Dr. Kiran Hanji

Hanji Dental Group - 106 Northampton Road

Inspection Report

106 Northampton Road,
Market Harborough,
Leicestershire,
LE16 9HF
Tel:01858 419600
Website:

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Overall summary

We carried out an unannounced comprehensive inspection on 27 February 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Background

Hanji Dental Group (Market Harborough Dental Practice) is a dental practice providing primarily NHS with some private care for adults and children. Where private treatment is provided this is on a fee per item basis. The practice is situated in a converted property on three levels and has four dental treatment rooms; two on the ground floor and two on the first floor. There is also an X-ray room and a reception and waiting area on the ground floor and a waiting room on the first floor. There were also other rooms used by the practice for office facilities and storage, some of which were on the second floor.

The practice is open from 8.30am to 6.00pm on Mondays and Wednesdays, from 8.30 to 5.00pm on Tuesday and Thursdays, from 8.30 to 1.00pm on Fridays and 8.30am to 2.00pm on Saturdays. The practice closes for lunch from 1.00pm to 2.00pm on Monday to Thursday.

The practice has three full time associate dentists and a part time orthodontist who was available every other Monday. They are supported by three dental nurses, three trainee dental nurses, three part time dental hygienists, three receptionists and a practice manager who was present on one or two occasions per week.

Summary of findings

The practice are able to provide general dental services including endodontic (root canal) treatment, orthodontic treatment and some cosmetic dentistry.

The practice owner is registered with the Care Quality Commission as an individual. At the time of our inspection the practice manager had submitted an application to become the registered manager. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

We spoke with three patients on the day of our inspection. All feedback was positive with patients commenting favourably on the quality of care and service they received and the helpful nature of staff.

Our key findings were:

- There was not an effective system for reporting incidents as staff were not aware of how to report an incident and there were no mechanisms for investigation, discussion and learning in order to improve safety.
- The system to manage safety alerts was not effective.
- The practice was visibly clean but we found that not all infection control procedures were in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health.
- The practice had medicines and some equipment for use in a medical emergency which were in accordance with national guidelines. However there was no automated external defibrillator, airways or portable suction available. Glucagon was not stored in a temperature monitored fridge or in the drugs kit with an appopriately reduced expiry date. The medicines were stored inappropriately on the second floor away from clinical areas and other medicines, for example antibiotics, were not stored securely.
- During our inspection we were unable to ascertain if there were sufficient numbers of suitably qualified staff working at the practice to meet patients' needs as a full staff list was not available, some staff files were not present and there was limited evidence relating to training and continued professional development (CPD). Staff appraisals had not been completed.
- The practice had suitable facilities. However evidence was not available to demonstrate that all equipment had been appropriately maintained.
- Not all risks had been assessed and where they had been not all identified actions had been implemented.
- Patients commented that they were pleased with the care they received and that staff were helpful, kind and caring.

We identified regulations that were not being met and the provider must:

- Ensure care and treatment is provided in a safe way for patients in accordance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, this includes processes and procedures related to infection control, legionella, the management of substances hazardous to health, availability and storage of medicines and emergency equipment, the safe use of X-ray equipment and assurance that staff are appropriately qualified.
- Ensure systems and processes are operated effectively to assess and monitor the service and risks in accordance with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, this includes; the management of significant events, patient safety alerts assessing and mitigating all risks, having an effective audit system, security of prescriptions and patient records, and ensuring dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice and the National Institute for Health and Clinical Excellence.
- Ensure staff are suitably qualified, competent, and skilled and receive support, training, supervision and appraisal.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.

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 that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action.

The practice did not have an effective system in place to identify, investigate and learn from significant events.

On the day of our inspection the provider was unable to confirm there were sufficient numbers of suitably qualified staff working at the practice to meet patients' needs as a full staff list was not available and some staff files were not present.

Records were not available to demonstrate that all staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Infection control procedures were not always in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health.

The practice had medicines and some equipment for use in a medical emergency which were in accordance with national guidelines. However there was no automated external defibrillator, or immediate access to one, no airways or portable suction available. Glucagon was not stored in a temperature monitored fridge or appropriately elsewhere. The emergency medicines were not stored in a readily accessible location and other medicines such as antibiotics were not stored securely.

