

Papineni Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 November 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 not providing well-led care in accordance with the relevant regulations.

Background

The practice is located within a purpose adapted residential property in Benfleet, Essex and offers a range of NHS general preventative, restorative and cosmetic dental treatments to adult patients and children.

The practice is open between 9.15am and 5.15pm on Mondays to Fridays and between 9.15am and 12.15pm on Saturdays. The practice closes between 12.15pm and 2.15pm for lunch.

The principal dentist and one other dentist work at the practice. The dentists are supported by one dental nurse and two receptionists.

The practice is registered with the Care Quality Commission (CQC) as an organisation. The principal dentist is the registered manager. 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 has one treatment room, a reception area and a waiting room. Decontamination takes place within the treatment room and a dedicated decontamination room (Decontamination is the process by which dirty and contaminated instruments are washed, inspected, sterilised and sealed in pouches ready for use again).

Our key findings were:

Summary of findings

- The practice had a procedure in place for sharing relevant information, investigating and learning from complaints, safety incidents and accidents. However, staff were not aware of their responsibilities to report incidents.
- The practice was visibly clean. Infection control practices were not in accordance with current guidelines, reviewed or audited to test their effectiveness.
- Dental instruments were not cleaned or stored in line with the current guidance to help minimise risks of cross infection.
- Clinical waste including sharps and needles were not stored securely in line with current waste regulations.
- The systems in place to help keep people safe, including safeguarding vulnerable children and adults were not robust, understood or followed.
- The practice medicines and equipment for use in the event of a medical emergency were in line with current guidelines.
- Medicines were checked frequently to ensure that they were in date.
- Staff had not undertaken training in respect of their roles and responsibilities within the practice.
- Patients reported that they were very satisfied with their treatment and that staff were respectful and helpful.
- The practice could normally arrange same day emergency appointments and a routine appointment within a few days. Appointments were flexible to meet the needs of patients.
- The governance arrangements in place for the smooth running of the service were not effective. Risks to patients and staff were not assessed or managed.
- Audits and reviews were not carried out to monitor and improve services.
- Patient's views were routinely sought to make improvements to the service where these were identified.

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

Ensure that there are systems in place to deliver safe care and treatment and to protect the health, safety and welfare of patients. This includes procedures to:

- 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'.

- The practice's sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01)
- The training, learning and development needs of staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff employed.
- Systems are implemented in respect of the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.

Ensure that there are systems in place for monitoring and improving the quality and safety of services carried out at the practice. This includes:

- Implementing protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Carrying out audits of various aspects of the service, such as infection control and radiography at regular intervals to help improve the quality of service. Practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure that all staff undertake training appropriate to their roles and responsibilities within the practice.
- Keeping the practice policies and procedures under regular review so that they reflect the management of the practice and current relevant legislation and guidance.

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

Following our inspection the provider told us that they had made improvements to the service in relation to the

Summary of findings

concerns we identified. They submitted some documents in relation to the improvements made. However we are unable to assess the effectiveness of the improvements we have been told about or be assured that these improvements are ongoing and embedded into practice.

We will assess these improvements when we carry out a follow up inspection in line with our methodology.

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 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 at the end of this report).

The practice systems and processes to provide safe care and treatment and to assess and minimise risks were not fully understood or followed. The recommendations from professionals who carried out fire and electric safety assessments had not been undertaken.

Risks in relation to fire safety, legionella and infection control were not assessed properly or managed to help keep patients and staff safe.

There were limited procedures in place to safeguard children and vulnerable adults. Staff had not undertaken safeguarding training appropriate to their roles and responsibilities. Staff who we spoke with did not understand their responsibilities in this area.

The procedures in place for cleaning and storing dental instruments were not in-line with the current guidance to help minimise risks of cross infection, however sterilisation procedures were in line with current guidance.

Equipment within the practice was regularly checked, serviced and maintained according to the manufacturer's instructions. The practice kept the range of recommended medicines and equipment for use in medical emergencies and staff were trained in basic life support procedures.

