Mr Gehad Philobbos

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Inspection Report

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Date of inspection visit: 29 August 2018
Date of publication: 24/10/2018

Overall summary

We carried out this announced inspection on 29 August 2018 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 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

Mr Gehad Philobbos is in Oldham and provides NHS treatment to adults and children.

There are two steps leading to the entrance of the premises. On street parking is available near the practice.

The dental team includes one dentist and two trainee dental nurses who also carry out reception duties. At the time of the inspection, the trainee dental nurses were on leave and temporary staff had been employed to ensure the continuation of services. The practice has one treatment room.

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.

Summary of findings

On the day of inspection, we collected 16 CQC comment cards filled in by patients and spoke with one other patient. Patients were positive about the service.

During the inspection we spoke with the dentist and a temporary staff member. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open two days a week:

Tuesdays and Thursdays 9.30am to 12.45pm and 2pm to 5.30pm

Our key findings were:

- Areas of the practice appeared unclean.
- Infection control procedures were inconsistent and did not reflect published guidance.
- Improvements were needed to the life-saving equipment available. Support staff did not have training or know how to deal with emergencies effectively.
- The practice did not have effective systems to help them manage risk to patients and staff.
- The practice did not have suitable safeguarding processes. Staff did not demonstrate they knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had, but did not follow staff recruitment procedures.
- Patient care and treatment was not consistently provided in line with current guidelines.
- Staff treated patients with dignity and respect. Improvements were required to protect their privacy and personal information.
- The provider was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- The practice did not have effective leadership. There was no evidence of continuous improvement.
- The practice asked patients for feedback about the services they provided.
- The provider had systems to deal with complaints.

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

Full details of the regulations the provider 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 protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services safe?

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

The practice had a recruitment policy and procedure to help them employ suitable staff. This had not been followed. There were no staff recruitment records for the two employed members of staff, or temporary staff. There was no evidence the practice had carried out essential checks.

The practice did not have clear systems to keep patients safe. Staff did not understand their responsibilities if they had concerns about the safety of children, young people and adults. Permanent and temporary staff had not received safeguarding training.

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. They did not meet current radiation regulations and had only generic information in the radiation protection file.

There were inadequate systems to assess, monitor and manage risks to patient safety. In particular, sharps, clinical waste disposal and legionella. Immediate action was required in relation to the lack of fire and health and safety policies, procedures, risk assessments and responsibilities to assess and act on safety concerns, and the lack of processes to assess the risks of hazardous substances.

The arrangements for environmental cleaning, and transporting, cleaning, checking and sterilising instruments were inconsistent and not in line with guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

There was no system to enable staff to record incidents or to receive and act on patient safety alerts.

The arrangements for dealing with medical and other emergencies required improvement.

Enforcement action

Are services effective?

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 practice did not have systems to keep up to date with all relevant current evidence-based practice. The dentist discussed and encouraged patients to reduce or stop smoking and alcohol consumption. A wide range of oral health information posters and leaflets were available in the waiting room to help patients with their oral health.

Enforcement action

Summary of findings

Patients said they were made to feel comfortable when receiving treatment. The dentist discussed treatment with patients so they could give informed consent. Information about treatment options and the risks and benefits of these were not documented in dental care records.

The provider had a basic understanding of the Mental Capacity Act 2005. They did not have a system to identify if a carer or family member was legally able to consent to treatment on the patient's behalf. They were not familiar with Gillick competence.

The practice had arrangements when patients needed to be referred to other dental or health care professionals. They did not monitor urgent referrals to make sure they were dealt with promptly.

The practice could not demonstrate that support staff in place at the time of the inspection had the skills, knowledge and experience to carry out their roles. For example, the temporary staff member was not up to date with knowledge or training in safeguarding, medical emergencies and infection prevention and control.

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 16 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, helpful and caring.

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

Staff showed some awareness of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. Paper records were stored in an unsecured room which was accessible to patients.

Patients said staff treated them with dignity and respect.

The provider had installed a closed-circuit television system (CCTV), internally in the reception and waiting room area. This recorded images and sound and could be played on the provider's mobile phone. Signs were not displayed to advise people they were being recorded, or advise them of their right of access to footage which contains their images.

Are services responsive to people's needs?

No action ✓

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

Summary of findings

The practice's appointment system was efficient and met patients' needs. Patients could choose to receive text message reminders for upcoming appointments.