Not all risks had been assessed and where they had been not all identified actions had been implemented.

Use of X-rays on the premises was not in line with the Regulations. Equipment had not been appropriately maintained as annual mechanical and electrical tests had not been carried out.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. Not all clinicians were aware of or used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

Staff demonstrated a commitment to oral health promotion.

Summary of findings

There was a lack of evidence to demonstrate that staff received on-going professional training and development appropriate to their roles and learning needs.

Clinical staff were registered with the General Dental Council (GDC).

The practice had a process in place to make referrals to other dental professionals when appropriate to do so.

Are services caring?

No action

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

We received feedback from three patients and these provided a positive view of the service the practice provided. Comments reflected that patients were satisfied with the care they received and commented on the helpful nature of the staff. Patients told us treatment options were explained to them and they were involved in decisions about their treatment.

We observed that patients were treated with dignity and respect.

We found that confidentiality of patients' private information was not always maintained.

Are services responsive to people's needs?

No action

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

Routine dental appointments were available, as were urgent on the day appointments.

The practice was in a converted building and the patient services which were on the ground floor of the building were wheelchair accessible.

Information about how to complain was available to patients and complaints were responded to appropriately.

The practice did not have access to telephone interpreter services should they be required for patients who did not speak English.

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.

Feedback was obtained from patients and discussed and acted upon to make changes to the service provided if appropriate.

We found that not all systems and processes within the practice were operated effectively. Some governance arrangements were in place but many areas identified during our inspection indicated a lack of oversight and effective leadership. There were some policies and protocols available but some were undated and not practice specific. Recruitment processes, the clinical audit system

Summary of findings

and the system for acting upon national patient safety alerts were not effective. Patient records and prescriptions were not kept securely and dental care records were not always maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice and the National Institute for Health and Clinical Excellence.

Not all risks had been assessed and where they had been not all identified actions had been implemented.

Hanji Dental Group - 106 Northampton Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out in response to concerns raised and to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an unannounced, comprehensive inspection on 27 February 2017. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We reviewed information we held about the practice prior to our inspection.

During the inspection we spoke with the practice manager, two dentists, dental nurses and receptionists.

To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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 therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents
The practice had limited systems and processes to report, investigate and learn from significant events and near misses. We were shown an undated significant events policy and there were no records of any reported significant events available. The practice manager told us there had been no significant events reported since they took up post in June 2016. Staff we spoke with were not aware of what a significant event was or the process to report one.

An accident book was available for staff to report accidents and we saw that needle stick injuries had been recorded adequately and included referral to occupational health. However these had not been recorded as significant events and no consideration given to any learning from the incidents to avoid a reoccurrence. We saw there was a policy relating to Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) with related guidance for staff.

There was not an effective system to deal with safety alerts. The practice manager had some awareness of national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. They told us alerts were dealt with by the provider but were unable to show us evidence of any alerts received or actions taken in respect of any safety alerts.

Reliable safety systems and processes (including safeguarding)
The practice had policies dated November 2015 in place for safeguarding children and vulnerable adults. The practice manager told us they were the safeguarding lead for the practice but there was no lead identified within the policy. There were contact details available in the reception area for the relevant local agencies in order to raise a concern. We were told that all staff had received safeguarding training to the appropriate level for their role. However evidence of this was not available for all staff on the day of our inspection.

The practice had an up to date employers' liability insurance certificate which was displayed in the reception area. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969. This was due for renewal in February 2018.

We spoke with two of the dentists regarding the use of rubber dams when providing root canal treatment to patients. One of the dentists told us there were no rubber dams available in the practice and never used them while another dentist told us that they used them whenever possible. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided in accordance with guidance from the British Endodontic Society.

We spoke with staff about the procedures to reduce the risk of sharps injury in the practice. The practice had a comprehensive needle stick injury protocol available in the infection control file.

We found that the practice were using conventional sharps and there was no risk assessment available relating to this or any evidence of moving towards using 'safer sharps' in line with the requirements of the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation. Following the inspection we were sent a risk assessment relating to sharps which was dated December 2016 which did not refer to the 2013 regulation or assess any risks within the practice.

Medical emergencies
The dental practice had medicines and equipment in place to manage medical emergencies. Staff were aware of their location and how to access them. However we found that they were sited in an office on the third floor which meant if they were required on the ground floor there could be a delay in them being available for use. We also found that other medicines such as antibiotics, were not stored securely. Emergency medicines were available in line with the recommendations of the British National Formulary. However we found that the Glucagon which the practice held for emergencies was being stored in the refrigerator. Glucagon is a hormone which helps to raise blood glucose levels. A glucagon injection kit is used to treat episodes of severe hypoglycemia, where a patient is either unable to treat themselves or treatment by mouth has not been successful.The temperature of the refrigerator was not being monitored to ensure a temperature of 2-8o (which is necessary for the Gucagon to remain effective) was being

maintained. Additionally the refrigerator was also being used for food storage which was not in line with national guidance. Glucagon can be stored outside of a refrigerator but with a shortened expiry date of 18 months.

Some equipment available for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK. However we found that there were no airways or portable suction available. Neither was there an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. This equipment forms part of the suggested minimum requirements in the recommendations of the Resuscitation Council UK. The GDC standards for the dental team which came into effect in September 2013 state that these must be followed by dental professionals. In the absence of an AED there was no risk assessment in place to indicate how one could be accessed in a timely manner.

There was a first aid kit available which was in date. We did not see any evidence of there being trained first aiders in the practice.

There was a system in place to ensure that all medicines and equipment were checked on a regular basis to confirm they were in date and safe to use should they be required. Records we saw showed that the emergency medicines and equipment were checked on a weekly basis and the oxygen on a daily basis. These checks ensured the oxygen cylinder was sufficiently full and the emergency medicines were in date.

We were told that staff based at the practice had completed practical training in emergency resuscitation and basic life support in July 2016. However certificates were not available for all staff. There were no arrangements to carry out ongoing training in emergency scenario simulations between the annual training.

Staff recruitment

The practice had an undated recruitment policy. We reviewed four recruitment files. Files were not available for all staff including one of the dentists and we could therefore not be assured that appropriate recruitment checks such as qualifications, photographic proof of identification and registration with the appropriate professional body had been undertaken. There was evidence of checks on some staff through the Disclosure and Barring Service (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We were told that some DBS checks had been applied for.

Monitoring health & safety and responding to risks

The practice did not have effective systems to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had carried out a health and safety risk assessment in January 2017. This included risk assessments for the autoclave, biological agents, sharps, clinical waste disposal, radiation and environmental hazards. However the control measures which were stated as being in place were not accurate. For example the risk assessment relating to radiation stated that X-ray equipment was regularly checked and maintained in line with manufacturer's advice but there were no record of annual checks having taken place. It also stated that those taking X-rays had received appropriate training but this was not evidenced.

A fire risk assessment had been carried out in July 2016 by an external contractor. The risk assessment had identified actions required. It was not clear which of the actions had been completed although the practice manager told us that some remedial building works had been carried out in response to the report. One of the requirements was for an Electrical Installation Condition Report which is a report on the condition of electrical wiring with an overall assessment of the safety of the wiring and is required to be undertaken every five years. We were shown an EICR dated 2012 but this had indicated that the findings were unsatisfactory. The practice manager told us that a further EICR had been carried out but was unable to produce this on the day of our inspection.

We were told that all staff had received fire safety training in July 2016 and we saw some certificates relating to this but they were not available for all staff. We asked to see evidence that fire drills had taken place but there was none available. We saw evidence that staff carried out checks of the fire alarm and emergency lighting on a monthly basis, however national guidance states that the fire alarm should be checked on a weekly basis. There was no record of any periodic visual checks of the fire extinguishers. We saw that firefighting equipment and the fire alarm had been regularly maintained by an external contractor, the last time being in July 2016.

Are services safe?

There were some arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information relating to cleaning products used in the practice but the practice manager told us the full COSHH file, containing risk assessments and safety data sheets relating to all products used in the practice was not available as it was at their head office. This meant that in the meantime if there was an incident with a product in the practice, the relevant guidance which detailed actions required to minimise risk to patients, staff and visitors would not be available for staff.

