Mr Saeid Karim-Shoshtari

Gidlow Dental Surgery

Inspection Report

328 Gidlow Lane
Wigan
Greater Manchester
WN6 7PJ
Tel: 01942 824167

Date of inspection visit: 30 July 2019
Date of publication: 06/09/2019

Overall summary

We carried out this announced inspection on 30 July 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

We found 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

Gidlow Dental Surgery is in Wigan, Greater Manchester and provides NHS and private treatment to adults and children.

There is level access via a portable ramp for people who use wheelchairs and those with pushchairs. A small number of car parking spaces are available immediately outside the practice. Patients who are blue badge holders can notify the practice if they required a parking space and arrangements will be made to reserve one.

The dental team includes three dentists and six dental nurses, two of whom are trainees. The practice has two treatment rooms.

Summary of findings

The practice is owned by an individual who is the principal dentist. They 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 collected 41 CQC comment cards filled in by patients and spoke with one patient. All feedback received was highly positive about the standard of care and treatment provided by the practice.

During the inspection we spoke with three dentists and two dental nurses. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open from Monday to Friday, 9am to 12.45pm and 1.45pm to 5.15pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Not all appropriate medical emergency equipment was available.
- Systems to help the provider manage risks to patients and staff were not always followed.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. Staff new to the practice had yet to receive safeguarding training.
- The provider had staff recruitment procedures in place, but these were not consistently followed.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Leadership and oversight were insufficient to support good governance.
- Audits contributed to the provider goals of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- The provider had suitable information governance arrangements.

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

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- Review the practice's protocols for completion of dental care records taking into account the guidance provided by the Faculty of General Dental Practice.
- Review the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.	We asked the following question(s).
Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

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

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

Staff had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. When we reviewed training records, we saw evidence that the majority of staff had received safeguarding training. The practice had two trainee dental nurses, who had been in post for three months and six weeks respectively. The provider could not demonstrate that these staff had undergone any safeguarding training.

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

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

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

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The provider had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at three staff recruitment records. These showed the provider followed their recruitment procedure for permanent clinical staff. However, when we discussed planning for shortfall in staffing, we found there was no system in place to assure checks in place for agency and locum staff. There were no recruitment checks in place for cleaning staff.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Staff ensured that equipment was safe and was maintained according to manufacturers' instructions. This included compressors, autoclave, suction units and portable appliances. The provider had not had safety testing carried out on the fixed electrics in the building within the last five years. Gas safety had not been tested and assured, as required.

Records showed that fire detection and firefighting equipment were regularly tested and serviced.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and we saw the required information was in their radiation protection file. When we made checks on the X-ray equipment in each treatment room, we saw that in one room, a circular collimator was still in use, even though a rectangular collimator, as referred to in recognised guidance, was available for use.

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

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

The practice had health and safety policies, procedures and risk assessments to help manage potential risk. We noted that some of these were not followed consistently.

Are services safe?

For example, there was a sharps risk assessment in place. This stated that sharps would only be dismantled by the user (the dentist). When we made checks in the decontamination room we saw sharps bins in use. When we asked about this, it was confirmed that dental nurses were dismantling sharps.

The provider had current employer's liability insurance.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

Staff knew how to respond to a medical emergency; when we spoke with them, they could confirm what actions they would take and describe training they had completed. We noted that the provider could not evidence basic life support (BLS) training for one of the dental nurses. All other staff, excluding the trainees, could evidence that they had completed training in emergency resuscitation and basic life support (BLS) every year.

Emergency equipment was not available as described in recognised guidance. When we checked equipment, we found only two airways available, in size two and three; there were no airways in sizes zero, one or four. There were three child face masks in sizes one and three only, two of which were out of date. The automated external defibrillator (AED) for use in an emergency, was a model subject to a recent recall due to problems with the battery. There was a spare battery with the equipment, but this had not been fitted. When we brought this to the attention of staff in our feedback at the end of the inspection, they appeared unaware of this safety alert. Although weekly checks on the emergency medicines and equipment was documented, the check sheet used did not reflect current guidance on equipment and medicines that should be available.

Following inspection, the provider contacted us to confirm they had checked the AED at the practice and confirmed that this was not a model with batteries that fell into the recall of this appliance.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team.

There were suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately.

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

The practice occasionally used locum and/or agency staff. We noted that these staff received an induction to ensure that they were familiar with the practice's procedures.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The provider had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

We found staff had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place. We noted that water temperatures were recorded at below 55 degrees centigrade, but that the taps where water was being temperature tested were fitted with thermostatic mixing valves. We discussed with the provider how they could assure that water reaching these valves was within the range required in a primary health care setting.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

Are services safe?

The provider and infection control lead nurse carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards. In areas where minor improvements were needed, there was a plan in place to address this. For example, to have waste bins with pedal operation.

