tips was located on top of the treatment room units, exposing them to aerosol contamination.

· Debris was observed on bagged, dated instruments, including a flat plastic instrument, a matrix band, a set of tweezers, and a pair of forceps. Staff said these instruments had been through the decontamination and sterilisation process.

· Several scaler tips and numerous dental burs were contained in uncovered racks in the treatment room drawers. Staff did not know when these had last been sterilised.

· The practice was not equipped with a magnifying inspection light for examining instruments to ensure they were clean.

This section is primarily information for the provider

Enforcement actions

· Several single-use Siqveland matrix bands were observed in their carriers. The bands were damaged and bent at the edges. Staff confirmed they had been through the decontamination and sterilisation process and were ready for re-use.

· The registered person could not confirm they had completed continuing professional development training in disinfection and decontamination as highly recommended by the General Dental Council within the recommended time period.

· Nailbrushes were located at the treatment room hand-washing sink and the hand-washing sink in the decontamination room.

· The registered person did not carry out infection prevention and control audits.

· The practice did not have detergent available for manually cleaning instruments.

· Staff did not record every sterilisation cycle and the autoclave was not fitted with a data logger or printer to do this. Test strips were only used with the first sterilisation load and not with subsequent loads. Staff did not record remedial action taken when the autoclave faulted.

· The decontamination room did not have clearly demarcated dirty and clean zones.

· The extractor fan in the decontamination room ceiling was visibly dirty.

· Dates marked on bagged sterilised instruments consisted of the day and month only.

· There was no information readily accessible and available to staff about the action to take should they sustain an injury from a used sharp.

· The practice had only one mop and bucket for cleaning the floors in the decontamination room, the toilet and the surgery.

Regulation 12 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The registered person had failed to ensure that all equipment used by the service was properly maintained.

How the regulation was not being met

1. The registered person did not know how often the recommended routine testing should be carried out on the X-ray machine. No information was available as to whether any specific recommendations had been made in relation to the safe use of the equipment in accordance with the recognised guidance, as the registered person did not have any relevant information about this and had not sought advice from the practice's Radiation Protection Adviser.

2. The registered person had not carried out appropriate maintenance or servicing of the X-ray machine or X-ray developing machine.

3. The written scheme of examination for the compressor recommended two yearly pressure vessel tests. The registered person did not know if it had been tested since 2006.

4. Staff said portable electrical appliance testing, (PAT), had last been carried out in 2016. No records of test were available to confirm this.

5. A label on the practice's medical emergency oxygen cylinder indicated it had last been maintained and serviced in 2013. Staff said it had not been serviced since. No checks were carried out on it by staff in accordance with the Resuscitation Council UK's recommendation to carry out such checks at least weekly.

6. The registered person had not carried out checks, at least weekly, on the automated external defibrillator, (AED), as recommended by the Resuscitation Council UK and was unaware the AED was not working.

Regulation 15 (1)

This section is primarily information for the provider

Enforcement actions

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

1. The registered person had limited means in place for achieving compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some policies and procedures were documented for staff to refer to but these did not refer to the specific circumstances in the practice or address how the practice would comply with the Regulations.

2. The registered person had a limited system in place for receiving and acting on patient safety alerts in that they were only aware of those forwarded by NHS England. The registered person was not aware of, and had not registered with the Medicines and Healthcare Regulatory Agency to receive safety alerts.

3. The registered person had an ineffective system for monitoring training and had limited means of ensuring staff were completing the General Dental Council's, (GDC), highly recommended continuing professional development, (CPD), in disinfection and decontamination, radiography and radiation protection, where appropriate, and the GDC's recommended CPD in safeguarding vulnerable adults, and children and young people. The registered person had no means in place for identifying their own or staff members individual training needs.

4. The job roles and responsibilities of staff were unclear. Staff were unclear who the practice's lead for infection prevention and control was. Staff were not assigned responsibilities for monitoring the quality and safety of the service by carrying out checks, including on stock dates, medical emergency equipment, and water temperature testing.

5. The registered person had ineffective recruitment procedures in place. These had not identified that

Enforcement actions

references, and Disclosure and Barring Service checks had not been obtained for recently employed staff prior to employing them. The registered person's procedures had not identified that risks were associated with staff working in a clinical environment where their Hepatitis B status was unknown.

6. The registered person had limited means in place to ensure risk assessments were regularly reviewed. The Legionella risk assessment had not been reviewed since 2011. The practice's fire risk assessment was undated. No system was in place to ensure these and others were regularly reviewed.

7. The registered person had no system to identify when checks, testing and maintenance of equipment were due. Various items of equipment including the X-ray machine, the medical emergency oxygen cylinder, the automated external defibrillator, and the compressor had not been tested at the recommended intervals.

8. The registered person did not record dental treatment options, associated risks and decisions taken, in the patients' dental care records.

Regulation 17 (1)