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College Dental Surgeries

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

College Dental Surgeries is located in Maidstone, Kent and offers general dentistry services on a private basis with the option of a national dental payment plan available. The practice has four dentists, two hygienists, five dental nurses and one receptionist. The team is supported by the practice manager who is also a registered dental nurse.

The practice has four treatment rooms, a separate decontamination room, a spacious reception, two waiting areas, and staff facilities.

The practice is open: Monday – Thursday 8.30am to 5.30pm and Fridays 8.30am to 12.30pm.

One of the partners 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'. 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.

On the day of inspection we received 47 CQC comment cards providing feedback and spoke to nine patients. The patients who provided feedback were very positive about the care and attention to treatment they received at the practice. They told us they were involved in all aspects of

Summary of findings

their care and found the staff to be excellent, great at responding to pain requirements, helpful and they were treated with dignity and respect in a clean and tidy environment.

Our key findings were:

- Patient care and treatment was planned and delivered in line with evidence based guidelines, best practice and current regulations.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were consistently involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs. Appointments were easy to book and emergency slots were available each day for patients requiring urgent treatment.
- There was a complaints system. Staff recorded complaints and cascaded learning to staff.
- The governance systems were effective.
- The practice sought feedback from staff and patients about the services they provided.
- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Strong and effective leadership was provided by the principal dentist.
- Infection control procedures were not carried out in accordance with current guidance
- The practice had not carried out the required checks on staff before they started work.
- .The practice was clean, spacious and very well maintained.

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

- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.

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?

Requirements notice 

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

The practice had arrangements for essential areas such as clinical waste control, management of medical emergencies at the practice. We found that processes in relation to infection control and some areas of radiography were not carried out effectively. We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice, although particular checks had not been conducted before staff had contact with patients. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

No action

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

We collected 47 completed Care Quality Commission patient comment cards and obtained the views of a further nine patients. These provided a positive view of the service the practice provided. All of the

patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

No action

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

Summary of findings

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to telephone interpreter services when required. The practice had ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

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).

Strong and effective leadership was provided by the principal dentist. The principal dentist, practice manager and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. The practice had robust clinical governance and risk management structures in place. Staff told us that they felt well supported and could raise any concerns with the principal dentist and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

Requirements notice 

College Dental Surgeries

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 inspection was carried out on 19 October 2016 by a CQC inspector who was supported by a specialist dental adviser. Prior to the inspection, we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their

latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During the inspection, we spoke with the principal dentist, a dentist on duty, dental nurses and receptionist and reviewed policies, procedures and other documents. We also obtained the views of nine patients following the day of our visit. We reviewed 47 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at 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.

Requirements notice

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff demonstrated a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The practice reported that had been no incidents during 2016 that required investigation. Staff showed us the reporting forms they would complete, explained what they would record and what discussions would take place so that incidents could be prevented in future.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). We discussed a recent alert regarding an emergency medicine which had been recalled, staff had checked the medicine in question and found it was not on the recall list.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. Dentists were also responsible for the disposal of used sharps and needles. The practice had a protocol for staff to follow should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked the principal dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. This was confirmed by the dental nurses we spoke with. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice manager acted as the safeguarding lead and acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was available for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been one safeguarding incident that required further investigation by appropriate authorities which was historical but demonstrated how their process worked.

Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment. The practice had emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

We reviewed recruitment files and found that most pre-employment checks had been undertaken for some staff. For example, evidence of qualifications, registration with the relevant professional body. However three

members of staff had not undergone checks through the Disclosure and Barring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We saw that indemnity insurance had been acquired for the clinicians and was current.

The practice did not routinely take up references for staff who had recently been employed, and there were no notes recorded of the interview held or the questions asked. Not all of the clinical staff had information recorded of their immunisation status.

Monitoring health & safety and responding to risks

The practice had arrangements to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

In one of the treatment rooms we saw there was a gas fire. Staff told us this was used in the colder months. We noted that there had been no risk assessment conducted with regard to the hazards the fire in use presented. There was no fire guard to restrict touching of the fire when in use or signage warning people. We discussed this with the provider who stated they would obtain and fit a fire guard as soon as possible.

The practice had a well-maintained comprehensive Control of Substances Hazardous to Health (COSHH) files. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

The practice demonstrated gaps in their processes to reduce the risk and spread of infection. The practice had an infection control policy that had been regularly reviewed. We observed the cleaning process and reviewed the practice protocols for HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were not being conducted in line with this guidance. We reviewed an audit of infection control processes carried out in October 2016 which had recorded a score of 96%. We noted that this percentage was not possible with the current processes the practice was using.

We saw that three dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. One surgery was cluttered and unorganised. We noted that there was no clear zoning in the surgeries or decontamination room to demark clean from dirty areas.

Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of three of the treatment rooms were inspected and these were clean, ordered and free from clutter. One treatment room was cluttered and disorganised. We found four expired dental materials and asked the provider to dispose of these immediately which they did. Each treatment room had the appropriate routine personal protective equipment available for staff use; this included protective gloves, masks and eye protection.

A dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2011. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

We saw that one of the treatment rooms had carpet which was within the one metre catchment zone of the dental

chair. We discussed this with the provider who stated that the carpet would be removed as soon as possible as it did not facilitate cleaning of a sufficient standard in a clinical area.

The practice had a separate decontamination room for instrument processing. Staff we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. We noted that there were no defined dirty and clean areas so could not be assured that a well-defined system of zoning from dirty through to clean was being observed. The practice used a system of manual scrubbing and an ultra-sonic cleaning bath for the initial cleaning process, following these two initial process instruments were inspected with an illuminated magnifier; then the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. Most pouches were dated with an expiry date in accordance with current guidelines but a number of pouches were not dated, staff told us that this had been an oversight and this would be addressed immediately by re-processing the pouched instruments in question. We saw the re-pouched instruments which were dated before the end of our inspection.

We were shown the systems to record activity of the autoclaves used in the decontamination process to ensure they were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were not complete or up to date. The records we viewed did not state which autoclave each test referred to and the daily TST strip test was only being conducted twice a week.

We could not be assured that all recommended tests to validate the ultra-sonic cleaning bath were carried out in accordance with current guidelines; there was no log book available for the ultrasonic bath so we could not be assured this piece of equipment was working effectively.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Environmental cleaning was carried out by an external cleaner. We noted that there was only one mop and bucket which was used for all areas of the practice. This did not follow national guidance.

Equipment and medicines

Equipment checks by engineers were regularly carried out in line with the manufacturer's recommendations. For example, the two autoclaves had been serviced and calibrated in 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in April 2016.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. However we did find some local anaesthetic cartridges had been removed from their blister packs. We brought this to the attention of the principal dentist who disposed of the cartridges immediately. We found that the practice stored prescription pads securely overnight to prevent loss due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and spill kits to deal with body fluid and mercury spillage.

Radiography (X-rays)

We were shown a radiation protection file in line with the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs, and a copy of the local rules. However, we noted that a critical examination test results were not available for a newly installed X-ray unit and there was no

Requirements notice

Are services safe?

Health and Safety Executive (HSE) notification available for this piece of equipment. The provider assured us that they would chase up the critical examination report and apply to the HSE for notification immediately.

No radiological audits for the dentists had been carried out. We were shown a list of radiographs taken but there was no information recorded regarding who was assessing the images, if at all. What was the percentage of grade 3 images and how many of these resulted in a second or further exposure or why the image was a grade 3. Therefore it was not possible to implement changes in practice to reduce the number of grade 3 images taken. Some dental care records we viewed contained records of why X-rays had been taken showing that these X-rays were justified, reported on and graded. These findings showed that practice was mostly acting in accordance with national radiological law. However we could not be assured that patients and staff were protected from unnecessary exposure to radiation.

We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 and IRR 99 Regulations.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we reviewed demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental therapist and two dental hygienists to work alongside of the dentists in delivering preventative dental care. One dentist we spoke with explained that patients at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition.

They also placed fissure sealants (thin coatings on the biting surfaces of permanent back teeth) on patients who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we reviewed demonstrated that dentists and the therapist and hygienists had given oral health advice to patients.

The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. Underpinning this was a range of leaflets explaining how patients could maintain good oral health.

Staffing

The practice had four dentists working different days over the course of a week and were supported by five dental nurses, and two dental hygienists. Other staff include a practice manager who is also a registered dental nurse, a receptionist and a cleaner. We observed a friendly atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. The staff appeared to be a very effective and cohesive team; they told us they felt supported by the principal dentist and other dentists. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress. We confirmed that the dental nurses received an annual appraisal and had personal development plans. These appraisals were carried out by the principal dentist. There was effective use of skill mix in the practice. This enabled the dentists to concentrate on providing care to patients whose needs were more complex whilst the dental hygienists provided routine care and advice.

The practice had a system for recording training that staff had completed and the details of continuing professional development (CPD). We saw confirmation of current General Dental Council (GDC) registration, and current

No action

Are services effective?

(for example, treatment is effective)

professional indemnity cover where applicable. All of the patients we spoke with said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards we received.

Working with other services

One of the dentists explained how they would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

We noted the practice used a referral tracking system to monitor referrals from the practice. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with the dentists about how they implemented the principles of informed consent; all of the dentists had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan and the patients dental care records. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

To underpin the consent process the practice had developed bespoke consent forms for more complex treatment including root canal treatment, surgical removal of teeth and dental implants. The dentists went onto explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed.

They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists or the hygienist. Conversations between patients and clinicians could not be heard from outside the treatment rooms which protected patient's privacy.

Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinets at various points in the practice. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 47 completed CQC patient comment cards and obtained the views of nine patients following the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed that they were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed on the patient notice board in the waiting area. Booklets were also available in the waiting area and on the practice website that detailed the costs of both NHS and private treatment.