The opening hours displayed in their information leaflet and the NHS Choices website were incorrect. The provider told us that staff were always available on weekday mornings to answer the telephone and make appointments.

The practice was open two days a week. Patients could get an appointment quickly if in pain. On days when the dentist was not working, arrangements were in place for patients to receive care at a nearby dental practice.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice did not have, but was aware of the availability of interpreter services and had arrangements to help patients with sight or hearing loss.

The practice had a policy to respond to concerns and complaints quickly and constructively.

Are services well-led?

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

On the day of the inspection, the provider was open to discussion and feedback to improve the practice. They were honest and frank about systems and records that were lacking, or where they did not know the whereabouts of policies and documents we requested to see. They demonstrated a very caring attitude for patients, many of whom they had treated for many years, and had acted with good intentions to obtain temporary staff to ensure that patients could continue to receive care, but had not understood the risks relating to this.

The provider did not demonstrate that they had the experience, capacity and skills to deliver high-quality, sustainable care and address risks to it. They demonstrated a lack of awareness of the need to review the systems to ensure that standards and procedures were in place or whether staff were up to date with, and following correct processes.

There was a lack of clearly defined responsibilities, roles and systems of accountability to support good governance and management.

There were ineffective systems to identify and mitigate risk in relation to infection prevention and control, fire safety, health and safety including the control of hazardous substances, patient safety alerts, waste management, safeguarding and radiological safety.

The provider had acted with good intentions to obtain temporary staff to ensure that patients could continue to receive care. There was no evidence that they had assessed the suitability of, or carried out essential checks of self-employed temporary and locum staff.

Enforcement action

Summary of findings

The practice did not have effective information governance arrangements. There were no control measures in place to restrict patients from entering the areas on the first floor where equipment, clinical waste and confidential records were stored. There were data protection and confidentiality concerns due to the surveillance system in operation which we shared with the Information Commissioner's Office.

Learning and continuous improvement was not evident. The practice did not have any quality assurance processes in place. For example, no audits of X-rays, dental care records or infection prevention and control were carried out. We were told that audits had never been carried out and they did not understand the need to do so.

The provider did not ensure that staff were registered with, or completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking decontamination and safeguarding training. They had not reviewed whether self-employed locum and temporary staff were up to date with training and competence.

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, Equipment & premises and Radiography (X-rays)

The practice did not have clear systems to keep patients safe.

Staff did not understand their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The information in the practice safeguarding policies was out of date. Local reporting procedures had been obtained just before the inspection to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that the dentist had attended training but it was not clear to what level. Permanent and temporary staff had not received safeguarding training. Staff could not demonstrate that they could raise or report safeguarding concerns appropriately.

The practice had a whistleblowing policy to raise concerns to the provider. This did not include information about other organisations that concerns could be raised with. The staff member working on the inspection day was not aware of the availability of a process to raise concerns.

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

The practice had a recruitment policy and procedure to help them employ suitable staff. This had not been followed. There were no staff recruitment records for the two employed members of staff, or temporary staff. There was no evidence the provider had requested that staff provide photo ID, evidence of qualifications, General Dental Council registration, indemnity, previous employment history or references. The provider showed us a Disclosure and Barring Service (DBS) check on one member of staff. At the time of the inspection, both members of employed staff were not available. The provider had directly employed temporary members of staff to provide chairside support to ensure that patients could continue to access services. No checks had been carried out to assess the suitability or competence of these individuals.

The temporary staff member providing chairside support on the day of the inspection was qualified but not registered with the General Dental Council (GDC). The dentist had appropriate professional indemnity cover, but was unaware if dental nurses working at the practice had indemnity in place. The dentist contacted their indemnity provider during the inspection who confirmed that dental nurses working at the practice were covered by the policy.

The practice did not ensure that all facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. An external company had carried out a fire risk assessment two weeks before the inspection. The report highlighted areas of high risk and immediate action was required in relation to the lack of fire safety policy, records or systems to ensure smoke alarms were working. Insufficient fire safety management systems were in place to protect patients and staff in the event of a fire. There were two smoke alarms located at the top and the bottom of the staircase. The smoke alarm on the first floor had been removed two weeks prior to the inspection to replace the battery, this had not been replaced. There was no provision for emergency lighting and combustible materials were stored in large quantities in areas with no fire safety measures in place. There were two small fire extinguishers located on the ground floor. These were regularly serviced, but insufficient for the size and layout of the premises as there was no provision for the first floor.