Information to deliver safe care and treatment

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

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings. We saw that patient dental records made by two of the three dentists were of a high standard. Some patient records required more information. We discussed how this could be achieved. Individual records were written and managed in a way that kept patients safe. Dental care records we saw were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

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

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

Staff did not store NHS prescriptions as described in current guidance and did not have a log in place that allowed tracking and tracing of prescriptions issued. Although numbers of batches of prescriptions delivered to the practice were kept, serial numbers of prescriptions issued by dentists were not recorded. Also, we found that blank prescription sheets were pre-stamped with the practice name and address, and that the prescription pad and practice stamp were stored together in an unlocked drawer.

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

Antimicrobial prescribing audits were not carried out annually. The provider told us that this was something they had planned as part of their continuous improvement.

Track record on safety and lessons learned and improvements

There were risk assessments in relation to safety issues. Staff monitored and reviewed incidents. This helped staff to understand risks, give a clear, accurate and current picture that led to safety improvements.

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

There were adequate systems for reviewing and investigating when things went wrong. The practice learned, and shared lessons identified themes and acted to improve safety in the practice.

There was a system for receiving and acting on safety alerts. On the day of inspection, we found that this was not fully effective. When we asked staff about receipt of alerts into the practice we were told they came to a central email address and that other staff had access to this. When checking emergency equipment, we saw that the practice had equipment that was subject to a safety alert. The equipment had not been checked to determine whether it was part of the recall issued. This indicated that the system to share alerts and updates did not work effectively. Following the inspection, the provider confirmed that they had checked the defibrillator and that it was not part of the recall issued.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. Dental records to support this lacked consistency across the practice and fell short of the standards required by the General Dental Council (GDC).

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay.

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

Staff were aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

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

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

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment. The practice had recently conducted an audit on consent, to identify where improvements could be made to ensure that consent was captured accurately at each consultation. This was part of the practice focus on continuous improvement.

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

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

Monitoring care and treatment

When we reviewed anonymised dental care records, of patients of the three dentists, we found for two of the dentists, the practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. These dentists assessed patients' treatment needs in line with recognised guidance. In some cases, we found the level of detail in patient dental records required improvement. This was in relation to diagnosis of periodontal disease, discussion of treatment plans and options available that were discussed.

The practice had not conducted an effective audit of patients' dental care records to check that dental records were consistent, across the practice.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. When reviewing staff records the provider could not evidence annual basic life support for one of the qualified dental nurses, although when we spoke to this staff member, they could confidently and competently

Are services effective?

(for example, treatment is effective)

describe what action they would take in a medical emergency. The two trainee dental nurses, who had been in post for three months and six weeks respectively, were yet to undertake their basic life support training.

Staff new to the practice had a period of induction based on a structured programme. We confirmed clinical staff completed continuing professional development required for their registration with the General Dental Council. We reviewed the professional development files for the dentists. These were structured, comprehensive and set out specific training aims which where timebound. There was no professional development plan in place for dental nurses. The provider said they were aware of this and that it was something that was due to be addressed within the next three months.

Staff discussed their training needs at annual appraisals and during clinical supervision. We saw evidence of completed appraisals.

Co-ordinating care and treatment

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

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

Staff had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The provider also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

Staff monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were wonderful, professional and welcoming. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. Patients could choose whether they saw a male or female dentist. Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the

Accessible Information Standards and the requirements under the Equality Act.

The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given. We saw:

- Interpreter services were available for patients who did speak or understand English. We saw notices in the reception areas informing patients that translation service were available.
- Staff communicated with patients in a way that they could understand, and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- Staff gave patients clear information to help them make informed choices about their treatment.
- Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them.
- The principal dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information leaflet provided patients with information about the range of treatments available at the practice.

The principal dentist described to us the methods they used to help patients understand treatment options discussed. These included for example photographs, models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

For example, when seeing patients with dental phobia, adults and children with a learning difficulty, and patients with long-term conditions.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had made reasonable adjustments for patients with disabilities. This included step free access and materials printed in large font.

A disability access audit had been completed and an action plan formulated to continually improve access for patients.

Staff telephoned some patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it in their information leaflet.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The practice's information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The provider took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The provider had a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The principal dentist was responsible for dealing with these. Staff would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The principal dentist aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the principal dentist had dealt with their concerns.

We looked at comments, compliments and complaints the practice received in the last 12 months.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

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 section at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The principal dentist had recently taken over the practice from two dentists that were previously partners, and who now worked as associate dentists. From our inspection we could see that this had increased management duties for the principal dentist. As a result of this, focus on leadership had reduced. The principal dentist was aware of this and was responsive to the findings of our inspection.

Staff recognised the principal dentist as their leader; they were visible and approachable. Staff told us they worked closely with them and others to make sure they prioritised compassionate and inclusive leadership.

We saw the provider had processes to develop capacity and skills, including planning for the future leadership of the practice.