Following our inspection the provider told us that they had made improvements to the service in relation to the concerns we identified. They submitted some documents in relation to the improvements made. However we are unable to assess the effectiveness of the improvements we have been told about or be assured that these improvements are on-going and embedded into practice.

We will assess these improvements when we carry out a follow up inspection in line with our methodology.

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Requirements notice



Are services effective?

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

The practice had policies and procedures to ensure the effective delivery of care and treatment. Patient consultations were carried out in line with good practice guidance from the National Institute for Health and Care Excellence (NICE).

No action



Summary of findings

There were systems in place to ensure that patients' medical histories were obtained and reviewed to help the dentists identify any risks to patients. The dentist told us that oral assessments were carried out in line with current guidance. However information in relation to assessments was not consistently recorded within patient treatment records.

The dentist told us that patients were offered options of treatments available and were advised of the associated risks and intended benefits. Details of these discussions were not consistently recorded.

Consent to care and treatment was sought in line with current relevant guidelines. Patients were provided with a written treatment plan which detailed the treatments considered and agreed together and the fees involved.

Patients were referred to other specialist services where appropriate and in a timely manner.

The dentists were registered with the General Dental Council (GDC). However staff did not undertake training in relation to their roles and responsibilities within the practice and the practice did not have robust systems to appraise staff performance or to identify training and development needs.

Are services caring?

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

The patients who we spoke with said that they were treated with respect and kindness by staff. They said that the dentists and dental nurse were patient, caring and understanding. Patients said that reception staff were kind and respectful.

Patients said that they were able to be involved in making decisions about their dental care and treatment. They said that they were allocated enough time and that treatments were explained in a way that they could understand, which assisted them in making informed decisions.

No action



Are services responsive to people's needs?

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

Information about the practice was available in a practice patient leaflet. This provided information about the dental team, opening times and how to access emergency dental treatments when the practice was closed.

Appointments could be booked in person or by telephone. The receptionist and dentist told us that patients who required emergency treatments would always be seen on the same day.

No action



Summary of findings

The practice was open between 9.15am and 5.15pm on Mondays to Fridays and between 9.15am and 12.15pm on Saturdays. The practice was closed for lunch between from 12.15pm to 2.15pm each day. Patients told us they were satisfied with the appointments system and that getting through on the telephone was easy.

The practice premises were accessible and provided step free access and sufficient room to cater for patients who used wheel chairs or other mobility aids.

The practice had a complaints process which was available to support any patients who wished to make a complaint. The process described the timescales involved for responding to a complaint and who was responsible in the practice for managing them.

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 Enforcement Notices at the end of this report).

The governance arrangements and leadership within the practice were not robust to ensure that appropriate systems were in place to monitor and improve the quality and safety of services. Relevant guidance and procedures in relation to safety and specific guidance in respect of dentistry was not fully understood or followed by the practice team.

Risks to the health, safety and welfare of patients and staff were not assessed or managed in a robust way. Audits and reviews were not carried out and used to monitor and improve the quality of the services provided.

The learning and development needs of staff were not reviewed and staff had not received appropriate training in relation to their roles and responsibilities.

The practice had systems to obtain and act on feedback from patients to improve the quality of the service provided.

Following our inspection the provider told us that they had made improvements to the service in relation to the concerns we identified. They submitted some documents in relation to the improvements made. However we are unable to assess the effectiveness of the improvements we have been told about or be assured that these improvements are on-going and embedded into practice.

We will assess these improvements when we carry out a follow up inspection in line with our methodology.

Requirements notice 

Papineni Dental Practice

Detailed findings

Background to this inspection

The inspection was carried out on 2 November 2016 and was led by a CQC inspector. The inspection team also included a dental specialist advisor.

The methods that were used to collect information at the inspection included interviewing patients and staff, observations and reviewing documents.

During the inspection we spoke with the principal dentist, the dental nurse and one receptionist. We also spoke with six patients and reviewed the comments made by 51 patients who completed CQC comment cards.