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. They did not meet current radiation regulations and had only generic information in the radiation protection file. The provider had access to a Radiation Protection Adviser. The provider had not registered their practice's use of dental X-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17) and was unaware of the requirement to do so. We asked to see evidence that the X-ray equipment, installed in 1984, was serviced. There were no records of the installation and critical examination, or routine testing to show when the last service took place. The provider contacted the servicing company who confirmed the last routine test was carried out in 2013. Routine tests should be carried out on a three-yearly basis.

Are services safe?

The provider rarely took X-rays. They reported on the findings of X-rays but did not record a justification for, or grade the image quality of radiographs. They told us if the quality of the X-ray was poor, they would throw it away and may not repeat it.

No radiography audits were carried out. This was not in line with current guidance and legislation.

The dentist had completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

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

The practice's health and safety policies and procedures were not up to date and provided insufficient information to staff. An external company had carried out a full premises health and safety risk assessment two weeks before the inspection. The report highlighted areas of high risk and immediate action was required in relation to the lack of health and safety policies, procedures, risk assessments and responsibilities to assess and act on safety concerns, and the lack of processes to assess the risks of substances hazardous to health in accordance with Control of Substances Hazardous to Health (COSHH) regulations.

Safety data sheets were only available for five domestic cleaning products. Safety data sheets and risk assessments were not in place for any other hazardous substances in use, particularly in relation to bottled mercury, surface disinfection products and instrument cleaning detergent.

We saw that manufacturer's instructions were not followed in relation to instrument cleaning detergent, and surface disinfectant was in an unmarked spray bottle with no instructions for use or contact time. Bottled mercury was still in use and available, although we were told dental amalgam was rarely used.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff did not consistently follow relevant safety regulation when using needles and other sharp dental items. Staff gave conflicting information about who was permitted to handle needles. A sharps risk assessment had not been undertaken.

We observed staff did not wear personal protective equipment including, heavy duty gloves when handling contaminated instruments during the decontamination process. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were clear about the importance of, and process to report inoculation injuries.

The provider did not have an effective 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. Of the employed staff, one had provided evidence of immunity and one was in the process of receiving the vaccinations. There was no risk assessment in place for unknown responders, or evidence that the provider had asked for proof that temporary staff providing chairside support had immunity.

Staff did not demonstrate that they knew how to respond to a medical emergency. The dentist and employed staff had completed training in emergency resuscitation and basic life support (BLS) every year. The provider had not ensured that two trained members of staff were on the premises in line with GDC standards. Arrangements for providing emergency life support had not been effectively discussed with temporary staff. For example, the temporary staff member providing chairside support knew the location of the medical emergency kit but was not familiar with how to operate the emergency medical oxygen or knew the location of needles for the syringes required to administer emergency medicines.

Emergency medicines were available as described in recognised guidance. Improvements were required to the equipment available. For example, the automated external defibrillator pads had expired in 2012, no oropharyngeal airways and no child sized self-inflating oxygen bag and mask were available. Weekly checks of the medical emergency equipment and medicines had been carried out until April 2018. After this time the provider told us they carried out visual checks. These had failed to identify the missing and expired items.

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

At the time of the inspection, the practice was directly employing the services of a temporary assistant and agency staff. They had shadowed other staff members,

were informed of the location of the medical emergency kit, shown decontamination processes and read the practice statement. There was no evidence the provider ensured these staff received an appropriate induction to ensure that they were familiar with the practice's procedures. One of these staff members had not worked in dentistry for over 10 years. There was no evidence that the provider had reviewed whether they were up to date with current standards of practise and no CPD evidence was available.

The practice had an infection prevention and control policy, dated 2007, containing brief and incorrect information. For example, that gloves could be washed. The provider had obtained up to date guidance, namely The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care, immediately before the inspection. Staff were unfamiliar with the guidance. Training records for the dentist showed they had attended infection prevention and control training in 2016. There was no evidence they had used this to review the standards in place at the practice.

The arrangements for transporting, cleaning, checking and sterilising instruments were inconsistent and not in line with accepted guidance HTM 01-05. The dentist told us they sometimes carried out decontamination of instruments when support staff were not able to do this. We asked both members of staff carrying out these procedures to demonstrate the process.