Culture

The practice had a culture of high-quality sustainable care.

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

The staff focused on the needs of patients.

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

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

Responsibilities for systems of accountability to support good governance and management, were in the process of being handed over from one of the associate dentists to the principal dentist.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They were responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities within the new organisational structure.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. Some of these required review by all staff to ensure they were working within guidance provided by the policies, For example:

- Highly recommended training was not in place for two dental nurse trainees, for example basic life support and safeguarding; for one of the qualified dental nurses there was no evidence of training in basic life support.
- There were no personal development plans in place in respect of the dental nurses.
- There was no system or process in place to take up assurance of recruitment checks carried out on locum staff. There were no recruitment checks carried out on cleaning staff.
- There was no effective system in place to ensure that health and safety checks on the premises were carried out. There was no safety certificate for the fixed electrics in the building or gas safety certificate.
- Management and oversight of staff was insufficient to promote safe, effective working. Although rectangular collimators for X-ray equipment were available, staff were still operating X-ray equipment with circular collimators, contrary to recognised guidance. Dental nurses were dismantling sharps, contrary to practice policy.
- Checks on emergency equipment were ineffective. These had not identified missing equipment, for example, airways in all sizes and bag mask valves in the sizes referred to in recognised guidance, or out of date equipment.
- The system in place to receive important safety alerts and updates did not work effectively.
- There was no effective audit of patient dental records. We found inconsistency in the detail of some dental records, which fell below the standards required.
- NHS prescription pads were not stored securely. There was no log in place that enabled the tracking and tracing of prescriptions, if required.

Are services well-led?

- Record keeping systems in place did not give the provider adequate oversight of staff training needs.

Following our inspection, the provider contacted us to confirm they had acted immediately on many of the issues identified in our inspection.

- Arrangements to check gas and electrical safety for the building have been made and certificates will be forwarded to us as soon as they are available.
- A prescription pad log is now in place. The practice of pre-stamping prescription sheets has been stopped.
- The batteries and serial number of the practice defibrillator have been checked against the alert and manufacturer recall. The provider has confirmed the model used by the practice is not affected by this.
- The system for receiving important alerts and updates has been reviewed. These will now be printed out and discussed with staff to ensure they understand them, and any follow-up actions will be recorded.
- Out of date equipment in the emergency kit has been replaced. Missing items have been ordered.

Appropriate and accurate information

Quality and operational information that was available, was used to ensure and improve performance. For example, clinical waste audits and audit of processes in the decontamination room.

Where applicable, the views of patients were considered when making any changes to the practice, for example, when reporting on the number of patients that have failed to attend appointments and any changes to the appointment system.

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

Engagement with patients, the public, staff and external partners

Staff involved patients, the public, staff and external partners to support high-quality sustainable services.

The provider used patient comment cards and any verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from patients that the practice had acted on. For example, we saw that straight-backed chairs had been provided for patients who had requested an alternative to the couches in the waiting area.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

The provider had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. Some of these audits required further development to be fully effective.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The dental nurses had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

The majority of staff could demonstrate they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. The provider supported and encouraged staff to complete CPD. Oversight of this required improvement to ensure all staff undertook highly recommended training and that comprehensive records of this were kept by the provider.

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:** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Locum staff via agencies had worked at the practice without the provider having assured that all required recruitment checks had been carried out before locum staff commenced work at the practice. • There was no gas safety check for the practice; no safety check had been carried out on the fixed electrics at the practice. • Staff were not following practice policy on the safe handling of sharps. • Emergency equipment as described in recognised guidance was not available and ready for use. • Action in response to an alert, issued by the Medicines and Healthcare Products Regulatory Agency, had not been taken to assure the safety of the defibrillator at the practice. · NHS prescription pads were not managed safely. Regulation 12(1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Record keeping systems in place did not give the provider adequate oversight of staff training needs. Highly recommended training was not in place for two dental nurse trainees, for example basic life support and safeguarding; and for one of the qualified dental nurses there was no evidence of training in basic life support.
- There were no personal development plans in place in respect of the dental nurses.
- There was no system or process in place to take up assurance of recruitment checks carried out on locum staff. There were no recruitment checks carried out on cleaning staff.
- Effective systems were not in place to ensure that health and safety checks on the premises were carried out.
- Management and oversight of staff required improvement. For example, in relation to the use of X-ray equipment by dentists, contrary to guidance, and of nurses handling sharps contrary to practice policy.
- Checks on emergency equipment were ineffective. These failed to identify missing equipment, and out of date equipment.
- The system in place to receive important alerts and updates did not work effectively.
- Audit of patient dental records was ineffective. This failed to identify a lack of consistency in dental record keeping across the practice, which fell below standards required.
- Oversight and management of secure items, for example, NHS prescription pads was insufficient.

Regulation 17(1)