We reviewed policies, procedures and other records relating to the management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a patient safety policy and the principal dentist was identified as the patient safety officer who held the responsibility to investigate, respond to and share learning from accidents, incidents and complaints. The dentist and the dental nurse who we spoke with were not aware of their responsibilities under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). They both told us that there had been no accidents, incidents or complaints for many years.

The principal dentist told us that they were aware of their responsibilities under the duty of candour. They described the action they would take if there was an incident or accident that affected a patient. They told us that affected patients would be contacted and offered an apology and an explanation of what actions had been taken to address the issues and to minimise the risks of this recurring.

The dentist told us that they reviewed alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness. Both the dentist and the dental nurse were able to demonstrate that they had reviewed and acted on recent safety alerts.

Reliable safety systems and processes (including safeguarding)

The practice did not have policies and procedures in place for safeguarding children and vulnerable adults. Staff had not undertaken safeguarding training and did not have information to refer to should they have concerns relating to the safety or welfare of patients. The principal dentist told us that staff were provided with the telephone number to contact the local safeguarding team and we saw that this was available in posters at the reception desk. However staff who we spoke with were not able to demonstrate that they had a good awareness of safeguarding procedures or their responsibilities in relation to these.

The practice did not have a whistleblowing policy to describe how staff could raise concerns. Staff who we spoke with told us that they would discuss any concerns with the dentist. They told us they felt confident and supported to raise concerns without fear of recriminations.

Medical emergencies

The practice had some procedures in place for staff to follow in the event of a medical emergency. Training records which we were provided with showed that all staff working at the practice had undertaken training in basic life support in October 2016. The previous training had occurred in 2014. Some staff who we spoke with were not clear about their roles and responsibilities in the event of a medical emergency.

The practice kept the recommended range of equipment and medicines including oxygen and an Automated External Defibrillator for use in a medical emergency in line with the 'Resuscitation Council UK' and British National Formulary guidelines. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

We were shown a list of the emergency medicines which included their expiry dates. The principal dentist told us that the medicines and equipment were regularly checked to ensure that they were in date and available for use if required. There were records maintained in respect of these checks.

We found that one medicine, glucagon (used to raise blood sugar levels) was not stored in line with the manufacturer's recommendations. This medicine was stored within a refrigerator. However the temperature was not monitored to ensure that it was maintained within the acceptable range to ensure the medicine's efficacy. Appropriate action was taken at the time of the inspection to ensure that this medicine was stored correctly in line with the manufacturer's instructions.

Staff recruitment

The practice had a recruitment policy, which described the process to be followed when employing new staff. The principal dentist told us that there had been no newly employed staff for many years and staff records which we were shown confirmed this. We saw that the dentists and the dental nurse had been checked by the Disclosure and Barring Service (DBS). The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Are services safe?

We saw that all relevant members of staff had personal insurance or indemnity cover in place. These policies help ensure that patients could claim any compensation to which they may be entitled should the circumstances arise. In addition, there was employer's liability insurance which covered employees working at the practice

Monitoring health & safety and responding to risks

The practice had some policies and procedures to cover the health and safety concerns that might arise in providing dental services generally and those that were particular to the practice. However these were not adhered to and discussions with the principal dentist and the dental nurse demonstrated that they did not fully understand these procedures or their responsibilities in relation to these.

There was a Health and Safety policy statement and a safety risk assessment template. However there was no risk assessment to identify risks to patients and staff in relation to premises or equipment.

There were some procedures for dealing with fire including safe evacuation from the premises. Fire safety equipment was checked annually by an external contractor and fire evacuation procedures were displayed. The principal dentist showed us a record of dates on which they told us that fire safety equipment was checked. However this did not include details of the equipment which had been checked and detailed records of fire safety checks were not maintained.

The last fire safety risk assessment had been carried out in October 2013 from which a number of recommendations were made. These included providing fire safety awareness training for staff. The principal dentist confirmed that staff had not undertaken training and told us that fire safety procedures were discussed during the practice meetings.

The records from the practice meeting in October 2016 indicated that the fire and evacuation procedures had been discussed with staff. However staff who we spoke with were unclear as to their responsibilities in the event of a fire.

The practice did not have procedures in respect of Control of Substances Hazardous to Health (COSHH). There was no information about the risks associated with chemical agents used at the practice or how exposure to these chemicals should be treated. COSHH was implemented to protect workers against ill health and injury caused by

exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way.

Infection control

There was an infection control procedure in place however this was not fully understood or followed. Records which we were shown indicated that the principal dentist and the dental nurse had not undertaken infection control training since 2014. Discussions with both the dentist and the dental nurse showed that they did not fully understand or follow infection control procedures to minimise risks to patients and staff.

The practice had a range of personal protective equipment including disposable gloves, face masks and protective eyewear. However we observed that the dentist and dental nurse did not follow recommended procedures around the effective use of this protective equipment. For example: the dentist and dental nurse were observed throughout the inspection leaving the dental surgery treatment room without removing their gloves. The dental nurse was observed manually cleaning dental instruments without wearing heavy duty gloves or protective eyewear to minimise the risks of injury with contaminated instruments or materials.

Records showed that the dentists and the dental nurse had received inoculations against Hepatitis B. It is recommended that people who are likely to come into contact with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections.

All areas of the practice were visibly clean. The principal dentist told us that a cleaner was employed three days each week and that they cleaned the practice on the remaining days. There were no cleaning schedules to demonstrate the frequency for cleaning equipment or clinical and non-clinical areas within the practice. The equipment for cleaning clinical and non-clinical area was not clearly identifiable and there was no system for zoning from 'dirty' to 'clean' areas within the dental surgery or the decontamination room to minimise the risk of cross infection.

Records in respect of the cleaning checks that should be carried out at the start/end of each day and between patient's treatments were not maintained.

Are services safe?

The dental nurse told us that dental instruments were manually cleaned in the dental surgery before being transported to the decontamination room for sterilisation. There were no procedures in place for staff to follow to ensure that this practice was done in a way to help minimise the risks of cross infection. We observed the dental nurse carrying out the process for cleaning and storing dental instruments and found that this process was not carried out in accordance with the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices. We observed dental instruments being scrubbed manually under running water which increased the risk of contamination within the surgery area. The temperature of the water used to clean instruments was not monitored so that it was maintained below 45 degrees in order ensure that protein was removed from the instruments. The dental nurse then transferred the wet dental instruments in a perforated tray from the dental surgery, through the reception area into the decontamination room, which further increased the risk of contamination.

Sterilised instruments were kept unpouched in various boxes and drawers within the dental surgery. The principal dentist and dental nurse told us that any unused instruments were re-sterilised at every 21 days, which is contrary to the current guidance. We also found quantities of visibly damaged dental instruments which were stored with dental instruments which were in use.

We saw records which showed that the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. Records were kept of the decontamination cycles of the autoclaves to ensure they were functioning properly.

The practice had a policy in place for handling clinical waste including needles and disposable dental instruments. However the dentist and dental nurse could not demonstrate that they understood and followed these procedures. Clinical waste including sharps was not stored securely for collection. We observed unlocked and overfilled sharps bins were stored on a shelf by the patient toilet. The dentist told us that they had recently arranged a contract with an authorised contractor for the collection and safe disposal of clinical waste. They told us that they were waiting for delivery of an outdoor clinical waste storage bin.

The practice had some procedures in place for minimising risks of legionella. Legionella is a term for a particular bacteria which can contaminate water systems in buildings. The dentist confirmed that no legionella risk assessments had been carried out to identify risks at the practice. They told us that dental waterlines were regularly flushed and disinfected.

Equipment and medicines.

The practice had systems in place for carrying out Portable Appliance Testing (PAT) for all electrical equipment. (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

We were shown records in relation to a fixed wiring installation assessment which had been carried out in 2013. The findings from this assessment identified that the immersion heating installed did not comply with current regulations and it was recommended that this equipment be decommissioned. The dentist when asked about this told us that the heating appliance had not been removed or decommissioned. They told us that this was used infrequently but confirmed that it was used.