- The dentist was aware of the availability of, and recommendation to wear heavy duty gloves for manual cleaning but chose not to wear these. The supporting member of staff was not aware what the heavy-duty gloves were for. We also noted the supporting member of staff wore rings, a bracelet and a watch, and was not bare below the elbow whilst assisting at the chairside or during decontamination processes.
- The dentist used a capful of detergent to clean dental instruments, they did not know if this was the correct amount to use. The supporting member of staff cleaned instruments in running water only.
- Instruments were transported to the decontamination area on open trays or a small container containing cleaning solution.
- The dentist and the supporting member of staff did not rinse instruments. When prompted by the inspector, the dentist rinsed instruments over the hand wash only sink whilst agitating them with their hands. This could pose an avoidable sharps risk.
- The dentist and the supporting member of staff were not aware of the need to inspect instruments prior to sterilisation. A handheld illuminated magnification device was available but the device was dirty and the light did not work. Only when prompted by the inspector, the dentist looked at the cleanliness of the instruments.
- Staff sealed dental handpieces in pouches prior to sterilisation. They were not aware that the device in use is for unwrapped instruments only. This is due to the equipment's inability to ensure steam penetrates wrapped or pouched instruments effectively. The dentist placed handpieces in a clean dry pouch after sterilisation.

The steriliser was fitted with a printer. Evidence of satisfactory sterilisation cycles were retained. The records showed staff carried out automatic control tests on the steriliser. An ultrasonic cleaner was sometimes used to clean instruments. The provider was not aware of the need to carry out validation processes, namely foil and protein residue tests to ensure the efficacy of the device and solution used in line with HTM 01-05. We saw evidence the steriliser was maintained and serviced in line with the manufacturers' guidance.

Staff disinfected dental laboratory work prior to being sent to a dental laboratory, but not before the returned item was fitted in a patient's mouth. It was not clear whether this was carried out by the dental laboratory.

The practice did not have effective procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. An external company had carried out a Legionella risk assessment two weeks before the inspection. The report highlighted the lack of managerial oversight of Legionella control and policies. A system had previously been in place to carry out monthly water temperature testing for the cold water, this ceased in February 2018. No systems were in place to monitor hot water temperatures.

There were no processes in place to ensure the management of the dental unit water line (DUWL). We were told that tap water was used in the DUWL and there were

Are services safe?

no systems to ensure that dental unit water lines were flushed appropriately or measures were in place to ensure the quality of the water was in line with potable water standards. We noted at the end of the day, the water bottle was left upturned in a dirty sink. This was not in line with the Approved Code of Practice and guidance L8, Legionnaires' disease (The control of Legionella bacteria in water systems).

Environmental cleaning of the practice was not carried out in line with recommended guidance HTM 01-05. We were told that staff cleaned the practice and clinical areas. There was no cleaning schedule in place and we found only two mops stored in buckets, one red and one grey with red tape on. There was no system to identify which mop should be used for cleaning the toilet area and not also used for the treatment room and decontamination room floors. The system was not operating effectively and cleaning standards were not monitored. We noted some surfaces appeared dirty, namely a sink in the dental surgery, the carpet to the first floor and the handrail on the stairway. Patients commented that the practice was usually clean.

The practice did not have policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance, however we saw that waste was segregated appropriately in the treatment room and decontamination area. Waste was stored on the first floor in unsecured rooms which could be accessed by patients. We were told that some waste, including amalgam sludge and used X-ray chemicals were collected upon request. We asked to see evidence of waste transfer notes which are required to be retained by the producer of waste in line with Management and Disposal of Healthcare waste (HTM 07-01). The provider was not able to provide waste transfer notes and was not aware where these might be kept.

The practice did not carry out infection prevention and control audits. The provider told us they did not need to do this as staff were qualified and knew all the processes. Opportunities to identify the issues highlighted during the inspection were missed as a result.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were legible. We saw that some dental care records were stored in an unsecured room on the first floor that was accessible to patients. The provider was not aware of the General Data Protection Regulation (GDPR) or its requirements.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. Improvements were needed to the security of prescription pads.

The practice did not store and kept records of NHS prescriptions as described in current guidance. They were unsecured and un-vetted staff had access to these. Prescription numbers were logged as they were issued to patients but there was no system to identify if any individual prescriptions were missing.

The provider was not aware of, or following nationally recognised Faculty of General Dental Practitioners standards for antimicrobial prescribing.

Track record on safety

There was no system to enable staff to record incidents. The provider thought there may be an accident book but did not know where it was. We were told there had never been any incidents or accidents.