We were shown a business continuity plan relating to the actions to be taken in the event of major incidents such as fire, loss of computer system or power failure. This was not yet complete as the practice manager told us they were in the process of updating it. They told us a copy of the plan would be kept away from the practice by key members of staff.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We discussed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures. We found that there were many areas where they were not complying with HTM01-05.

The practice had an infection control folder which was available in the staffroom for staff to refer to. This gave guidance on areas which included the decontamination of instruments and equipment, spillage procedures, waste disposal and environmental cleaning of the premises.

The practice did not have an annual infection prevention control statement in line with the Department of Health code of practice and the practice manager was not aware of the requirement for this.

The decontamination process was performed in a dedicated decontamination room and we discussed the process with the lead dental nurse who also demonstrated the process.

Instruments were initially cleaned manually. We saw that hot water was used during manual cleaning and was not temperature controlled at less than 45 degrees celcius as required. There was insufficient depth of water to allow for underwater cleaning and during the demonstration instruments were being cleaned out of the water. The instruments were then further cleaned in an ultrasonic bath (this is designed to clean dental instruments by passing ultrasonic waves through a liquid). We were told that they were then inspected under an illuminated magnifier before being sterilised in one of two autoclaves (a device used to sterilise medical and dental instruments). There was also a washer disinfector in the decontamination room which the lead nurse told us was used at the end of each week

We asked the dental nurse about the systems in place to ensure that the equipment used in the decontamination process was working effectively. We were shown records relating to one of the autoclaves but there were no records relating to the second autoclave which we were told did not belong to the practice. Similarly there were no records of any routine tests on the ultrasonic bath to ensure its effectiveness, such as protein and foil tests. Furthermore, there were no records to assess the effectiveness of the washer disinfector which we had been told was used occasionally. We asked the practice manager about this and were told it was never used.

We saw that the required personal protective equipment such as an apron, mask and visor were not being used during the decontamination process and staff told us that they never used a mask and visor during this process.

On the day of our inspection we saw that staff were processing orthodontic instruments despite the last orthodontist session having been five days before our visit. We asked the reason for this and were told that due to the frequent use of agency dental nurses they were not confident that the correct process for cleaning the instruments had been followed. They were therefore reprocessing them to be satisfied they were processed correctly.

The segregation and storage of clinical waste was not in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and general waste were not stored in accordance with current guidelines. The practice used an approved contractor to remove clinical waste from the practice. We saw the appropriate waste consignment notices. However we found that the large clinical waste bin was situated in the practice car park which was accessible from the road.

Are services safe?

When we arrived at the practice we saw that the bin was not locked, was overflowing with clinical waste bags and was not secured to the building to prevent removal from this open area.

Practice staff told us how the dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. There was no legionella risk assessment available but the practice manager told us this had been booked with an external contractor. There was no evidence of any legionella control measures such as monthly water temperature monitoring or dip slide testing.

We saw evidence that some clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact). However this was not evident for all clinical staff on the day of our inspection.

The waiting area, reception and toilets were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towels. Hand washing protocols were also displayed appropriately in various areas of the practice. We looked at two dental treatment rooms and found one of them to be cluttered and untidy. We also found that the floor covering in one of the treatment rooms was severely split and the headrests in both of the treatment rooms we accessed were split. There was a log book in each treatment room which detailed the daily set up routine, including cleaning of work surfaces. We saw that the log book had not been completed for the last two weeks.

We were told the lead nurse carried out all the daily environmental cleaning tasks at the end of their working day. We saw there were records of cleaning in line with the schedule; however the last time this had been completed was two weeks before our inspection.

Equipment and medicines

Staff told us they had enough equipment to carry out their job and that there were adequate numbers of instruments available for each clinical session to take account of decontamination procedures. We saw evidence that some equipment checks had been carried out in line with the manufacturer's recommendations. The practice's X-ray machines had been surveyed in 2015 but there was no evidence of annual mechanical and electrical tests since then.

