Review of compliance

Dr. Khalid Khan Khan Dental - Allerton Dental Care	
Region:	North West
Location address:	121a Allerton Road Mossley Hill Liverpool Merseyside L18 2DD
Type of service:	Dental service
Date of Publication:	April 2012
Overview of the service:	This dental practice is situated in the Mossley Hill area of Liverpool and is a mixed NHS and Private practice with a special interest in Cosmetic Dentistry. The surgery is open from 09.00 until 18.00 Monday to Friday.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Khan Dental - Allerton Dental Care was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 13 March 2012 and talked to staff.

What people told us

We did not discuss the issues or concerns regarding the reviewed outcomes with patients attending the surgery for treatment.

What we found about the standards we reviewed and how well Khan Dental - Allerton Dental Care was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Overall, we found that the registered provider was not meeting this outcome.

There was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states that the registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. The often illegible and poorly completed records failed to demonstrate that a thorough assessment of the patients needs had been completed and that the planning and delivery of treatments always ensured the welfare and safety of the patient.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Overall, we found that the registered provider was not meeting this outcome.

There was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states that the registered person must protect service users against the risks associated with the unsafe use and management of medicines.

Failing to check and record the expiry dates of emergency drugs and inappropriate antibiotic prescribing means that service users may not be receiving their medicines in a safe manner.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Overall, we found that the registered provider was not meeting this outcome.

There was a breach in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states that the registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record.

Some of the notes we examined were incomplete and did not provide an accurate and personalised record of that patients care.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We did not discuss this outcome with people using the service during our visit.

Other evidence
We were told that the dental team at the practice comprised two part time dentists, the provider and an associate, two part time receptionists and two dental nurses.

During the inspection we examined in detail several sets of patient's medical records. This was to establish whether the provider was both carrying out an assessment of the needs of the patient and that treatment was being planned and delivered in order to meet those individualised needs. We asked to look at the notes of patients who had recently completed treatment or whose treatment plan was in progress. Contemporaneous clinical notes detailing examination and treatment planning were hand written and not always legible. In some cases basic charting and periodontal examinations (BPE) were not completed. BPE is a measurement on a scale of 0-4 of the health of the soft tissue (e.g. gums) around the tooth. We saw in one case that there was no written evidence of basic vitality tests being undertaken on teeth where it was appropriate to do so. Vitality tests are used routinely to evaluate the health of the dental pulp or nerve running through the centre of the tooth. We also saw that the records contained a standard medical history questionnaire, which we were told was completed and signed by the patient at their initial consultation. This form recorded the patient's relevant medical history, for example the presence of any allergies like penicillin or aspirin.

One of the records we examined related to the care and treatment of a child. The consent to treatment had been signed by the child's parent. However, we were told that the child had been given the opportunity to take part in the discussions about treatment choices and decisions to the fullest extent possible. Some of the notes we saw did not reflect in their content that the patient had adequately been involved in the decision making about their treatment options nor that they had been fully informed of other treatments that they might require.

We saw that a range of x-rays had been taken for all the patients whose notes we examined. Staff told us that these x-rays were taken to aid diagnosis and inform treatment options. In one case, the proposed plan of treatment did not take into account all aspects of the patient's individual circumstances, their immediate and longer term needs. This means that potentially the patient might not receive appropriate personalised care, treatment and support.

Within the surgery itself we saw two different types of x-ray machines. We saw records to demonstrate that both machines had been serviced within the last 12 months. Displayed alongside each of the x-ray machines were a photo copy of the required "local rules". These "local rules" are required by the Ionising Radiation Regulations 1999 and should set out the working practices to be followed to ensure that staff and all other persons, are safe when working with and using radiation. All clinical personnel have a duty to exercise reasonable care and act responsibly in relation to radiography. We were told that the provider had recently completed an online update in radiation protection. Not all the clinical staff who were undertaking x-rays had signed the local rules to indicate that they had both read them and intended to abide by them.

Within the patients' notes we saw examples of a number of different x-ray that had been taken. These included bite-wing x-rays, taken to help evaluate the condition of crowns and fillings in posterior teeth. In addition, we saw panoramic scanning x-rays of the upper and lower jaw (OPGs) and periapical x-rays, which were used to view the full root of the tooth. We saw that the clarity and subsequent clinical value of some x-rays had been affected by the patient wearing jewellery whilst the x-ray had been taken (e.g. ear rings and tongue piercing). In some cases the x-rays had not been reported on or recorded in the clinical notes. This represents a breach in the Ionising Radiation (Medical Exposure) Regulations 2000, which states that a clinical evaluation of x-ray exposures has to be recorded in every case.