Records were kept in respect of checks and maintenance carried out for equipment such as the X-ray equipment and autoclaves which showed that they were serviced in accordance with the manufacturers' guidance. The regular maintenance ensured that the equipment remained fit for purpose.

There were procedures in place to ensure that medicines including local anaesthetics and emergency medicines were in date and accessible as needed. The principal dentist told us that regular checks were carried and records maintained in respect of these checks.

Radiography (X-rays)

The practice had a radiation safety policy in place and was registered with the Health and Safety

Executive as required under Ionising Radiations Regulations 1999 (IRR99). Records we were shown demonstrated that the dentists were to date with their continuing professional development training in respect of dental radiography.

A radiation protection advisor had been appointed as required by the Ionising Regulations for Medical Exposure Regulations (IR(ME)R 2000. One of the dentists was listed as

Are services safe?

the radiation protection supervisor to oversee practices and ensure that the equipment was operated safely and by qualified staff only. There was a radiation protection file available with information for relevant staff to access and refer to as needed. This file included a record of all X-ray equipment including the service and maintenance history.

There were local rules available and displayed in all areas where X-rays were carried out. Local rules state how the X-ray machine in the surgery needs to be operated safely.

The dentist confirmed that they did not carry out audits to monitor the quality of dental X-rays images in accordance with the National Radiological Protection Board (NRPB) guidelines to help ensure that they were graded to an acceptable standard. Dental care records demonstrated that dental X-rays were not justified or reported on as part of measures to assure that X-rays are taken appropriately.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with six patients during our inspection and reviewed the comments made by 51 patients who completed comments cards. All the comments received reflected that patients were very satisfied with the quality of their dental treatment and a number of patients made positive comments about the confidence they had in the dentist and other staff.

The dentist told us that all new patients to the practice were asked to provide their medical history including any health conditions, current medication and allergies. They also told us that patients were asked to confirm any changes in their health at subsequent visits. We saw that patient's medical history was recorded and updated in the patient dental care records, which we were shown. This ensured the dentists were aware of the patient's present medical condition before offering or undertaking any treatment.

The dentist told us that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. The patient dental records which we reviewed did not include information about oral examinations which dentists carry out to assess oral health and to help identify abnormalities. There were no records of the assessment of patient's gums and soft tissues and there were no record of basic periodontal examination (BPE) – a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. There was no recorded information about the discussions between the dentist and patient regarding diagnosis, treatment options available and any associated risks.

Health promotion & prevention

The patient reception and waiting area contained a range of information that explained the services offered at the practice. The dentist told us that they offered patients information about effective dental hygiene and oral care including information on diet, alcohol and tobacco consumption and maintaining good oral hygiene. However there was no record regarding health promotion advice offered to patients within the dental records which we were shown.

Staffing

There was a stable and established staff team at the practice, all of whom had worked there for many years. They told us there were enough of them for the smooth running of the service and a dental nurse always worked with the dentist and the hygienist.

Files we viewed demonstrated that the dental staff were appropriately qualified and had current professional validation and professional indemnity insurance. Through a review of records and discussion with the dentist we found that staff had not undertaken training in areas such as safeguarding patients, infection control, fire safety awareness or information governance.

Records which we were shown included a staff appraisal document. However these were not completed and contained only a staff self-appraisal. There was no appraisal or record in respect of staff performance and there was no assessment of training or development needs for staff.

Working with other services

The dentist told us that patients requiring specialist treatments that were not available at the practice were referred to other dental specialists. They told us that when patients were referred to other services the referral information was given to the patient to post. They confirmed that they did not retain a copy of the referral documents, and discussions with the dentist and dental nurse indicated that there was an ad hoc arrangement for following up to ensure that the referral had been received and that they waited for communication from the provider to whom the patient had been referred. There were systems in place for monitoring patients after they had undergone their treatment and were referred back to the practice.

Consent to care and treatment

Patients told us that they were provided with detailed information during their consultation and the dentists explained treatments to them in a way that they understood. Evidence of patients' consent to treatment had been recorded in the dental care records we were shown.

The dentist understood the relevant consent and decision-making requirements of legislation and guidance,

Are services effective?

(for example, treatment is effective)

including the Mental Capacity Act 2005 (MCA). They also had an understanding of Gillick competence and how its principles applied when gaining consent from younger patients.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. Staff who we spoke with were able to demonstrate that they understood the practice policies and procedures and their responsibilities in relation to these.

Staff understood the importance of maintaining patients' confidentiality. The principal dentist was the lead for information governance with the responsibility to ensure patient confidentiality was maintained and patient information was stored securely.

We observed the receptionist interact with patients both on the phone and face to face and noted they were consistently polite and helpful towards them, creating a welcoming and friendly atmosphere.

Six patients who we spoke with on the day of the inspection told us that the receptionists, dentists and the dental nurse were kind and helpful. They told us that they were treated with respect and that the dentist demonstrated understanding and empathy when carrying out dental treatments. This was also reflected in the comments we received in the 51 CQC comment cards.

Involvement in decisions about care and treatment

The patients who we spoke with said that the dentists explained their treatments in a way that they could understand and that they were involved in making decisions about their dental care and treatment. Patients said that the different treatment options, where available were explained and discussed with them.

The practice had procedures in place for meeting the needs of people who may require extra support. Staff told us that patients with disabilities or in need of extra support were given as much time as was needed to explain and provide the treatment required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Information displayed in the waiting area described the range of services available. There was a patient information leaflet available which included information such as the practice opening times and how patients could access emergency dental treatment when the practice was closed. Information was also available explaining the practice's complaints procedure. A range of information leaflets on oral care and treatments were available in the practice.

The practice was open between 9.15am and 5.15pm on Mondays to Fridays and between 9.15am and 12.15pm on Saturdays. The practice was closed for lunch between from 12.15pm to 2.15pm each day. Patients told us they were satisfied with the appointments system and that getting through on the telephone was easy.

We were shown the results from a survey that was conducted around patients' satisfaction with access to the service. This included waiting times and access to appointments. This survey was not dated and the results had not been analysed by the practice. However we reviewed the results and this showed that the majority of patients were very satisfied with the availability of appointments and they expressed that they did not have to wait too long to be seen.

Tackling inequity and promoting equality

The practice had equality and diversity and disability policies to support staff in understanding and meeting the needs of patients. Staff told us that patients were offered treatment on the basis of clinical need and they did not discriminate when offering their services.

The dental practice was located on the ground and the first floor of a purpose adapted property. The practice had step free access and sufficient space to accommodate patients who used wheelchairs.

The practice did not have a hearing loop to assist patient with impaired hearing who used a hearing aid device. During the inspection we observed members of staff assisting patients in a sensitive manner where required.

Staff told us that they had could access a translation service for patients whose first language was not English should this be required.

Access to the service

Four patients who we spoke with told us that they could always get an appointment that was convenient to them. Patients could book appointments in person or by telephone.

Staff told us that appointments usually ran to time and the patients we spoke with said that they did not have to wait too long to be seen. The receptionist told us that they advised patients if the dentist was running behind time.

Concerns & complaints

The practice had a complaints policy and procedure. This was in line with its obligations to investigate and respond to complaints and concerns. The principal dentist was the dedicated complaints manager.

Information to describe how patients could raise complaints was displayed in the patient waiting area and included in the practice patient leaflet

The patients who we spoke with told us that if they had concerns or complaints that they would raise these with the dentist directly. Each of the six patients who we spoke with told us that while they had no reason to complain they felt confident that any issues or concerns would be dealt with appropriately.

The receptionist, dental nurse and dentist told us that there had been no complaints made about the practice for many years.

Are services well-led?

Our findings

Governance arrangements

The practice did not have suitable governance arrangements in place for monitoring and improving the services provided for patients. The responsibility for the day-to-day running of the practice was shared between the principal dentist and the dental nurse. There were some policies and procedures in use to support the management of the service. However a number of these policies were not practice specific and our observations and discussions with the dentist and dental nurse showed that policies and guidance in relation to a number of areas including infection control and specific guidance in respect dentistry were not fully understood or followed.

