Mr. David Gilkeson

Dental Surgery - Stonegate

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 31 May 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 not 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 Dental Surgery, Stonegate is situated in the centre of York, North Yorkshire close to public transport links. The practice has two treatment rooms, one on the first floor and a decommissioned surgery on the second floor which now acts as a decontamination area. There is a waiting area and a dark room for processing radiographs. Staff facilities were located on the first floor with offices located on the second floor.

Due to the practice being located on the first and second floor, patients with mobility requirements are referred to a local practice that can help with access more easily.

There is one Dentist, a receptionist and two dental nurses.

The practice is open:

Monday – Friday 09:00 – 12:00 & 14:00 – 17:00.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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 23 CQC comment cards providing feedback and spoke to three patients. The patients who provided feedback were very positive about the care and attention to treatment they received

Summary of findings

at the practice. They told us they were involved in all aspects of their care and found the staff to be sensitive, friendly, caring and informative and they were treated with dignity and respect in a clean and tidy environment.

Our key findings were:

- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice did not have access to an automated external defibrillator and the medical oxygen cylinder available on the premises had no supporting evidence that it had ever been serviced or that the oxygen was in date. Staff had not been trained to manage medical emergencies.
- Staff had not received safeguarding training; however they knew how to recognise signs of abuse but not how or who to report it to.
- Patients were treated with dignity and respect.
- The practice did not undertake appropriate pre-employment checks for staff.
- There was a complaints system in place. Staff recorded complaints and cascaded learning to staff.
- Governance arrangements were in not place for the smooth running of the practice; the practice did not have a structured plan in place to audit quality and safety including infection control, radiographs and patient care records.
- The practice sought feedback from staff and patients about the services.
- The practice did not have a structured plan in place to audit quality and safety of services provided. The policies and procedures were not localised to the practice or updated in line with current legislation and guidance.
- The practice staff worked as a team; however they lacked support for undertaking their roles and with professional development.

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

- Ensure protocols for the availability and checks of all medicines and equipment to manage medical emergencies is implemented, giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD).
- Ensure that all staff had undertaken relevant training, to an appropriate level, in safeguarding of children and vulnerable adults. Ensure that systems and processes are established and operated effectively to safeguard patients from abuse and review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Ensure the practice undertakes a Legionella risk assessment, 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 HSE Legionnaires' disease. Approved Code of Practice and guidance on regulations L8.
- Ensure COSHH risk assessments are implemented for all materials used within the practice. Review the practice responsibility in regards to 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 the practice implements a protocol for X-ray audits to ensure they are carried out annually and they are carried out in line with the National Radiological Protection Board (NRPB) guidelines.
- Ensure that the practice is compliant with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000. Ensure local rules are available and a nominated RPA is in place.
- 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

Summary of findings

- Ensure pressure vessels are serviced and certificated to ensure safe care of equipment in line with the Pressure Systems Safety Regulations 2000 and review the practice protocol for reviewing the PAT testing certificates.
  - You can see full details of the regulations not being met at the end of this report.

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

- Review the practice's 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.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result.
- Review dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping. Adopt an individual risk based approach to patient recalls having regard to National Institute for Health and Care Excellence (NICE) guidelines
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'delivering better oral health: an evidence-based toolkit for prevention'.

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 notice section at the end of this report).

The practice did not have effective systems and processes in place to ensure all care and treatment was carried out safely. There were some systems in place for infection prevention and control, clinical waste control and management of medical emergencies. Not all emergency equipment and medicines were in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. We found the medical emergency cylinder had not been tested, serviced or replaced since 1992. Some of the medical emergency equipment was not available including needles and syringes. The oropharyngeal airways, a self-inflating bag, face masks and tubing was out of date. The practice did not have a spacer device and access to an AED. None of the staff had completed CPR training recently and staff did not feel confident in providing emergency care to patients if the need arose. Evidence was sent after the inspection to the inspector to show training had been booked and equipment ordered.

Staff had not received training in safeguarding adults or children. Staff were aware of how to recognise the signs of abuse but not who to report it to or how to report it. The process and protocol for reporting was last reviewed in 2007.