We saw that equipment and drugs for use in a medical emergency were available in the dentist's surgery upstairs. This equipment included an oxygen cylinder that was connected to tubing and a face mask. There were also a selection of airways and an Ambu bag and mask. In an emergency this equipment could be used to assist a patient who was having difficulty breathing. The surgery did not have an automated external defibrillator (AED), whilst it is not mandatory to have an AED, it is recommended by the Resuscitation Council (UK).. This is a machine used in an emergency to deliver a synchronised shock to the heart to correct an abnormal heart rhythm. Emergency drugs were being stored in a cupboard in the surgery. We saw a checklist, which was completed daily for equipment within the surgery but this document did not include a check to ensure that the emergency drugs were in date.

We were told that not all staff had received basic life support training in the past 12 months although this was planned for the future. There was no evidence of any

emergency drills or scenarios being undertaken.

Our judgement
Overall, we found that the registered provider was not meeting this outcome.

There was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states that the registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. The often illegible and poorly completed records failed to demonstrate that a thorough assessment of the patients needs had been completed and that the planning and delivery of treatments always ensured the welfare and safety of the patient.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not discuss this outcome with people using the service during our visit.

Other evidence
We were told that the surgery did not store or manage any controlled drugs. However, the surgery did have a stock of midazolam, which was kept alongside the other emergency drugs. Midazolam is a schedule 3 drug and it is not required to be stored in a controlled drug cupboard or recorded in a controlled drug register. Those emergency medicines required quickly in cases of resuscitation or other medical emergencies were available in tamper proof packaging that allowed them to be used as quickly as possible. We did see that a box of adrenaline 1 in 1000 ampoules for injection was taped to the inside of the drug cupboard door, for ease of access in an emergency. We saw that this box of adrenaline ampoules had an expiry date of February 2012. In order for the provider to be assured of any drugs efficacy it should not be used once its expiry date has passed. Whilst there was a daily surgery checklist completed this did not include a check of the emergency drugs. The drug cupboard also contained a box of emergency drugs in which there was an in date box of adrenaline 1 in 1000 ampoules.

An emergency supply of oxygen was available within the surgery and the cylinder was attached to a mask and tubing, ready for use.

The surgery did not have a drug fridge.

Staff told us that any patients requiring antibiotics or painkillers were given a prescription to take to the community pharmacy.

Examination of the notes also raised concerns about the prescribing of antibiotics. These included issues in some cases about the dose, type and justification for antibiotic prescription.

Our judgement
Overall, we found that the registered provider was not meeting this outcome.

There was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states that the registered person must protect service users against the risks associated with the unsafe use and management of medicines.

Failing to check and record the expiry dates of emergency drugs and inappropriate antibiotic prescribing means that service users may not be receiving their medicines in a safe manner.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are major concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not discuss this outcome with people using the service during our visit.

Other evidence
We examined in detail ten sets of medical notes for patients that had either recently completed treatments or were the process of receiving treatment. We saw that the practice used a paper based system for recording its clinical patient records. The records we saw were handwritten and not easily legible. There was evidence of medical histories being taken in the form of a health questionnaire completed, signed and dated by the patient.

The records of one patient showed that clinical photographs had been taken though no consent for this procedure had been recorded in the notes. Not all the records demonstrated basic periodontal examinations and in some cases the records failed to record that any preventative advice had been given.

We saw written evidence that the practice had previously been subject to scrutiny of its medical records by the local commissioners. The results of their clinical records audit had revealed concerns about the poor standard of record keeping on more than one occasion.

On the basis of the records looked at during the visit patients could not in all cases be

confident that their clinical records were accurate or fit for purpose.

Our judgement
Overall, we found that the registered provider was not meeting this outcome.

There was a breach in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states that the registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record.

Some of the notes we examined were incomplete and did not provide an accurate and personalised record of that patients care.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People who use this service are generally safe but there are risks to their outcome, heath and wellbeing.	
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People who use this service are generally safe but there are risks to their outcome, heath and wellbeing.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People who use this service are generally safe but there are risks to their outcome, heath and wellbeing.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met:	

	There were out of date emergency drugs. Emergency drugs were not included in the daily safety checks. Episodes of inappropriate antibiotic prescribing were seen. The registered person was not protecting service users in all cases against the risks associated with the management of medicines.	
Surgical procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: There were out of date emergency drugs. Emergency drugs were not included in the daily safety checks. Episodes of inappropriate antibiotic prescribing were seen. The registered person was not protecting service users in all cases against the risks associated with the management of medicines.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: There were out of date emergency drugs. Emergency drugs were not included in the daily safety checks. Episodes of inappropriate antibiotic prescribing were seen. The registered person was not protecting service users in all cases against the risks associated with the management of medicines.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The registered person was not in all cases ensuring that patients were protected against the risks of unsafe or inappropriate care and treatment due to shortfalls in the standard of record keeping.	

Surgical procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The registered person was not in all cases ensuring that patients were protected against the risks of unsafe or inappropriate care and treatment due to shortfalls in the standard of record keeping.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The registered person was not in all cases ensuring that patients were protected against the risks of unsafe or inappropriate care and treatment due to shortfalls in the standard of record keeping.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	Copyright © (2010) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA