Pro-Dent Dental Surgery Partnership

Pro-Dent Dental Surgery

Inspection report

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Overall summary

We carried out this unannounced inspection on 20 October 2021 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 Care Quality Commission, (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 three questions:

• Is it safe?

• Is it effective?

• 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 this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services well-led?

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

Summary of findings

Background

Pro-Dent Dental Surgery is in Southampton and provides NHS dental care and treatment for adults and children.

There is level access to the practice for people who use wheelchairs and those with pushchairs. Car parking spaces, including dedicated parking for people with disabilities, are available near the practice.

The dental team includes three dentists, five trainee dental nurses, a dental hygienist, a practice manager and a receptionist. The practice has three treatment rooms.

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Pro-Dent Dental Surgery is the practice manager.

During the inspection we spoke with two dentists, two trainee dental nurses, a receptionist, two practice managers, an area manager and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday 8am to 6pm
- Tuesday 8am to 6pm
- Wednesday 8am to 6pm
- Thursday 8am to 6pm
- Friday 8am to 6pm
- Saturday 9am to 5.30pm

Our key findings were:

- The provider must ensure that the practice is visibly clean and well-maintained, including a five yearly mains wiring certificate.
- The provider must ensure that infection control procedures are carried out in accordance with published guidance. Records must include water testing and dental unit water line management results.
- Staff knew how to deal with emergencies. The provider must ensure that appropriate life-saving equipment is available according to guidance and stored appropriately.
- The provider must ensure that risk systems to help them manage risk to patients and staff are actioned and recorded, in particular, the fire risk assessment and COVID-19 fallow time.
- The provider had safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider must ensure that sharps are used in accordance with guidance.
- The provider must ensure staff recruitment procedures and records are maintained in line with current legislation.
- The provider must ensure that there is sufficient equipment for patient treatment plans, that all equipment is maintained and, supplied with consumables; and that records are available to confirm maintenance has been completed.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.

Summary of findings

- The provider must ensure that waste is correctly stored and disposed of according to guidance and regulation.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider had not asked staff and patients for feedback about the services they provided
- The provider did not have records of staff training available and had not completed staff appraisals.
- The provider should ensure that anti-microbial audits take place annually.
- The provider dealt with complaints positively and efficiently.
- The provider had information governance arrangements.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure all premises and equipment used by the service provider is fit for use.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed and specified information is available regarding each person employed.

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

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

- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.

The registered manager accepted the clinical and managerial shortfalls that we raised and took immediate action the day of our inspection to begin to address these.

Where evidence is sent that shows the relevant issues have been acted on, we have stated this in our report but we cannot say that the practice is compliant for that key question as this would not be an accurate reflection of what was found on the day of our inspection.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

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

We have told the provider to take action (see full details of this action in the requirement notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

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

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider had a system to highlight vulnerable patients and patients who required other support such as with mobility or communication, within dental care records.

The provider had an infection prevention and control policy and procedures.

Staff did not follow guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care, in particular:

- We found three used dip sample collection tubes, two were dated 2018 and one from February 2021 in a drawer in the decontamination room. These should have been disposed of in line with guidance. If opened or damaged the decontamination processes could be compromised. We were later sent photographic evidence indicating that the items had been removed and staff advised about waste disposal.
- We saw that liquid was left in the washing bowl and ultrasonic cleaner after use, at the conclusion of the morning session. Guidance says that after use the content of these items should be disposed of at the end of each session to avoid comprising the decontamination processes. Staff were unaware of this guidance. We were later sent evidence to confirm that staff had been advised of the correct disposal of waste products after use.
- The practice used a mixture of water and specialist detergent to manually clean some instruments, which is temperature and volume dependant. There was no thermometer evident or available, in line with manufacturers guidance on the use of these products for decontamination processes. We were later sent evidence to confirm that a thermometer had been purchased and staff advised of the correct procedures for detergent use.
- There were no instructions clearly available, such as posters, to guide staff for the correct use of PPE in the decontamination room; instructions for use of the ultrasonic cleaner, manual cleaning process or action to be taken in the event of a sharp's injury.
- We saw that instruments were transferred in a box from the treatment room to the decontamination room. We saw a transfer box in surgery two which was dry. Used instruments temporarily stored prior to decontamination should be kept moist and ideally stored in a pre-enzymatic liquid to aid the decontamination process. We were told by staff that no liquid was used in these boxes. Staff were unaware of guidance. We were later sent evidence that staff had been advised of the transfer and storage chemicals prior to commencement of decontamination processes for used instruments.

Are services safe?

- There was one autoclave to sterilise instruments. We saw that the autoclave was linked to a printer, which was unable to provide automatic records of equipment operations as there was no paper in the printer, or available in the practice. The practice manager reported there was a USB storage device / data logger for the autoclave, but neither were currently in use. As a result of this situation information about the autoclaves operation should be recorded in manual records. This includes timing of operations and internal operation of the autoclave. This had not been carried out. We were later sent evidence to confirm that automatic logging was now in operation; with the addition of an electronic recording device and the ordering of printer paper.
- We observed that when the autoclave was used, quality assurance procedures were not carried out in line with guidance. There was guidance available to guide staff about the use of TST (Time, Steam and Temperature**)** strips and a stopwatch to record equipment functioning in the event of a printer, or data logging failure, but these were not being recorded consistently in logbooks. *TST* Sterilisation *Strips* indicate the correct temperature, steam, and Time and are used in autoclaves to indicate that the sterilisation cycle is complete. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed.
- We saw that the records for the validation of the ultrasonic bath indicated that the last visual examination of load items was dated 4 October 2021, but this should be a daily task. The last evidence of the quarterly foil tests was on 4 October 2021. The foil strips had not been retained. There was no evidence of a soil or protein test done for the ultrasonic bath as required in guidance. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed. `

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations in the assessment had been actioned.

However, we could not be shown records of water testing and dental unit water line management. We did see that chemicals were used to maintain dental unit water lines in accordance with the risk assessment. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed and that records were correctly made in accordance with guidance.

We saw cleaning schedules for the practice. When we inspected, we saw:

Treatment Room two

- Dirty ledge with hair and dust after morning session posing an infection control risk as they indicated that these areas had not been cleaned. We were later sent evidence to indicate that staff had received instruction to ensure that the correct cleaning regime was followed, and that the area had been cleaned.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance, however we saw

Treatment room two.

- Overloaded medical waste bin left after morning session comprising waste management guidance. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to waste management.

Treatment room one, two and three

- Inappropriate storage of used amalgam capsules and dappen (amalgam mixing) pots comprising waste management guidance. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to waste management.

Are services safe?

Decontamination room

- Dip slide tests from February 2021 and 2018 were stored in a drawer comprising decontamination if accidently opened. These items should be disposed of after use with records capturing the results. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to waste management.

The infection control lead carried out infection prevention and control audits twice a year. The latest audit had not indicated that the practice was not meeting the required standards. There was no action plan with the audit to drive improvements.

The provider had a Speak-Up policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used dental dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where dental dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, we saw this was documented in the dental care record and a risk assessment completed.

The provider had a recruitment policy and procedure.

We examined the staff recruitment records for 11 staff and two locums.

- There were no records available for the locum dentists.
- There were only five records of DBS checks for staff, excluding the locum dentists.
- Induction records were available for 4 staff excluding all dentists.
- There were no records of other information gathered in line with regulation for any staff.
- We were later sent evidence to indicate that fully recorded staff records, in line with regulation, were now available.

Facilities

We saw the following issues for the facilities, in particular:

Surgery one

- damage to drawer used to store burs resulting in the possibility of collapse and comprising patient and staff safety.
- stool with damage and foam beginning to show through comprising decontamination cleaning. We were later sent evidence to show that new furniture had been obtained to replaced damaged items.
- chair in poor condition and material showing through comprising

decontamination cleaning. We were later sent evidence to show that new furniture had been obtained to replaced damaged items.

- Inappropriate storage of used amalgam capsules and dappen pots comprising waste management guidance. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to waste management.

Surgery two

- An X-Ray unit had been removed following replacement, and an exposed cable was temporarily covered (not known if live) and left in place with the protentional to compromise staff and patient safety. We were later sent evidence showing that the exposed cable was covered, and an electrician had been called to rectify the issue.
- Face shield and FFP3 mask stored on open work surface following morning session. It was not known if these had been used. This could compromise the items cleanliness if unused, or compromise staff and patient safety if they had been used. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to PPE storage.

Decontamination room

Are services safe?

- The mask of the self-inflating bag with reservoir from the emergency medical equipment storage area appeared dirty compromising patient safety. We were later sent evidence to show that the self-inflating mask and bag had been replaced and were safely stored.
- Medical emergency and equipment storage was cluttered and disorganised comprising access in the event of an emergency. We were later sent evidence to show that the medical emergency equipment was safely stored, to enable unhindered access.
- Ultrasonic cleaner, which had been used during the morning session was left with liquid during lunch break of staff compromising decontamination processes. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to waste management and decontamination procedures.
- Equipment cleaning sink used during morning session was left with liquid during the staff lunch break compromising decontamination processes. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to waste management and decontamination procedures.
- Staff member reported problem with rinsing sink plug compromising decontamination.

Surgery three waiting area

- Two chairs with foam showing compromising decontamination. We were later sent evidence to show that new furniture had been obtained to replaced damaged items.

Staff toilet

- Fire alarm sensor hanging from ceiling, appears still operational compromising staff and patient safety. We were later sent evidence to show that the fire alarm sensor was now repaired, and the fire alarm system maintained according to manufacturer's requirements.

Main corridor

- Bulb missing and exposed light fitting compromising staff and patient safety. We were later sent evidence indicating that the exposed light fitting had been repaired.

Equipment

- Lack of equipment

A member of staff told us that there was a lack of equipment. In particular we were told that there was only one ultrasonic scaler unit shared between two rooms.

- Equipment servicing.

There were no records available for servicing of the autoclave, two compressors, fire alarm system, emergency lights, fire extinguishers and three air conditioners.

We were later sent evidence indicating that all servicing of equipment had been carried out or was planned to take place shortly.

There were no records of a fixed mains wiring check and certificate.

Fire risk assessment

We saw a fire risk assessment for the practice dated 2019.

We saw that an action plan had identified 19 actions however, not all of these had been completed.

The items outstanding included:

- The provision of a fixed wiring check which we were told had not been completed.

Are services safe?

- The servicing of the three air conditioner units which we were told had not been completed. We were later sent evidence indicating that all servicing of equipment had been carried out or was planned to take place shortly.
- There was no staff room fire blanket.
- There was no evidence that staff had received fire warden training.

X-Ray equipment

The practice had arrangements to ensure the safety of the X-ray equipment and some of the required radiation protection information was available. We found the following gaps in documentation:

- There were no records available for servicing of the three intraoral X-ray equipment. We were later sent evidence indicating that all servicing of equipment had been carried out or was planned to take place shortly.
- We saw that one of the intraoral X ray unit's three year quality assurance test was due in April 2021 but this had not been completed. We were later sent evidence indicating that all servicing of equipment had been carried out or was planned to take place shortly.
- There were no training records available for dentists, including IRMER qualifications. We were later sent evidence of staff training records, including IRMER qualifications.

We saw evidence the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits every year following current guidance and legislation.

Risks to patients

The provider had implemented systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment.

- We saw that the practice held both safer sharps and traditional needles. We were told by staff that traditional needles were preferred for use instead of the safer sharps. There were no needle gauntlets to protect users. We spoke to dentists who told us that they recapped needles, passing them to the nurse to dispose of. This is not in line with either guidance or company policy. We were later sent evidence to indicate that staff had received instruction to ensure that correct procedures were followed in relation to safe management of sharps and disposal.
- There were no records available to indicate that clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. We were later sent evidence of vaccinations records for all staff in line with guidance.
- There was no evidence that staff had completed sepsis awareness training. We were later sent evidence of staff training for sepsis.

Sepsis prompts for staff and patient information posters were displayed throughout the practice. This helped ensure staff made triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care

We looked at the emergency medicines and equipment and found the following:

- We saw that the self-inflating bag with reservoir mask looked dirty and could compromise patient safety if used. We were later sent evidence to indicate that the self-inflating bag with reservoir mask had been replaced in line with guidance.
- There was only one size two clear face mask, marked with an expiry date of 14 October 2021. There were no other clear masks available other than a visibly dirty mask on a self-inflating bag. We were later sent evidence to indicate that equipment was available in line with guidance

Are services safe?