Portable appliance testing had last been carried out in July 2016. We saw evidence that the autoclaves had been serviced in November and December 2016. We were told that a new ultrasonic bath was purchased annually, which would mean servicing was not required but there was no documentation to confirm this. There was no evidence available of servicing of the washer disinfector.

Dentists used the British National Formulary but one of the dentists was not aware of the process for reporting any patient adverse reactions to medicines through the MHRA. We found that there was no system to track prescribing including antibiotics.

Radiography (X-rays)

We were unable to ascertain if the practice were complying with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice used four intra-oral X-ray machines which can take an image of one or a few teeth at a time. They also used an Orthopantomogram machine which can take a panoramic scanning dental X-ray of the upper and lower jaw. The practice displayed the 'local rules' of the X-ray machine in the room where each X ray machine was located. However these were not unit specific.

The practice used exclusively digital X-rays, which were available to view almost instantaneously, as well as delivering a lower effective dose of radiation to the patient. We found that none of the X-ray machines were fitted with rectangular collimators. This is recommended good practice as it reduces the radiation dose to the patient.

We were unable to view the practice radiation protection file on the day of our inspection as the practice manager told us it was at the head office in Birmingham for revision. There was a generic version at the practice which had been supplied by the company contracted by the practice to oversee radiation protection. This was not populated with current staff details. This has not been provided subsequently.

We saw evidence that full surveys had been carried out of the X-ray machines in 2015 but there was no evidence of

required annual mechanical and electrical tests having been carried out, neither was there evidence that dental professionals were up to date with radiation training as specified by the General Dental Council.

The justification for taking an X-ray as well as the quality grade, and a report on the findings of that X-ray were documented in the dental care record for patients as recommended by the Faculty of General Dental Practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with two dentists regarding their awareness of National Institute for Health and Clinical Excellence (NICE) and the Faculty of General Dental Practice (FGDP) guidelines. We found that one of the dentists was aware of new guidance and had implemented it but the other was not up to date with national guidelines. For example they were not aware of a NICE guideline relating to oral health which had been published in December 2015. The guideline covered how general dental practice teams could convey advice about oral hygiene and the use of fluoride as well as diet, smoking and alcohol intake. Neither were they aware of guidance from the FGDP regarding record keeping.

Therefore our discussions with the dentists and the records we reviewed demonstrated that not all consultations, assessments and treatment were in line with these recognised professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. In the sample of the dental records we reviewed, we did not always see evidence of an oral health assessment at each examination or risk assessments covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

We saw that records included details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). However we found that the clinical assessment records did not always reflect a full description of the options discussed and the outcomes. Many of the records we looked at were identical, despite being made by different dentists, for different patients and with widely different BPEs.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive. Records we looked at showed that radiographs had been recorded including their justification and grading.

Health promotion & prevention

Not all dentists we spoke with were aware of and applying guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

The practice sold a range of dental hygiene products to maintain healthy teeth and gums such as toothbrushes and mouthwashes. These were available in the reception area. There were limited health promotion leaflets available in the waiting room.

We saw evidence in clinical records of dentists discussing smoking and alcohol cessation with patients. Staff we spoke with were not aware of local smoking cessation services to signpost patients to.

Appointments were available with hygienists in the practice to support the dentists in delivering preventative dental care.

Staffing

The practice was staffed by three full time associate dentists and a part time orthodontist who was available every other Monday. They were supported by three dental nurses, three trainee dental nurses, three part time dental hygienists, three receptionists and a practice manager who was present on one or two occasions per week.

Following our visit we checked the registrations of the dental care professionals we were able to confirm were working at the practice and found that they had up to date registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, orthodontic therapists and dental technicians. We asked to see evidence of indemnity cover for relevant staff (insurance professionals are required to have in place to cover their working practice) and were shown cover for most of the dental professionals.

Staff we spoke with told us they had access to ongoing training to support their skill level and they were able to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). However we found that there was no system to monitor the training needs of staff and we were unable to ascertain if clinical staff were up to date with their recommended CPD as detailed by the GDC as training

Are services effective?