The practice had minimal COSHH safety data sheets in place to risk assess any materials stored on the premises. Minimal materials had a specific risk assessment in place and the practice specific risk assessments that were in place were due to be reviewed by the registered provider.

There was a decontamination room within a decommissioned surgery and guidance for staff to provide effective decontamination of dental instruments was in place.

Patients' medical histories were obtained verbally before any treatment took place. This provided the dentist with up to date information about any health or medication issues which could affect the planning of treatment.

The practice did not have a recruitment policy to ensure suitably trained and skilled staff met patients' needs. Dental nursing staff had never had a DBS check or supporting ID checks.

A Radiation Protection advisor (RPA) had not been appointed and no local rules were available on the day of the inspection in line with the requirements of the Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000. The equipment had not been serviced or critically tested since 2010.

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

Consultations were not carried out in line with current practice guidance from the National Institute for Health and Care Excellence (NICE). Patients were recalled after an agreed interval for an examination, during which their medical histories and examinations were updated but were not always recorded. Risk factors were not a factor the dentist reviewed, BPEs and radiographs were not always recorded or discussed.

The practice did not follow current practice guidelines when delivering dental care. This would include guidance from the Faculty of General Dental Practice (FGDP) and NICE. The practice focused on prevention although the dentist was not aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice. Oral hygiene advice was not routinely recorded.

Summary of findings

Patients' dental care records provided minimal information about their current dental needs and past treatment. The dental care records we looked at did not include discussions about treatment options. Radiographs were not taken in accordance with NPRB guidelines and those taken were not justified, graded or reported on. The practice did not monitor any changes to the patients' oral health as no BPE was taken or recorded until the day of the inspection.

Staff were not supported in the delivery of effective care through training and development. The clinical staff could not provide clear evidence of continuous professional development (CPD). They were not supported to meet the requirements of their professional registration and no systems were in place to monitor this. Staff were registered with the General Dental Council (GDC).

Are services caring?

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

Staff explained that enough time was allocated in order to ensure the treatment and care was fully explained to patients in a way which patients understood. Time was given to patients with complex treatment needs to decide what treatment options they preferred although we did not see evidence of this in patient records.

Comments on the 23 completed CQC comment cards we received included statements saying they were involved in all aspects of their care and found the staff to be sensitive, friendly, caring and informative and they were treated with dignity and respect.

We observed patients being treated with respect and dignity during interactions at the reception desk and over the telephone. Privacy and confidentiality was not always maintained for patients using the service on the day of the inspection due to the lack of a reception area and appointments openly being made in the waiting room; patients were also verbally asked about their medical history in the waiting room. We also observed the staff to be welcoming and caring towards the patients.

Are services responsive to people's needs?

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

Patients could access routine treatment and urgent care when required. The practice offered daily access for patients experiencing dental pain which enabled them to receive treatment quickly. If the practice was closed patients would be directed to the NHS 111 service or patients who had a private plan were directed to an out of hours contact number.

The practice had no disability access; they did work closely with a local practice to signpost patients with requirements to their services.

The practice had a complaints process which was not accessible to patients who wished to make a complaint. The practice did not have information about how to complain in a practice leaflet and no information about external agency details had been incorporated. Staff would record complaints and cascade learning to staff, but no complaints had been received.

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 section at the end of this report).

Staff reported the registered provider was approachable; they were able to raise issues or concerns at any time although they did not feel supported in their roles. The culture within the practice was seen by staff as open and transparent.

Summary of findings

There was a clearly defined management structure in place. The registered provider was responsible for the day to day running of the practice.

The practice sought feedback from patients in order to improve the quality of the service provided. No action plans were in place to review and discuss the feedback provided from patients.

The practice had not undertaken any audits to monitor their performance and help improve the services offered. No X-ray audit, infection prevention and control audit and dental care record audit had been completed.

Dental Surgery - Stonegate

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was carried out on 31 May 2016 and was led by a CQC Inspector and a specialist advisor.