Lessons learned and improvements

A system was not in place to receive and act on safety alerts. The provider thought they were signed up to receive these by email. We saw the most recent alert was received in March 2017. The provider signed up to MHRA on the day of the inspection to ensure alerts were received.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice did not have systems to keep up to date with all relevant current evidence-based practice. The dentist was aware of and followed National Institute for Health and Care Excellence (NICE) guidance in relation to the frequency of recalls and referrals for wisdom tooth extraction. We discussed how the dentist used radiographs as part of the assessment process. The provider was not aware of accepted guidance from the Faculty of General Dental Practice (UK) for the frequency of radiographs. They told us they rarely took X-rays as they knew their patients and their needs well. When X-rays were taken, they did not document a justification for taking them. Basic Periodontal Examinations (BPE) were carried out inconsistently. The BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need. The dentist confirmed they did not carry out six-point pocket charting as indicated in national guidance.

Helping patients to live healthier lives

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

The dentist did not prescribe high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay.

The dentist discussed and encouraged patients to reduce or stop smoking and reduce alcohol consumption. The practice had a selection of dental products for sale. A wide range of oral health information posters and leaflets were available in the waiting room to help patients and inform parents of the importance of maintaining oral health.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice and providing disclosing tablets to help patients to improve their toothbrushing technique.

They told us how they admonished parents if their child presented with dental decay.

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

Consent to care and treatment

The systems to record consent to care and treatment required improvement.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist gave patients information about treatment options and the risks and benefits of these so they could make informed decisions but this was not documented in dental care records. Patients comments confirmed the dentist listened to them and gave them clear information about their treatment.

The dentist had a limited understanding of the Mental Capacity Act 2005 when treating adults who may not be able to make informed decisions. The dentist described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly. They did not have a system to identify if a carer or family member was legally able to consent to treatment on the patient's behalf. They were not familiar with Gillick competence, by which a child under the age of 16 years of age can give consent for themselves. Staff were not aware of the need to consider this when treating young people under 16 years of age.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The practice did not audit patients' dental care records to check that the necessary information was recorded.

Effective staffing

The practice could not demonstrate that support staff in place at the time of the inspection had the skills, knowledge and experience to carry out their roles. For example, the temporary staff member was not up to date with knowledge or training in safeguarding, medical emergencies and infection prevention and control. The provider told us there was no need to check as they were qualified.

The temporary staff member described how they had been shown round the practice and told of the location of the

Are services effective?

(for example, treatment is effective)

medical emergency equipment and shadowed another member of staff. There was no evidence of an appropriate induction or structured approach to assessing staff competence. There was no evidence that staff other than the dentist completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

The dentist 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 obtained a unique reference number for each referral which was also provided to the patient.

The practice did not have a system to identify, manage, follow up and where required refer patients for specialist care when presenting with significant bacterial infections (sepsis). If patients felt unwell they would not come into the practice when showing signs of sepsis.

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

The practice did not monitor urgent referrals to make sure they were dealt with promptly. Patients were issued with an urgent letter and to let the practice know if they had not heard from the hospital.

Are services caring?

Our findings

Kindness, respect and compassion

We saw that staff treated patients with kindness, respect and compassion and that patients appreciated the care that they received.

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

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

Patients said staff were compassionate and understanding and helpful when they were in pain, distress or discomfort.

Practice information and thank you cards were available for patients to read.

Privacy and dignity

Staff showed some awareness of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. We noted that the surgery door was left open when patients were treated. 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 in an unsecured room which was accessible to patients.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the requirements of the Accessible Information Standards to establish and meet patients' communication needs and the requirements under the Equality Act.

- The practice did not use, but were aware of the availability of local interpretation services for patients who did not have English as a first language. Patients were also told about multi-lingual staff that might be able to support them.
- 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 about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. These were not recorded in the dental care records.

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

The provider had installed a closed-circuit television system (CCTV), internally in the reception and waiting room area. This recorded images and sound, and the provider could view and listen to real time activity in this area on their mobile phone. Signs were not displayed to advise people they were being recorded, or advise them of their right of access to footage which contains their images. The Information Commissioners Office (ICO), had not been informed of the use of CCTV. We referred the provider to the ICO for the use of covert surveillance.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was open two days a week. It took account of patient needs and preferences.

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

The practice had made some reasonable adjustments for patients with disabilities. These included a hearing loop, hand rails and a call bell in the toilet, which had a sign on the door in braille.