(for example, treatment is effective)

records were not available and some staff files were not present. We did see evidence of safeguarding training, fire training and emergency resuscitation and basic life support for some staff.

There were no records of completed annual appraisals for staff at the practice. We were shown a self-appraisal for one member of staff from October 2016 but the appraisal interview with a supervisor had not yet taken place. We were told by the practice manager that they planned to complete an appraisal for all staff members.

Working with other services

The dentists and receptionist explained how they worked with other services. The dentists referred patients to a range of specialists in primary and secondary services for more complex endodontic, periodontic and orthodontic treatments and minor oral surgery when the treatment required could not be provided in the practice. General referrals were made either by letter or electronically. Referrals for suspected cancer were fast tracked and made by a faxed letter and followed up with a letter by post.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The practice manager told us that all staff had undertaken training in the MCA to ensure they were aware of its relevance when dealing with patients who might not have capacity to make decisions for themselves and when a best interest decision may be required. However one of the dentists we spoke with told us they had not undertaken any training in the MCA and had no awareness of Gillick competence which relates to children under the age of 16 being able to consent to treatment if they are deemed competent. There were no training records available to determine which staff had completed the training.

Dentists told us that they explained and discussed different treatment options with patients, outlining the pros and cons and consequences of not carrying out treatment. However one dentist stated that he never showed patients X-rays or photographs, nor supplied information leaflets to enable them to gain educated and valid consent. We saw that patients were given written treatment plans and signed a consent form.

Are services caring?

Our findings

Respect, dignity, compassion & empathy
We spoke with three patients on the day of our inspection. They all commented favourably on the care and service they received. Staff were described as helpful, kind and polite.

We found that the confidentiality of patients' private information was not always maintained. Patient care records were computerised and the practice computer screens at reception were not visible. However we found that the X-ray room situated next to the public rear entrance to the practice was unattended and accessible and the computer screen was displaying a patient's confidential records from a previous visit, which could be viewed by other patients.

Treatment room doors were closed when patients were with dentists and conversations between patients and dentists could not be overheard from outside the rooms.

Involvement in decisions about care and treatment
From our discussions with dentists, extracts of dental care records we were shown and feedback from patients it was apparent that private patients were given clear treatment plans which contained details of treatment options and the associated cost.

A price list for NHS treatment was displayed in the practice.

Patients told us that they felt listened to and plenty of time was taken to explain treatments to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we found that the practice had good facilities and was equipped to treat patients and meet their needs.

We saw that the practice waiting area displayed some information. We were told there was usually a patient information leaflet available but this was not available on the day of our inspection. We saw there was complaints information and information about the cost of treatments.

Patients commented that they were able to get appointments that were convenient to them and sufficient time was given for appointments to allow for assessment and discussion of their needs.

Tackling inequity and promoting equality

Patient services were on the ground and first floor of the premises and facilities on the ground floor were accessible to all patients, including those patients with limited mobility, wheelchair users, as well as parents and carers using prams and pushchairs. There were steps to the front of the building but the rear entrance was fully accessible from the practice car park. There was also a wheelchair accessible toilet.

The practice did not have access to a formal translation service to support patients whose first language was not English if this was required. However the practice manager told us that a number of languages were spoken by some of the staff. The practice did not have a hearing loop in the reception area to assist patients with a hearing impairment. However following our inspection the practice manager told us a hearing loop had been purchased.

Access to the service

The practice was open from 8.30am to 6.00pm on Mondays and Wednesdays, from 8.30 to 5.00pm on Tuesday and Thursdays, from 8.30 to 1.00pm on Fridays and 8.30am to 2.00pm on Saturdays. The practice closed for lunch from 1.00pm to 2.00pm on Monday to Thursday.

The practice was situated in the town of Market Harborough and the practice had a car park available for patients. There was also on street car parking nearby.

The practice told us they would arrange to see a patient on the same day whenever possible if it was considered urgent. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised through the telephone answering service when the practice was closed.

The practice manager told us there was a practice website but we were unable to access this.

The practice operated a reminder service for patients who had appointments with the dentists. Patients were sent a text reminder on the first day of the month in which there appointment was. We were told that if they did not respond to this kit was followed up with a letter the following week.

Concerns & complaints

The practice had a complaints' policy which explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the policy.

Information about how to complain was displayed in the reception area and complaint forms were available for reception staff to give out on request.

The practice manager told us there had been one complaint since they became manager in June 2016 and this had been made through the NHS choices website. The documentation we reviewed showed the complaint had been dealt with appropriately.

Are services well-led?

Our findings

Governance arrangements

During our inspection we found that some systems and processes were not being operated effectively. Some governance arrangements were in place but many areas identified during our inspection indicated a lack of oversight and effective leadership. We were told that much of the documentation relating to the practice was currently at the company head office for updating. However this meant that in the meantime, staff lacked guidance in certain areas, for example in respect of COSHH safety data sheets.

Arrangements relating to recruitment and staffing were not effective as there was no evidence of some employees having a DBS certificate and neither was there a risk assessment relating to this. Some staff files were not present and we were unable to ascertain the current staffing at the practice as on the day of our inspection we were given different lists of staff who were based there and these did not correlate to the staff files which were available. There was no system to monitor training and we were unable to ascertain if all staff had undertaken required training. We were unable to ascertain if all staff had appropriate indemnity cover. Evidence was not available that all clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact).

The system for dealing with safety alerts was not effective. There was no log of safety alerts received or actioned by the practice. We could not be assured that published alerts had been acted upon.

Some risk assessments had been carried out but there was a lack of evidence that identified actions had been addressed. For example, there was not a satisfactory electrical installation condition report despite this having been identified as a requirement in the last two fire risk assessments. There was no legionella risk assessment available and no control measures such as water temperature monitoring in place. There was no AED and DBS certificates were not available for some members of staff but no risk assessment had been carried out in respect of these risks.

Infection control arrangements were not effective as we found areas where HTM 01-05 was not being followed.

We saw that the practice had some policies and procedures to provide guidance to staff. However some were undated and were not practice specific. We looked at policies which included those which covered infection control, health and safety, complaints and safeguarding children and vulnerable adults.

We found that although there was a policy for identifying, investigating and learning from significant events, staff were not aware of what a significant event was and therefore there were no reported incidents.

The arrangements relating to medical emergencies were not effective. Some vital equipment was not present, including an AED. The glucagon held by the practice for use in a medical emergency was not stored in accordance with national guidelines as it was kept in an unmonitored fridge and alongside food products. The medicines were not stored securely and not correctly labelled.

Leadership, openness and transparency

The leadership team within the practice consisted of the practice manager who told us they attended the practice once or twice a week as they also managed a number of other practices across a wide geographical area. Overall accountability for the practice was held by the provider as an individual registered with the CQC. They were not based at the practice but available remotely.

Staff told us they were able to contact the practice manager by phone when they were not in the practice if there was an issue. The practice manager told us that when they took over management of the practice in June 2016 they had identified areas for improvement and were in the process of reviewing systems within the practice. However we could not be assured that the limited time they spent at the practice provided adequate leadership and supervision or sufficient oversight of the required changes for them to be effected in a timely way.

On the day of our inspection we were shown minutes of a staff meeting from February 2017. Following our inspection we were sent minutes of a clinical meeting with the provider and two of the dentists in December 2016 which reflected discussion of NICE guidelines. We were also sent minutes of a practice meeting in November 2016 which stated that policies were discussed but did not identify which policies and that a scenario in reception had been discussed.

Are services well-led?

Learning and improvement

We saw that there was a schedule of clinical audits for the purpose of monitoring quality and to make improvements. We were told that infection control audits were carried out on a six monthly basis and we were shown the last infection control audit which had been carried out by the practice manager in January 2017. However this had not identified some of the issues we identified. For example the audit stated that all surfaces were free from damage despite there being a severe split in the flooring in one treatment room. Also we were told by the practice manager that a washer disinfector was not in use yet the audit indicated it was being used which was confimed by another staff member and also stated that relevant tests had been carried out on the equipment despite records not being available to evidence this.

There were no audits available in respect of the quality and justification of radiography (X-rays). The practice manager told us these were in the process of being implemented.

We were shown the summary of the findings of a clinical record keeping audit. However this was undated, was not clear it was specific to the practice and although issues had been identified, there was no associated action plan or evidence of discussion within the practice.

Other audits we were shown related to disability access which had been completed in January 2017.

We did not see evidence to show that staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD) or that clinical staff were up to date with the recommended CPD requirements of the GDC.

We saw evidence that some staff had undertaken training in cardio pulmonary resuscitation (CPR), infection control, safeguarding of children and vulnerable adults but this was not evident for all staff on the day of our inspection. Evidence of relevant radiography training was not available. Following our inspection we were sent copies of certificates for two members of staff relating to infection control training.

There was no evidence that staff had received appraisals although some staff had completed self-appraisals.

Practice seeks and acts on feedback from its patients, the public and staff

The practice manager told us they had recently carried out a patient survey and we were shown the record of a practice meeting which had taken place in January 2017 to discuss the findings. This evidenced that patients had raised the time spent waiting in the practice for their appointment as an issue. We saw that action had been taken to address this and that there was a plan to audit waiting times in the future to evaluate if there had been an improvement. There was a suggestion box in the waiting room for patients to leave feedback.

Staff we spoke with told us they were able to raise issues if they felt it necessary.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The practice were unable to evidence that all staff were suitably qualified, competent, and skilled. Staff had not received appraisals. Regulation 18 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The practice's recruitment arrangements were not in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks were in place for all staff and the required specified information in respect of persons employed by the practice is held. DBS checks had not been undertaken for all staff where appropriate. Regulation 19 (1)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: There was no legionella risk assessment for the location. Staff were unsure about the processes for reducing the risk of Legionella developing and control measures such as water temperature monitoring were not in place.Conventional sharps were in use and an adequate sharps risk assessment had not been completed. There was no Automated External Defibrillator (AED) and no suitable arrangements in place in view of its absence. There were no airways of any size or portable suction device.Medical emergency medicines and equipment were not stored securely and were not immediately available. Treatment rooms were on the ground and first floor and the emergency medicines and equipment were sited on the second floor. This meant in the case of an emergency in the treatment or waiting rooms medicines and equipment would have to be collected from the second floor causing an unnecessary delay. Glucagon was stored incorrectly as it was in a refrigerator which was not temperature monitored and the refrigerator was also being used for food and drink storage. During the decontamination process manual scrubbing of contaminated instruments was carried out above water and no temperature checks done on the solution for scrubbing. Staff did not wear the appropriate personal protective equipment such as an apron, mask and visor during the decontamination process. There were no records of daily validation of one autoclave. There were no records of routine tests being carried out on the ultrasonic bath or washer disinfector to ensure they were working effectively and there were no servicing records. Not all substances in use at the practice had been appropriately risk assessed in line with the Control of Substance Hazardous to Health

This section is primarily information for the provider

Enforcement actions

(COSHH) Regulations 2002. There was not a full file of COSHH information available to provide guidance for staff. The clinical waste bin was not locked, was overflowing with clinical waste bags and was not secured to the building to prevent removal from the open area where it was situated.There was no evidence of annual mechanical and electrical servicing of radiation equipment since 2015. Rectangular collimation was not being used and there was no evidence of appropriate training for operators of X-ray equipment available.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not have effective systems in place to ensure that the regulated activities at Hanji Dental Group – 106 Northampton Road were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included: There was no process to assess, monitor and improve as a result of incidents. We were shown a policy relating to significant events. Staff we spoke with had no training about significant events and consequently a lack of understanding about what a significant event was and the process for handling them. There were no recorded significant events despite incidents having taken place which would have constituted a significant event. There was no assessment of the risk of not having an automated external defibrillator on site should an emergency arise. The practice did not have an effective system to update and review practice policies. A number of policies we looked at were not specific to the practice and not dated. There was not an effective system in place for disseminating and acting on patient safety alerts. There was no system in

This section is primarily information for the provider

Enforcement actions

place to monitor the security of FP10 prescription pads. There was no process in place to track them within the practice. The system for maintaining equipment in the practice was not effective.

Patient records were not kept securely.

Regulation 17(1)