The dentists we spoke with paid particular attention to patient involvement when drawing up individual treatment plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at the examples of Information the practice had available for people. We saw that the practice waiting area displayed a wide variety of information including the practice patient information leaflet and leaflets about the services the practice offered, , how to make a complaint, fire procedures for patients to follow and the practices quality assurance policy.

The patient information leaflet explained opening hours, emergency 'out of hours' contact details and arrangements, staff details and how to make a complaint. The practice website also contained useful information to patients such as leaflets about different types of treatments which patients could down load and how to provide feedback on the services provided. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that would hamper them from accessing services. The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

To improve access the practice had level access and treatment rooms on the ground floor The practice was spacious and easily accessible for patients with disabilities or infirmity as well as parents and carers using prams and pushchairs.

Access to the service

The practice was open Monday to Thursday 8.30am to 5.30pm and Friday 8.30am to 12.30pm. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet, practice website, at the entrance to the practice and on the telephone answering machine when the practice was closed.

Concerns & complaint

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the patient leaflet, poster in the waiting area and patient website.

The practice had received four complaints during the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. We saw that the complaints had been managed according to the practice's policy.

Requirements notice

Are services well-led?

Our findings

Governance arrangements

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for the practice was facilitated by the principal dentist who was responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures. All of the staff we spoke with were aware of the policies and how to access them. We noted all policies and procedures were kept under review by the principal dentist and practice manager on a regular basis. We found that auditing activity for infection control held little value in achieving improvement. We looked at the most recent infection control audit which had scored 98%. This percentage pass was not achievable with the current processes carried out in the practice. We saw that there had been minimal auditing activity in relation to the quality of X-rays taken. We asked to see the most recent X-ray quality assurance audit. We noted that the information supplied was a collection of data; a list of X-rays taken and their grades. There had been no analysis of this information to determine the percentages of each grade taken.

Leadership, openness and transparency

Strong and effective leadership was provided by the principal dentist. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice manager or the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern however minor. We found staff to be hard working, caring and committed to the work they did. All of the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and the standards for dental professionals and were happy with the practice facilities. Staff reported that the principal dentist was proactive and resolved problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs by means of an appraisal system and a programme of clinical audit. For example we observed that the dental nurses and receptionists received an annual appraisal; these appraisals were carried out by the principal dentist. These were held on a six weekly basis and were chaired by the principal dentist. Subjects discussed at recent meetings included consent, specific dental cases, mouth cancer and the Mental Capacity Act.

The practice used the principle of the 'daily chats' which were carried out by the staff to increase their awareness of the particular needs and risks of patients including issues around their medical, social and clinical needs; to ensure the smooth running of the service and to double check that work from the laboratory had been received.

We found there was a rolling programme of some clinical and non-clinical audits taking place at the practice. These included infection control and clinical record keeping. We were shown lists of radiographs taken by each dentist but no audit activity in relation to the quality of X-rays. The infection control audit results did not reflect the processes and procedures currently used by the practice. Therefore we could not be assured that audits were used to drive improvement.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council for medical emergencies, but mainly sourced their own training. Staff at the practice used a variety of ways to ensure they completed staff training which included internal training and staff meetings as well as online courses.

We saw that the practice did have records of staff training but there was no process to identify when training would need to be completed or refreshed to be on track for revalidation with the GDC.

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

The practice had gathered feedback from patients through compliments and complaints. We saw that there was a robust complaints procedure in place, with details

Are services well-led?

available for patients in the waiting area, practice leaflet and on the website. The practice' ran a patient satisfaction survey programme. Staff had discussed the content of the patient satisfaction survey at the most recent staff meeting.

Staff told us that the principal dentist was very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every six weeks and the minutes of these were made available if they could not attend. Records we viewed confirmed this. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • Decontamination processes were not in line with HTM 01- 05 guidance. Clinical areas did not have dirty to clean flow demarcation. • One treatment room was cluttered, disorganised and had carpet in the one meter aerosol zone around the chair. • The autoclaves were not being checked daily as per HTM-01-05 guidance. • The ultrasonic bath was not maintained as per HTM-01 05 guidance by means of a weekly protein residue check and a quarterly foil ablation test. • The environmental cleaning was not being carried out effectively. There was only one mop and bucket being used to clean the floors, including the toilets and the treatment rooms. • Auditing activity for infection control did not reflect current infection control practice and did not pick up the gaps identified. • Radiography quality assurance was not taking place to drive improvement and to reduce unnecessary exposure to radiation.

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 always aquire the documents in Schedule 3 when employing staff. Three members of staff had not been subject to a Disclosure and Barring check before they had contact with patients.**

This section is primarily information for the provider

Requirement notices

- The provider did not aquire satisfactory evidence of conduct in previous employment to ensure staff were safe to work with vulnerable adults and children.