A Disability Access audit had recently been completed and made additional recommendations, including the provision of a portable ramp to improve access for patients.

Timely access to services

Patients commented they could access care and treatment from the practice within an acceptable timescale for their needs. Patients could choose to receive text message reminders for upcoming appointments.

The opening hours displayed in their information leaflet and on the NHS Choices website were incorrect. Staff were always available on weekday mornings to answer the telephone and make appointments.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent advice or care were offered an appointment the same day on Tuesdays and Thursdays. On days when the dentist was not working, arrangements were in place for patients to receive care at a nearby dental practice. Patients said they had enough time during their appointment and did not feel rushed.

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

Listening and learning from concerns and complaints

The practice had a policy providing guidance to staff on how to handle a complaint. This was displayed behind the reception desk in the waiting room. The practice information leaflet explained how to make a complaint.

The dentist was responsible for dealing with these. Staff would tell them about any formal or informal comments or concerns straight away so patients would receive a quick response.

The dentist had never received any complaints. Information was not available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

Are services well-led?

Our findings

Leadership capacity and capability

The provider did not demonstrate that they had the experience, capacity and skills to deliver high-quality, sustainable care and address associated risks.

They lacked knowledge about issues and priorities relating to the quality and delivery of services. We discussed the need for them to understand the challenges, take responsibility for, and put resources in place to address them.

Systems were not in place to ensure compliance with the Health and Social Care Regulations. The practice did not have effective processes to develop leadership capacity and skills.

Governance and management

There was a lack of clearly defined 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. They demonstrated a lack of awareness of the need to review the systems to ensure that standards and procedures were in place or whether staff were up to date with, and following correct processes.

The practice had minimal governance arrangements in place. Upon announcing the inspection, the provider told us they were not aware of the location of the policy file. Of the policies and risk assessments we looked at, most had never been reviewed, or the policy had been signed to state it had been reviewed without ensuring the information within the policy was updated where necessary.

There was no evidence staff had read and understood the polices. Policies were outdated and contained minimal information that was not up to date. This was most apparent in relation to whistleblowing, infection prevention and control, safeguarding adults and children, confidentiality,

data security, resuscitation equipment, waste disposal and staff recruitment.

There were ineffective systems to identify and mitigate risk in relation to infection prevention and control, fire safety, health and safety including the control of hazardous substances, patient safety alerts, waste management, safeguarding and radiological safety. The practice had engaged the service of an external company to carry out practice risk assessments two weeks before this inspection in relation to fire safety, health and safety, legionella and disability access. The reports from these highlighted the lack of management systems, policies, procedures and safety measures. The provider was unaware of a clause in their public liability insurance contract that required them to carry out five yearly electrical installation safety checks.

A recruitment policy was in place but had not been followed. The provider did not ensure that recruitment checks were carried out as specified in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Schedule 3). There was no evidence that they had assessed the suitability of, or carried out essential checks of self-employed temporary and locum staff. A system was not in place to ensure that self-employed locum and temporary staff were fit and proper persons to employ.

Appropriate and accurate information

The practice did not have effective information governance arrangements. There were no control measures in place to restrict patients from entering the areas on the first floor where equipment, clinical waste and confidential records were stored. There were data protection and confidentiality concerns due to the covert surveillance in operation.

Engagement with patients, the public, staff and external partners

On the day of the inspection, the provider was open to discussion and feedback to improve the practice. They were honest and open about systems and records that were lacking, or where they did not know the whereabouts of policies and documents we requested to see. They demonstrated a very caring attitude for patients, many of whom they had treated for many years, and had acted with good intentions to obtain temporary staff to ensure that patients could continue to receive care, but had not understand the risks relating to this.

The practice had a suggestion box and obtained verbal comments to obtain staff and patients' views about the service.

Are services well-led?

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

Continuous improvement and innovation

Learning and continuous improvement was not evident. The practice did not have any quality assurance processes in place. For example, no audits of X-rays, dental care records or infection prevention and control were carried out. We were told that audits had never been carried out and they did not understand the need to do so as they were a single-handed provider and staff were qualified.

The provider did not ensure that staff were registered with, or completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking decontamination and safeguarding training. They had not reviewed whether self-employed locum and temporary staff were up to date with training and competence.

We saw evidence that the dentist completed Continuing Professional Development (CPD) required by The General Dental Council. There was no evidence that attendance at CPD events had led to a review and improvement of the systems in place at the practice.