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5 De Parys Dental Care - Bedford

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 November 2015 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 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

5 De Parys Dental Care is a private dental practice in the centre of Bedford. It is situated on the ground floor of a converted Victorian townhouse.

The practice has three surgeries. The practice offers a range of general dental treatment and tooth whitening. They also give the option of treatment under conscious sedation.

The principal dentist offers a range of facial aesthetic treatments (these are cosmetic treatments including dermal fillers and botulinum toxin treatment) in addition to the general dentistry.

The practice staff includes a principal dentist, three further dentists (although one had not commenced working at the time of our visit), one hygienist, one therapist, three dental nurses and a practice manager.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons 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 practice is open Monday to Friday, with one late evening (until 7.00 pm) and Saturday appointments available once a month.

We received feedback from 29 patients, who made very positive comments about the service. They described how the staff were always friendly and professional, and patients were always treated with dignity and respect. Some patients told us that appointments sometimes ran late.

Our key findings were:

- Patients were treated with care, dignity and respect.
- The practice had systems in place to manage risk to patients, staff and visitors. These included infection prevention and control, and health and safety.
- Governance procedures for continuous improvement of the service were not sufficiently robust.
- The practice had robust policies and procedures in place for child protection and safeguarding vulnerable adults.
- The practice ensured that patients' valid consent was obtained for all care and treatment.
- Emergency equipment and drugs were found to be present in accordance with the relevant guidelines.

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

- Ensure that justification for taking an X-ray is recorded in the dental care records. Ensure that audits of the quality of X-rays are complete, including an action plan to improve overall quality. Ensure that radiation training is up to date for all appropriate members of staff. Giving regard to the Ionising Radiation (Medical Exposure) Regulations 2000.
- Ensure that staff employed have all appropriate checks performed in accordance with Schedule 3 of the Health and Social Care Act 2008 to ensure employment of fit and proper persons.
- Ensure that staff employed have the necessary immunisation against Hepatitis B to protect them against blood borne transmission.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Implement a robust servicing schedule for the equipment in the practice to ensure its safety.
- Review the frequency of tests required for autoclaves within the Health and Technical Memorandum 01-05.
- Implement a schedule of yearly staff appraisals, where training needs of the individual could be discussed.

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?

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

The practice demonstrated robust policies and procedures for protection of children and safeguarding of vulnerable adults, staff knew the signs of abuse and who they would report them to.

The practice was performing adequately under the guidance of the Health and Technical Memorandum 01-05 (HTM01-05) in infection control, although infection control audits were overdue, and no action plans to address identified short falls were seen following previous audits.

Staff were suitably qualified for their roles; however there were omissions in the recruitment protocol and staff files meaning that we could not be assured that the practice had employed fit and proper persons.

Medical emergency equipment and drugs were available, and staff had good knowledge of what action to take in a variety of medical emergencies.

Are services effective?

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

A robust assessment of patients' oral health was made at each check-up appointment, including checks of the soft tissues of the mouth and checks on gum health.

Staff had a good understanding of the core principles of the Mental Capacity Act 2005. Particularly its relevance in acquiring consent from patients who might lack the capacity to consent for themselves.

Are services caring?

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

Feedback we received from patients described their experiences at the practice as friendly, respectful, kind, and caring.

Patients felt that their treatment options were always explained thoroughly to them by staff, including the costs involved.

Are services responsive to people's needs?

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

The practice arranged their opening times to be flexible for as many of their patients as possible, with late evenings once a week, and Saturday opening once a month.

Out of hours the patients were able to contact the principal dentist at any time should they have a dental emergency.

Any complaints to the practice were thoroughly investigated, and handled in accordance with the practice's complaints policy.

Are services well-led?

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

Summary of findings

The principal dentist took overall leadership responsibility within the practice, supported by the practice manager.

The registered manager (who was the principal dentist) did not keep records of the continuing professional development of the associate dentists, and therefore could not be certain that essential training had been undertaken by them.

Practice policies and risk assessments, although in place, had often not been reviewed for several years, and so their relevance and accuracy could not be assured.

Essential monitoring by way of clinical audit was not always carried out to an appropriate standard. For example an audit on the quality of radiographs taken was carried out within the last year, but there was no action plan to improve outcomes in the future.

5 De Parys Dental Care - Bedford

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 planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The provider was inspected by a lead inspector, accompanied by a specialist advisor with general dental practice experience.

We informed Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our visit we spoke with two members of staff (the principal dentist and a dental nurse). We also spoke with patients and reviewed comment cards completed by patients. We reviewed documents made first hand observations of the practice.

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 an open and transparent way of working. Staff were encouraged to raise any concerns to the principal dentist or practice manager.

The practice had an accident book in which forms were filled out for each incident that occurred, appropriate actions were noted and incidents were discussed with staff during informal lunchtime meetings. However, minutes of these meetings were not kept.

A comments and complaints log was noted, this demonstrated that incidents were investigated thoroughly, and apologies were issued to patients in an appropriate and timely manner.

The practice had a policy regarding the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) to which the principal dentist would refer should she have to make such a report. There had not been any such incidents in the past 12 months.

The practice received alerts from the Medicines and Healthcare products Regulatory Service which were e-mailed to the practice manager, who, with direction from the principal dentist disseminated the relevant information to the staff.

Reliable safety systems and processes (including safeguarding)

The practice had robust policies and procedures in place for child protection and safeguarding vulnerable adults. Relevant contact numbers for staff to raise a safeguarding concern were easily accessible both in policies and also from a poster on the staff room wall.

The principal dentist was the safeguarding lead in the practice and all staff had undergone training in child protection and safeguarding vulnerable adults appropriate to their role.

We spoke with staff about signs that may lead them to believe a child or vulnerable adult was at risk, and what action they would take in such circumstances. Staff we spoke with had a good understanding of what to look out for, and how to raise a safeguarding concern.

The practice did not have a whistle blowing policy in place to guide staff about what to do if they wanted to raise concerns about a collegaue's practice. However, following our inspection, we received evidence that this was now in place.

The dentists in the practice used rubber dams (this is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth). It is recommended by The British Endodontic Society for use during root canal treatment as it prevents the patient from inhaling or swallowing debris or small instruments. Root canal treatment is where the dentist removes the nerve from an infected tooth using very small files. The empty canals are then shaped and filled to prevent any further infection.

On the occasions that a rubber dam could not be used (for example if it was not tolerated by the patient) staff would ensure that dental floss was tied around each small instrument. In this way the risk was reduced as instruments could be retrieved from the mouth with ease.

The practice used a system of disposable syringes. These have an outer plastic tube that slides over the needle and locks into place after it has been used. The needle can then be disposed of safely without any risk of needlestick injury. This was in accordance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The dentist took sole responsibility for disposing of the sharps in surgery mitigating the risk to the dental nurse.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. An automated external defibrillator (AED) was available in the building. 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 was stored together with the emergency drugs case, emergency oxygen and some of the emergency equipment in a marked cupboard behind the reception desk. Other emergency equipment was located in a marked cupboard in one of the surgeries.

Emergency equipment was available and in accordance with the guidance by the issued Resuscitation Council UK. The emergency drugs were found to be present and in date in accordance with the British National Formulary.

Are services safe?

A weekly check was carried out on the emergency drugs and records were found to this effect.

Glucagon is an emergency drug that is used to treat diabetics with low blood sugar. It needs to be stored between two and eight degrees Celsius in order to be effective until the expiry date. We found that although this medication was being stored in a medicines fridge, the temperature of the fridge was not being taken so it could be monitored. Therefore the practice could not be sure that this medicine would be effective in the case of a medical emergency. Following our visit we received confirmation from the practice that this medication is now stored appropriately.

Staff underwent regular training in basic life support, with their next refresher scheduled in the month following the inspection. Staff we spoke with had a good understanding of how to react in a medical emergency, and how specific medical emergencies should be handled.

Staff recruitment

Four staff recruitment files were viewed and found not to be compliant with the requirements of Schedule 3 of the Health and Social Care Act 2008.

Formal references were not sought for three members of staff, although the principal dentist explained that they were employed through a personal recommendation.

Immunisation records were also incomplete, with no records of Hepatitis B status for two members of staff. Hepatitis B is a virus that is carried in the blood and may be transmitted person to person by blood on blood exposure.

Contracts of employment were missing for three members of staff, but these were subsequently provided after the inspection.

Without full and comprehensive staff recruitment procedures the practice cannot be certain of employing fit and proper persons.

Monitoring health & safety and responding to risks

The practice had a comprehensive health and safety policy to help keep staff, patients and visitors to the practice safe. This was easily accessible to all staff in the practice. In addition a Health and Safety Law poster with appropriate contact details was displayed in the staff room.

The practice had undergone a fire risk assessment, and the results of this assessment had been implemented throughout the building. This included monthly fire safety tests (checking fire exits, smoke alarms and call points),yearly evacuation drills and regular servicing of the fire extinguishers.

There were systems in place to ensure that people's confidential information was kept safe. A data protection policy was in place in the practice.

Dental care records were stored electronically and password protected. Staff we spoke with described how they would log off the computer when they walked away from it. In addition it was noted that the screen at reception was positioned beneath a high counter and in this way could not be viewed by a patient standing at the desk.

Paper records were kept on site in locked drawers behind the reception counter.

There were adequate arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a comprehensive file of information pertaining to hazardous substances used in the practice, and actions described to minimise the risk to staff, patients and visitors.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising, and storage of dental instruments and reviewed their policies and procedures.

There was a written policy on cross infection control easily accessible in the practice. This included policies pertaining to transfer of instruments, ultrasonic cleaning, decontamination and hand hygiene. In addition infection control policy information was displayed in the decontamination room, and in each surgery.

Decontamination is the process by which contaminated instruments are washed, inspected, sterilised and packaged ready for use again. The practice had a separate room on the premises for this process to be carried out.

We were walked through the decontamination process in the practice by a dental nurse. Washing of the instruments

Are services safe?

was carried out by lidded ultrasonic cleaner. An ultrasonic cleaner is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound passing through a liquid.

The instruments were rinsed in a dedicated sink. After this the instruments were inspected individually under an illuminated magnifier to confirm all visible debris had been removed.

The practice had two different types of autoclave for sterilising the dental instruments. The steriliser that was used most often was a Type N autoclave meaning that instruments could not be sterilised inside pouches, instead instruments were removed from the autoclave before being sealed inside pouches.

This "pouching" of instruments was carried out in the "clean" area of the decontamination room, and each pouch was marked with the date it was sterilised and the date at which it would require re-sterilising.

The practice had developed a system to ensure all instruments were re-sterilised before they expired. Despite the fact that sterilised instruments can remain in pouches for up to one year before they have to be re-sterilised, the practise stamped all instruments to "expire" on one particular day a year (31 March). On this date all the instruments in the practice were re-sterilised. This method ensured that all instruments (even those that are used infrequently) were sterilised and ready for use at any time.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. They showed us paperwork they used to record and monitor checks daily and weekly checks of the equipment. In this way sterilisation could be assured over time.

The ultrasonic cleaners were also tested to confirm they were working efficiently, these tests were in line with HTM01-05 guidance.

The second autoclave which was used occasionally was a Type B autoclave. This means that instruments can be sterilised inside pouches. For this type of autoclave a different test should also be carried out called a steam penetration test. This test should be carried out daily, but the practice was performing this test weekly. After speaking to the registered manager this was implemented immediately.

We saw that the practice's reception, treatment rooms and decontamination room were visibly clean and clutter free. The clinical area had hard floor coverings that were in a good state of repair. Dental chair coverings were found to be intact and covered in a non-porous material, which enabled effective cleaning.

Infection control audits were noted up to 29 April2015, but as these should be carried out every six months, this was now overdue. In addition previous infection control audits had no action plans detailing how to improve and there was no evidence that learning was fed back to the dental team.

Records showed that a Legionella risk assessment had been carried out by an external contractor in June 2015. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. We found evidence that the action plan put in place following the risk assessment was being carried out. This included monthly monitoring of the mains water temperatures, regular disinfecting of the dental water lines, and running the dental water lines at the start of every day and in between every patient.

The practice employed a cleaner who was responsible for the floors and general cleaning of the practice. A cleaning schedule for these areas was available for reference.

The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises as described by the National Patient Safety Agency. This ensures that equipment used for cleaning is specific to the area that is being cleaned. For example, equipment used to clean sanitary areas is different to equipment used to clean the kitchen.

The practice demonstrated appropriate storage and disposal of their clinical waste and sharps. Waste consignment notices were seen pertaining to the removal of mercury amalgam, sharps, clinical waste bags and spent fixer and developer used to develop the X-ray images.

Equipment and medicines

We saw the practice had equipment to enable them to carry out the range of treatments they provided. They had a surgical drill unit and sterile saline for the placement of dental implants.

Are services safe?

Most equipment was up to date with servicing, the X-ray machines, X-ray developer, and autoclaves had all been serviced within the previous 12 months, and appropriate certification achieved.

It was noted that servicing was overdue for the compressor (used in the dental surgery to power the dental drills). This was bought to the attention of the registered manager who immediately made arrangements for an engineer to undertake a service.

Portable Appliance Testing had been carried out within the last year.

Temperature sensitive medicines were stored in a designated fridge; however the temperature of the fridge was not monitored to ensure the medication was stored at the correct temperature.

The practice dispensed antibiotics for patients who required it. We found these medicines to be stored securely in the practice and records kept of their use.

Local anaesthetic cartridges were store appropriately in blister packs and records of their expiry dates and batch numbers made in the patients' dental care records.

Radiography (X-rays)

The practice had intra-oral X-ray units as well as a dental panoramic tomograph (DPT) unit, which takes a larger X-ray to show the whole of the jaws and teeth on one radiograph.

The practice kept a radiation protection file in relation to the safe use and maintenance of X-ray equipment.

The local rules pertaining to the X-ray set were available both in the file, and also displayed on the wall alongside the X-ray units. The practice had in place a Radiation Protection Advisor and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 (IRR99). Included in the file were the critical examination pack for the X-ray sets and evidence that the principal dentist was up to date with the mandatory radiation training.

We did not see evidence that any of the associate dentists had undertaken mandatory radiation training. The registered manager informed us that they managed their training themselves, and that information was not held on file. We could not, therefore, be assured that this training was up to date.

The practice demonstrated they were mostly working in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Radiographs were quality assured and audited to ensure consistent good quality. The most recent audit of X-rays was 2015, although there was no action plan derived from this audit. Therefore continuing improvement in quality could not be assured.

Dental care records we looked at failed to indicate the justification for taking radiographs, as required by IR(ME)R, although the principal dentist assured us that she always discussed the reason for taking an X-ray with the patient.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the principal dentist and samples of dental care records were checked.

We found that patients' medical history was checked, updated and re-signed at every visit to the surgery; this meant the dentist was kept reliably informed of any medical changes that might impact treatment.

Assessments of the patients' oral health were made at each check-up appointment. A thorough examination of the soft tissues of the mouth and face was carried out and recorded in the patient notes. The dentist regularly checked the gum health by undertaking a basic periodontal examination (BPE). This is a screening tool that identifies concerns with gum health and triggers further examination or treatment if necessary.

Risk of gum disease and decay were noted in dental care records and used to determine recall interval in accordance with the guidelines from the National Institute of Clinical Excellence.

X-rays were taken at appropriate intervals and in accordance with the guidance issued by the Faculty of General Dental Practitioners. This guidance was also displayed for reference on the wall. Radiographs were reported in the patients' dental care records, but there was no written justification noted.

Children visiting the practice were given fluoride treatments at every check-up in accordance with the Delivering Better Oral Health toolkit This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Health promotion & prevention

The practice had in place several strategies to promote good oral health. One of the dental nurses was training as a dental health educator, which will enable her to give targeted, specific advice in dental health to individual patients. As part of her training, she had designed a poster that was displayed in the waiting room entitled "Sugar Uncovered"; this described the dangers posed by sugar to oral health.

Children were targeted for a positive oral health message both by this poster, and also by engaging in the "Colgate Bright Smiles" initiative. Free samples of toothpaste were available on reception, for patients and visitors to the practice.

We discussed with the principal dentist her strategies for advising patients in their wider health concerns. Advice was offered to patients regarding smoking, alcohol consumption and diet, when the need arose.

Staffing

Staff were supported in maintaining the continuous professional development (CPD) requirements made by the General Dental Council. Staff informed us that the practice subscribed to a dental nursing publication which meant they were able to stay up to date with new developments in their field.

We saw evidence of on-going CPD for the dental nurses, including mandatory requirements pertaining to medical emergencies and infection control. Other CPD undertaken in the last year included Health and Safety, Equality and Diversity and Child and Adult Safeguarding.

We did not see any CPD evidence pertaining to the dentists. The principal dentist explained that they all kept their own CPD records and copies were not kept at the practice.

There was an appropriate skill mix of staff to deliver the services offered. One of the nursing staff had completed her sedation training with SAAD (Society for the Advancement of Anaesthesia in Dentistry) to assist the sedating dentist.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. Urgent referral were made to the hospital by both faxing and sending the letter to ensure it arrived in a timely manner.

Referrals were made locally to specialists in root canal treatments and oral surgery and could be made privately or on the NHS.

A record of all referrals were made in a book at reception, this ensured that patients' referrals could be tracked and chased up necessary, reducing any potential delay to patients in receiving their treatment.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The practice ensured that patients' valid consent was obtained for all care and treatment. Staff we spoke with told us that all treatment options were discussed in detail, including the risks and benefits of a particular treatment option and costs involved before decisions were made. Written treatment plans were provided and patients were encouraged to take them away, and if necessary, arrange a further appointment to discuss any additional concerns prior to starting treatment.

The dental staff demonstrated a good understanding of the core principles of the Mental Capacity Act 2005 (MCA) .The MCA 2005 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 dentist informed us of the circumstances when a young person might be deemed Gillick Competent. This is when a young person (aged 14-16) understands enough about their treatment and the consequences that they are able to consent for themselves, not requiring a parent to consent on their behalf.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from 29 patients who had attended the practice in the last two weeks. Patients described the practice and staff as friendly, respectful, kind and caring. Comments were made regarding the professionalism from the staff; and the aftercare following tooth extraction was also singled out as an area of appreciation from the patients.

Patients who had had bad experiences at other practices reported how well they were put at ease by the staff at the practice, and were always treated with dignity and respect.

Staff described how they put children at ease in the practice, using simple terminology for example “sugar bugs” (to describe oral bacteria) to engage them on their oral health.

We observed patients were welcomed in a friendly and professional manner. In most cases the patients knew that staff well, indicating how long some of the patients had been attending the practice.

Involvement in decisions about care and treatment

Patients we spoke with during our inspection were all happy that treatment options were explained to them by staff, and they felt involved in their treatment. Risks and benefits of treatment options were explained to them.

We received comments that the costs of treatment were always clearly discussed with them in advance. A price list was available as a leaflet in the waiting room.

Dental care records also documented the options that had been outlined to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

The answerphone message for the practice gave an out of hours mobile number. This mobile phone was kept by the principal dentist at all times. In this way the practice was able to provide for the patients' out of hours needs, and arrange to see them if necessary.

Patients were reminded of their appointments by text message, and patients commented at how useful this was.

We were informed by the patients that it was generally easy to get an appointment at a time that suited them. The practice offered both early and late appointments Monday to Friday and Saturday appointments once a month.

Conscious sedation was offered at the practice for the treatment of anxious adults. This is where an intravenous sedative is given slowly over a period of time to relax you to a point where you are still able to respond, but you feel calm and relaxed. Dental treatment is then carried out, which the patient will typically have no memory of after the event.

The dentist who provided the sedation was not present on the day of the inspection, and therefore we were not able to discuss with him his practice regarding this. The principal dentist informed us that the dentist providing sedation brought the required monitoring equipment with him when he visited the practice, and she did not monitor his training in this field. One of the qualified dental nurses had completed a course in sedation, and she acted as his assistant.

Some patients commented that appointments could overrun, and they were not always seen on time.

Tackling inequity and promoting equality

The practice welcomed patients from diverse backgrounds and cultures. Several languages were spoken by members of the practice staff, including, French, Spanish Italian and Urdu.

The practice undertook a disability audit in July 2015. They had put in place ramp to the front of the property to improve access for wheelchair users. Wheelchair users could access a surgery with ease, although there was no disabled toilet on site.

Access to the service

Practice opening hours were from 9.00 am to 5.30 pm Monday and Wednesday, 8.30 am to 6.00 pm on Tuesday, 8.30 am to 7.00 pm on Thursday, 9.00 am to 5.00 pm on Friday and Saturdays once a month from 9.00 am to 4.00 pm.

On street parking was available outside the practice, but was limited to one hour. A larger pay and display car park was two minutes walk from the practice.

If patients had an emergency, the practice informed us they would always see them on the same day, even if it meant working later into the evening.

Concerns & complaints

The practice had a comprehensive complaints policy. Information for patients on how to make a complaint was available on the wall outside the waiting room, and on their website.

We saw evidence that complaints had been handled by the practice in accordance with their policy, apologies had been issued to patients appropriately, and actions take to prevent the re-occurrence of particular issues.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took overall leadership in the practice, leading on clinical, management and quality monitoring roles including child protection and safeguarding vulnerable adults. They were supported by a practice manager. There was a dental nurse lead for infection control.

In regard to staff recruitment, formal references were not sought for three members of staff. Immunisation records were also incomplete, with no records of Hepatitis B status for two members of staff. Hepatitis B is a virus that is carried in the blood and may be transmitted person to person by blood on blood exposure.Contracts of employment were missing for three members of staff, but these were subsequently provided after the inspection.

All of the staff at the practice worked part time and the inspection team felt there were inadequate measures in place to ensure messages were communicated effectively across the team. Formal staff meetings did not take place, although staff described informal lunchtime meetings, these would typically only involve the staff working on that day. No agendas or minutes of these meetings were kept or shared so it was not clear how information was communicated to staff who could not attend.

The registered manager did not have access to, and did not request, information regarding the continuing professional development of the associate dentists. As such, they were unable to provide assurances that mandatory training regarding radiation (X-ray) safety, infection control and medical emergencies training had been carried out.

Documentation pertaining to the required training for a dentist carrying out sedation was also kept personally by the individual dentist and not reviewed by the registered manager. Therefore we could not be assured on the day of inspection, that this training was up to date.

The practice had policies and procedures in place to support the management of the service, and these were readily available in hard copy form. Many of the policies had not been reviewed since 2012; therefore the continued relevance and accuracy of these policies could not be assured.

Staff were not offered an annual appraisal, although this would be of benefit in establishing the training needs of each member of staff. Staff we spoke with felt comfortable discussing their training needs informally. The practice has subsequently informed us that a programme of formal appraisals of staff has been implemented.

Leadership, openness and transparency

Staff we spoke with felt comfortable raising concerns with the practice manager or principal dentist and felt they would be supported if they did so. The open culture at the practice encouraged candour and transparency.

Any concerns that the staff had could be bought up at a lunchtime meeting, or privately and would be dealt with or discussed as appropriate.

Learning and improvement

The practice demonstrated some commitment towards continuous improvement.

We observed that essential training requirements for the individual nursing and administration staff were monitored to ensure they were kept up to date. Staff were supported to fulfil the General Dental Council requirements in continuing professional development (CPD). Training had been carried out in the last year pertaining to, safeguarding vulnerable adults, child protection and health and safety. The practice funded a subscription to a dental journal for the staff to stay up to date with any changes in the field, and staff we spoke with expressed how useful they found this.

Essential monitoring of services was not always carried out to an appropriate standard. Infection control audits were noted up to 29 April2015, but as these should be carried out every six months, this was now overdue. In addition previous infection control audits had no action plans detailing how to improve and there was no evidence that learning was fed back to the dental team.

Similarly radiographs were quality assured and audited to ensure consistent good quality. The most recent audit of X-rays was 2015, although there was no action plan derived from this audit. Therefore continuing improvement in quality could not be assured.

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

Are services well-led?

The practice had in place a comment book, and suggestion box in the waiting room. We did not find any recent action plan resulting from patient surveys to address the issues raised by them.

Staff we spoke with described how they have acted in response to patients' comments regarding late running appointments by making appointment times longer for certain procedures.

The practice gathered feedback from staff informally between sessions and in lunchtime meetings.

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 **How the regulation was not being met:** We found the provider had not reviewed many of their policies and procedures to ensure their continued relevance and accuracy. Clinical audit in Infection Control and X-ray quality and had not been completed to an appropriate standard, with no action plans drawn up or carried out. The registered manager did not ensure that the associate dentists had performed the relevant mandatory training to carry out particular procedures for example taking X-rays. This was in breach of Regulation 17(1), 17 (2) (a), 17 (2) (b) and 17 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider did not operate effective recruitment procedures. Written references were not always sought for new members of staff. Hepatitis B status information was not recorded for all staff. Contract information was not on record for all staff. This was in breach of Regulation 19 (1) (a), 19 (2) (a) of the Health and Social Care Act.