- We found an open eyewash bottle, which had been opened and not disposed of after use. We found a bodily fluid spillage kit with an expiry date of January 2020. These items were removed for disposal and replacement.
- The storage of airways equipment in the decontamination room and the medicine in the office area was disorganised. The emergency medicine box had multiple boxes of face masks stored on top of it. In the event of an emergency locating first aid equipment could be difficult for staff. We were later sent evidence to indicate that the storage of emergency equipment enabled safe access in an emergency.
- Adrenaline and glucagon were stored in a mixed use (including food) fridge.
- No records were available for the weekly checking of emergency equipment and medicines. We were advised these were sent via email weekly to head office. We were later sent evidence of record checking in line with guidance for emergency medical equipment.

A dental nurse worked with the dentists and the dental hygienist when they treated patients in line with General Dental Council Standards for the Dental Team. A risk assessment was in place for when the dental hygienist worked without chairside support.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice used locum staff.

- There were no records available for the locum dentists. we could not be shown that these staff received an induction to ensure they were familiar with the practice's procedures. We were later sent evidence to indicate that fully recorded staff records, in line with regulation, were now available, including details of induction.

Covid-19

- We saw no evidence of the calculation of fallow time for each treatment room. We were told these calculations were held centrally. Fallow time is the required time between an aerosol generating procedure (AGP) and the safe time when operations can be carried out in the treatment room after a complex dental procedure to enable safe operations for staff and patients. Fallow time is dependence on a number of variables, which differ from treatment room to treatment room.
- We did see a member of staff wearing appropriate PPE to carry out an AGP walking to reception. We were told that the clinician had changed PPE after conducting the AGP procedure and this was fresh PPE.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that individual records were typed and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines.

There was a stock control system of medicines which were held on site.

We saw staff stored and kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines.

Are services safe?

- We could not be shown antimicrobial prescribing audits which are usually carried out annually. We were later sent evidence of an antimicrobial audit having been completed.

An antimicrobial prescribing audit should confirm that dentists are following current guidelines.

Track record on safety, and lessons learned and improvements

The provider had implemented systems for reviewing and investigating when things went wrong. There were comprehensive risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks which led to effective risk management systems in the practice as well as safety improvements.

Where there had been a safety incident. We saw this was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again

The provider had a system for receiving and acting on safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep dental professionals up to date with current evidence-based practice. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided leaflets to help patients with their oral health.

Staff were aware of and involved with national oral health campaigns and local schemes which supported patients to live healthier lives, for example, local stop smoking services. They directed patients to these schemes when appropriate.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The staff were aware of the need to obtain proof of legal guardianship or Power of Attorney for patients who lacked capacity or for children who are looked after. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We saw this documented in patients' records. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances. Staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

Are services effective?

(for example, treatment is effective)

The provider had quality assurance processes to encourage learning and continuous improvement. Staff kept records of the results of these audits, the resulting action plans and improvements. These audits, for example infection prevention control, had not identified the issues we saw in relation to the decontamination of medical instruments, equipment servicing and condition of the facilities.

Effective staffing

Staff new to the practice, including locum dentists, told us they had a structured induction programme, however we there were only limited records available to confirm this.

We examined the staff training records for 11 staff and two locums.

- Induction records were only available for 4 staff, excluding all dentists. We were later sent evidence to indicate that fully recorded staff records, in line with regulation, were now available.

Clinical staff told us they completed the continuing professional development required for their registration with the General Dental Council. Records to confirm this were limited. We examined the staff training records for 11 staff and two locums.

- There were no training records available for dentists, including IRMER qualifications. We were later sent evidence to indicate that fully recorded staff records, in line with regulation, were now available including all training records and IRMER qualifications.

Co-ordinating care and treatment

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

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services well-led?

Our findings

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

We have told the provider to take action (see full details of this action in the requirement notices section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

We found the practice manager had the capacity, values and skills to deliver high-quality, sustainable care and was knowledgeable about issues and priorities relating to the quality and future of the service. They understood the challenges and were addressing them.

The provider had a strategy for delivering the service which was in line with health and social priorities across the region. Staff planned the services to meet the needs of the practice population.

Culture

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

- Staff appraisals

There was no evidence of staff appraisals.

- Staff training

We examined the staff training records for 11 staff and two locums.

- There were no training records available for dentists, including IRMER qualifications. We were later sent evidence to indicate that fully recorded staff records, in line with regulation, were now available including all training records and IRMER qualifications.

We saw the provider had systems in place to deal with staff poor performance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The providerwas aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff told us they could raise concerns and were encouraged to do so. We saw no evidence of feedback being obtained by the practice from staff to monitor and improve the service:

Governance and management

The registered manager had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. Policies and procedures were not followed by staff which was evidenced by the number of issues we saw.

The practice was part of a corporate group where teams including human resources, finance, and clinical support were based in a head office. The processes and systems the company used were not effective; staff did not follow guidance or identify issues during audits evidenced by the number of issues we saw.

Appropriate and accurate information

Are services well-led?

The provider had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

We saw no evidence of feedback being obtained by the practice from staff to monitor and improve the service:

We obtained feedback from four people working at the practice on the day.

- One respondent told us that they were waiting to be put on a basic training course for their role.
- One respondent told us that more dentists and receptionists were needed. Equipment and new chairs were also needed.

We saw no evidence of feedback being obtained by the practice from patients to monitor and improve the service:

We obtained feedback from eight patients on the day.

- One respondent gave negative feedback about the practice running on time. Four respondents were neutral about the practice running on time.
- Most respondents were positive about the practice and staff.

Continuous improvement and innovation

The provider had limited quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. Staff kept records of the results of these audits and resulting actions plans. We found, in particular, the infection prevention and control audit had not identified various discrepancies in procedures we saw.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. They told us the provider supported and encouraged staff to complete continuing professional development.

- Staff training records were not available to view on the day. We were later sent evidence to indicate that fully recorded staff records, in line with regulation, were now available including all training records and IRMER qualifications.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17** **Good governance** Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. **In particular:** • Feedback was not obtained from staff and patients to improve the service. **Regulation 17 (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 18**

This section is primarily information for the provider

Requirement notices

Staffing

Requirements in relation to staffing

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

In particular:

- Staff appraisals had not been undertaken.
- Staff training was not monitored by the practice.

Regulation 18 (2)

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 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 19** **Fit and proper persons employed** The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. **In particular:** • A full employment history. • Proof of identity. • Health assessment. • Eligibility to work in the UK. • Hepatitis B vaccination effectiveness test result. **Regulation 19 (1) (2)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 12** **Safe care and treatment** Care and treatment must be provided in a safe way for service users. The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. **In particular:** • Sharps use was not in line with guidance and company policy. • Decontamination procedures were not carried out in line with guidance. There were insufficient quantities of equipment to ensure the safety of service users and to meet their needs. **In particular:** • Emergency equipment was not available for use in line with guidance. • There was not a sufficient supply of equipment for staff to carry out regulated activity. The premises being used to care for and treat service users were not safe for use. **In particular:**

This section is primarily information for the provider

Requirement notices

- Water testing and dental unit water line management were not carried out in accordance with the risk assessment.
- Fire risk assessment action plan had not been completed.

There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

In particular:

- SARS COVID19 fallow times were not calculated in line with a risk assessment.

Regulation 12 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 15** **Premises and equipment** Premises and equipment The registered person had failed to ensure that all equipment used by the service was properly maintained. **In particular:** • Equipment was not serviced according to manufactures requirements. • A three yearly quality assurance test had not been completed for an intraoral X ray unit in line with guidance.

This section is primarily information for the provider

Requirement notices

- Mains wiring safety certificate had not been completed in line with regulation.
- Facilities had not been maintained.

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

In particular:

- Medical equipment generating waste products were not used in line with guidance.
- Medical equipment was not operated with required consumable materials or devices in line with guidance.

The registered person had failed to ensure that all premises used by the service were clean.

In particular:

- Used medical waste was not stored in line with guidance.
- Work surfaces were not clean.

Regulation 15 (1) (2)