We informed NHS England (NHSE) area team and Healthwatch North Yorkshire that we were inspecting the practice; however we did not receive any information of concern from them

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

During the inspection we spoke with the registered provider and two dental nurses. We saw policies, procedures and other records relating to the management of the service. We reviewed 23 CQC comment cards that had been completed.

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

The practice had no policies and procedures in place to investigate, respond to and learn from significant events. Staff were not aware of the reporting procedures in place but were encouraged to raise safety issues to the attention of colleagues and the registered provider.

Staff had a basic understanding of the process for accident and incident reporting including their responsibilities under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The staff told us any accident or incidents would be discussed at practice meetings or whenever they arose. We saw the practice had an accident book which had no entries recorded in the last 12 months; no evidence was available to show how the practice responded to accidents or significant events.

The registered provider told us they did not have a thorough system in place to receive 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. No evidence of a recent safety alert was available on the day of the inspection relating to medical emergency medicine recall and no evidence this had been actioned.

Reliable safety systems and processes (including safeguarding)

We reviewed the practice's safeguarding policy and procedures in place for safeguarding vulnerable adults and children using the service. They did not include the contact details for the local authority safeguarding team, social services and other relevant agencies. The policy was last reviewed and updated in 2007. The registered provider was the lead for safeguarding however there was no evidence they or any other member of staff were trained to level two. This role would include providing support and advice to staff and overseeing the safeguarding procedures within the practice. The registered provider demonstrated their awareness of the signs and symptoms of abuse and neglect.

The registered provider told us they never used a rubber dam when providing root canal treatment to patients or had any other safety measures in place. A rubber dam is a small square sheet of latex (or other similar material if a patient is latex sensitive) used to isolate the tooth operating field to increase the efficacy of the treatment and protect the patient in line with guidance from the British Endodontic Society.

The practice did not have a whistleblowing policy within the practice and staff were not aware of whom to raise concerns with if they could not approach the registered provider. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations with the registered provider.

Medical emergencies

The practice did not have procedures in place for staff to follow in the event of a medical emergency and none of the staff had received training in basic life support including the use of an Automated External Defibrillator (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).

The practice kept medicines and equipment for use in a medical emergency. These were not in line with the 'Resuscitation Council UK' and British National Formulary guidelines. The medical emergency oxygen had not been serviced, filled or replaced since 1992. No checks were in place to review the oxygen. Equipment including oropharyngeal airways face masks and self-inflating bags were out of date. Needles to draw up adrenaline and a spacer device were not available. The practice did not have an AED and no risk assessment had been implemented to review the practice need to have access to one. Staff were unaware where the closest AED was located.

Staff were not trained in the provision of a medical emergency and they told us they did not feel confident in the use of the medical emergency drugs or equipment. Evidence was sent to us after the inspection to show this training had been booked.

We saw the practice kept quarterly logs which indicated medical emergency medicines were checked. However a more robust process of checking the equipment needed to be reviewed to ensure all equipment was checked thoroughly. This would ensure the equipment and medical oxygen was fit for use and the medication was within the manufacturer's expiry dates.

Staff recruitment

Are services safe?

The practice did not have a recruitment policy in place. A process had not been followed when employing the newest member of staff. A relevant policy would include obtaining proof of their identity, checking their skills and qualifications, registration with relevant professional bodies and taking up references. The staff did not have a recruitment file.

We saw only the registered provider 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. No other staff had been asked to complete a check and no ID checks were in place to prove staff identity. This was brought to the attention of the registered provider on the day of the inspection.

Immunisation status were not recorded and no evidence staff had completed and immunisations was available on the day of the inspection.

We saw that all relevant staff had personal indemnity insurance (insurance professionals are required to have in place to cover their working practice). In addition, there was employer's liability insurance which covered employees working at the practice.

Monitoring health & safety and responding to risks

There was limited evidence the practice had undertaken any risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice. The practice had a Health and Safety policy which included guidance on fire safety and manual handling of clinical waste. There were no dates on the policy to show when the policy had been implemented and reviewed. Some of the guidance was now outdated.

The practice had minimal information on Control of Substances Hazardous to Health (COSHH). Risk assessments had only been completed for seven materials used on the premises and no safety data sheets were available on the day of the inspection. 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. We brought this to the attention of the registered provider during the inspection and a CD rom was ordered.

We observed one of the three fire extinguishers had been checked in August 2014, the other two extinguishers had no certificates or stickers to say when they were last checked or serviced. This would ensure they were suitable for use if required. There was no evidence that a fire drill had been undertaken. These and other measures should be taken to reduce the likelihood of risks of harm to staff and patients.

Infection control

The practice had a decontamination area within a decommissioned surgery that was not set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices. All clinical staff were aware of the work flow in the decontamination area from the 'dirty' to the 'clean' zones.

There was no separate hand washing sink for staff available and only one sink for decontamination work. The procedure for cleaning, disinfecting and sterilising the instruments was clearly displayed on the wall to guide staff. We saw that appropriate personal protective equipment was available in the decontamination area and this included disposable gloves and protective eye wear.

We found instruments were being cleaned, sterilised and generally in line with published guidance (HTM01-05). The dental nurses were knowledgeable about the decontamination process and demonstrated that they followed the correct procedures. For example, instruments were hand scrubbed, placed in an ultrasonic bath and sterilised in an autoclave and then examined under illuminated magnification, however this was taking place after sterilisation rather than after decontamination. Sterilised instruments were correctly packaged, sealed and dated. Instruments were transported between the surgeries and the decontamination room in lockable boxes.

We saw records which showed the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of the decontamination cycles of the autoclaves to ensure that it was functioning properly. No evidence was available on the day of the inspection that protein testing or steam penetration testing was in place.

Are services safe?

We saw from staff records that no staff member, including the registered provider had received infection control training within the past CPD cycle.

There was adequate supplies of liquid soap and paper hand towels in the decontamination area and surgeries although the handwashing area was also used for rinsing and processing dirty instruments. A poster describing proper hand washing techniques was displayed above all the hand washing sinks. Paper hand towels and liquid soap was also available in the toilet.

We saw the sharps bins were being used correctly and located appropriately in the surgery. Clinical waste was not always stored securely for collection and on the day of the inspection we found clinical waste in a shared area of the building, this was brought to the attention of the registered provider and we were assured they would move and store in a more appropriate area. The registered provider had a contract with an authorised contractor for the collection and safe disposal of clinical waste.

The recruitment files we reviewed did not show any clinical staff had received inoculations against Hepatitis B. It is recommended that people who are likely to come into contract with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections. New members of staff new to healthcare should receive the required checks as stated in the Green book, chapter 12, Immunisation for healthcare and laboratory staff however no evidence was available on the day of the inspection.

We saw no evidence a Legionella risk assessment had taken place, and no evidence of recent water testing being carried out. Disinfecting tablets were in the practice to use in conjunction with the daily water bottle used on the dental unit water lines however these were not used in line with the manufacturer's instructions. The registered provider sent evidence after the inspection to show the assessment had been booked.

Equipment and medicines

We saw the Portable Appliance Testing (PAT) (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use) was last undertaken in 2011 and no visual checks had been recorded, this was brought to the attention of the registered provider on the day of the inspection and contact was made with the electrician to PAT test the equipment.

We saw one of three fire extinguishers had been checked in August 2014 to ensure that they were suitable for use if required. This was due to be reviewed.

We saw maintenance records for equipment such as autoclaves. Evidence the compressor had been fitted in 2010 was available but we did not see evidence the compressor had been serviced or certificated since. The regular maintenance would ensure the equipment remained fit for purpose in line with the Pressure Systems Safety Regulations 2000.

Only one local anaesthetic type was stored within the practice and this was stored appropriately, a log of batch numbers and expiry dates was not in place. Other than emergency medicines no other medicines were kept at the practice.

Radiography (X-rays)

The X-ray equipment was located in the surgery. The local rules were not in date and not in line with the make or model of the equipment. The X-ray equipment was last examined in 2010. Evidence was sent to the inspector to show the equipment maintenance had been scheduled.

We reviewed the practice's radiation protection file and asked the dentist about their procedures. The dentist told us they had not appointed a radiation protection advisor.

We saw the registered provider was up to date with their continuing professional development training in respect of dental radiography. The registered manager told us they did not undertake annual quality audits of the X-rays taken in accordance with the National Radiological Protection Board (NRPB).

X-rays were not justified, graded or reported on. No evidence of findings on the X-ray were in place or recorded within the patient care records we viewed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept paper dental care records. We used guidance from the Faculty of General Dental Practice (FGDP) to help us make our decisions about whether the practice records and record keeping were meeting best practice guidelines. We then looked to see whether you had your own systems in place that were equal to or better than what was recommended in the FDGP guidance and we could find no evidence that this was in place.

The records we viewed did not contain detailed information about the patient's current dental needs and past treatment. The dentist carried out an examination; recorded the medical history information within the patients' dental care records. At all subsequent appointments patients were asked to review and update a medical history form. This ensured the dentist was aware of the patients' present medical condition before offering or undertaking any treatment. Oral health was not always monitored or recorded in the patients dental care records. BPEs were rarely recorded and this was confirmed by staff.

We saw no evidence of a discussion of treatment options or the risks and benefits with the patient. Soft tissue examinations, diagnosis and a full assessment of each patient's needs had also not been recorded.

The dentist told us they always discussed the diagnosis with their patients and parents or guardian and, where appropriate, offered them any options available for treatment and explained the costs if required. By reviewing the dental care records we found these discussions were not recorded.

Patients' oral health was not monitored in line with the National Institute for Health and Care Excellence (NICE) recommendations. We saw from the dental care records and confirmed in discussion that the dentist was led by patients' wishes rather than risk based needs. The practice did not follow National Institute for Health and Care Excellence (NICE) guidelines when recalling a patient.

The practice was not in line with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentist was not applying the guidance from the FGDP on X-ray frequency. Justification for the taking of an X-ray, a grade of each X-ray and a detailed report was not recorded in the patient's dental care record.

Patients requiring specialist treatments that were not available at the practice, such as conscious sedation or orthodontics, were referred to other dental specialists.

Health promotion & prevention

The patient waiting areas contained no information that explained the services offered at the practice. NHS and private fees for treatment were displayed in the waiting room. Staff told us they did not always offer patients information about effective dental hygiene and oral care in the surgery.

The dentist told us they did not always provide patients with oral health advice and did not use all elements of Department of Health's policy, the 'Delivering Better Oral Health' toolkit; this includes information on fluoride applications. Fluoride treatments are a recognised form of preventative measures to help protect patients' teeth from decay.

Patients were not always given advice regarding maintaining good oral health. We did not see evidence that patients who had a high rate of dental decay were provided with diet advice which should include advice about snacking between meals, hidden sugars in drinks and tooth brushing. We did not see evidence of patients who had a high rate of dental decay being risk assessed or prescribed high fluoride toothpastes to help reduce the decay process.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. We saw evidence of completed induction checklists in the recruitment files. An informal chat with staff members to familiarise themselves with how the dentist worked and how the decontamination equipment was used.

Staff told us they had no access to on-going training to support their skill level and they were not encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC).

Staff told us they had annual informal appraisals and training requirements were discussed at these. Staff also

Are services effective?

(for example, treatment is effective)

felt they could approach the registered provider at any time to discuss continuing training and development as the need arose but were not always supported to enhance their skills.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient and in line with NICE guidelines where appropriate. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics and sedation.

The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice had a process for urgent referrals for suspected malignancies and worked closely with a variety of locations to ensure this suited the patient's needs.

Consent to care and treatment

We were told that patients were given appropriate information to support them to make decisions about the treatment they received although we saw no evidence in dental care records that individual treatment options, risks, benefits and costs were discussed with each patient. Staff ensured that a treatment plan was signed by the patient.

Staff were not fully aware of how to ensure patients had sufficient information and the mental capacity to give informed consent and had a basic understanding of the principles of the Mental Capacity Act (MCA) 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from the patients was positive and they commented they were treated with care, respect and dignity. They said staff supported them and were quick to respond to any distress or discomfort during treatment. Staff told us they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions over the telephone.