The practice's infection control procedures were not carried out in line with relevant guidelines.

Risks in relation to health and safety of patients and staff including risks associated with premises, hazardous materials, fire and legionella had not been assessed and the principal dentist could not demonstrate that they were aware of relevant guidance in relation to these areas.

Leadership, openness and transparency

There was a lack leadership and oversight at the practice. The principal dentist and the dental nurse were responsible for areas such as safeguarding, infection control and patient safety. However their lack of awareness about relevant policies and guidance meant that the practice staff were not supported to deliver services in line with these.

The principal dentist and staff could demonstrate that they understood their responsibilities to comply with the duty of candour and they told us should there be an incident or accident that affected a patient the practice would act appropriately and offer an apology and an explanation.

We found the dentist to be open and accepting to feedback during the inspection, and demonstrated that they were clearly keen to address the issues we found during our inspection.

Learning and improvement

The practice did not have systems in place to ensure that relevant information was shared or used to make improvements where this was required. Practice meetings were held infrequently and the dentist could not provide assurances that information such as changes in guidance in relation to dentistry was reviewed, shared or used to make improvements.

Staff did not have an appraisal of their performance and there were no training and development plans to support staff with their training needs.

Staff working at the practice had not undertaken training in areas including infection control, safeguarding or fire safety and staff who we spoke with demonstrated limited understanding about their roles and responsibilities in relation to these areas.

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

The practice had systems for obtaining patient and staff feedback. The practice had conducted a patient satisfaction survey around waiting times; however it was unclear as to when this had taken place as none of the questionnaires were dated. The results from this survey indicated that patients were happy with the access arrangements and waiting times. Patients could give feedback via a comments book and a feedback box which were available in the patient waiting area. The principal dentist told us that patient feedback was obtained informally during consultations and appointments.

Staff who we spoke with told us that they could make suggestions about how improvements could be made to the service.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Risks to the health, safety and welfare of patients were not assessed and the provider did not have systems in place to mitigate these risks. For example;</p> <ul style="list-style-type: none">• The provider was not aware of their responsibilities in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).• The provider did not have suitable procedures in place to safeguard children and vulnerable adults against the risk of abuse or harm. Staff had not undertaken training and they were unaware of their responsibilities to identify and report concerns.• The provider did not have suitable arrangements in place to manage risks associated with the premises. There was no health and safety risk assessment to identify risks associated with the premises and equipment at the practice. The most recent fire risk assessment was carried out in 2013 and the areas for improvement identified had not been acted on to minimise the risk of fire.• The provider did not have suitable arrangements to assess and minimise the risk of the spread of infections. Staff did not use personal protective equipment appropriately. Dental instruments were not cleaned or stored in accordance with the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01- 05), decontamination in primary care dental practices. Clinical waste matter was not stored safely or securely. There was no legionella risk assessment. <p>Regulation 12(1) (2)</p>

Regulated activity	Regulation
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This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 Regulations 2014 Good governance

The provider did not have systems or arrangements in place to monitor and assess the quality and safety of the services provided and to make improvements where these were identified. For example;

- Audits were not carried out to test the effectiveness of the infection control procedures within the practice and to ensure that relevant guidance was followed to minimise the risks to patients and staff.
- The provider did not carry out audits to monitor the quality of dental X-ray images and ensure that they were justified, graded and reported on appropriately..
- There were limited arrangements for assessing and identifying risks associated with the practice premises or the risk associated with legionella.
- The provider had not acted on the areas for improvement where these were identified following a fire safety risk assessment.
- The provider did not have systems in place for supervising and appraising staff performance or monitoring staff training to ensure that staff were suitably qualified and knowledgeable about their roles and responsibilities.

17 (1)

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- The provider did not ensure all staff members received appropriate support, training and supervision

This section is primarily information for the provider

Requirement notices

necessary for them to carry out their duties. Staff had not undertaken training and lacked awareness in areas such as safeguarding people, infection control, fire safety and information governance.

- Staff did not receive regular appraisal of their performance in their role from an appropriately skilled and experienced person.

Regulation 18(1) (2)