We observed privacy and confidentiality were not always maintained for patients who used the service on the day of inspection. Medical histories and appointments were verbally updated in a small waiting room. We observed staff were helpful and respectful to patients.

Patients' dental care records were secure stored. We observed records organised for the week ahead were kept in an unsecure location.

A selection of magazines was available in the waiting room and children's books and toys were also available.

Involvement in decisions about care and treatment

There was no evidence on the day of the inspection to suggest the practice provided patients with information to enable them to make informed choices. This was brought to the attention of the registered provider.

Patients told us they were involved in decisions and treatment options although when we asked about preventative care there was no evidence this had been provided.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book there were dedicated emergency slots available each day for the dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

The patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinic ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

Reasonable adjustments had been made to the premises however the practice could not accommodate restricted mobility patients. The staff worked closely with a local practice and would refer patients to them.

The practice did not have equality and diversity policy to support staff and no training had been provided or undertaken to provide an understanding to meet the needs of patients. The practice had access to translation services for those whose first language was not English.

Access to the service

The practice displayed its opening hours in the premises and in the practice information leaflet. The opening hours are Monday – Friday 09:00- 12:00 & 14:00 -17:00.

The patients told us they were rarely kept waiting for their appointment. Where treatment was urgent patients would be seen the same day and if not within 24 hours. The patients told us when they had required an emergency appointment this had been organised the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service on the telephone answering machine.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. The registered provider was in charge of dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the registered provider to ensure responses were made in a timely manner.

We looked at the practice's procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. This was in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The practice had received no complaints in the last year, and no historical evidence could be found to review the process had been responded to in line with the policy. The practice policy aimed to respond to the complaint within three working days and providing a formal response within 14 days if not before.

The complaints procedure was not displayed in the waiting room and had no information about external agencies. The practice also had no information about how to complain in the practice leaflet.

The practice also had no patients' advice leaflets or practice information leaflets available in the waiting areas.

Are services well-led?

Our findings

Governance arrangements

The practice had minimal governance arrangements in place including minimal policies and procedures for monitoring and improving the services provided for patients. All of the practice policies had not been recently updated or reviewed, guidance had been updated and no changes had been made to the policies. Staff were aware of their roles and responsibilities within the practice.

The patient dental care record audit had not been undertaken following the guidance provided by the Faculty of General Dental Practice.

The X-ray audit had not been undertaken and the registered provider was not aware of their responsibility in to comply with accordance with the National Radiological Protection Board (NRPB) or IR (ME) R.

The infection prevention and control audit had not been completed; HTM 01-05 states that an audit of the practice's infection prevention and control processes should be conducted every six months. This was brought to the attention of the registered provider to review the process.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team. All staff were aware of whom to raise any issues with and told us the registered provider was approachable, would listen to their concerns and would act appropriately. We were told there was a no blame culture at the practice and the delivery of high quality care was part of the practice ethos.

The registered provider was aware of their responsibility to comply with the duty of candour and told us that the preferred to address any concerns or issues immediately should they arise.

The registered provider would address with any issues regarding complaints or concerns from patients about any treatment received.

Learning and improvement

The practice did not maintain records of staff training. No evidence was available on the day of the inspection that staff were up to date with their training. We noted no members of staff had received safeguarding training in adults or children. Infection prevention and control training had also not been completed.

No staff personal files were available on the day of the inspection. Staff stated they felt insufficient time was set aside to complete training for their roles or that they have the opportunity to undertake additional training.

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

The registered provider explained the practice had a good longstanding relationship with their patients. The practice was participating in the continuous NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The practice had completed a patient satisfaction survey during 2015- 2016, there was no evidence that the feedback had been reviewed or acted upon.

We saw the practice held fortnightly practice meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions. The registered provider told us if anyone was not at the meeting they would receive a copy of the minutes.

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 Regulation 12: Safe Care and Treatment The registered provider failed to assess the risks to the health and safety of service users of receiving the care or treatment. • The registered person had not completed COSHH risk assessments for hazardous materials used or stored in the premises. • The registered person did not have a recruitment policy and had not followed safe recruitment procedures. The provider did not have DBS checks for staff so had failed to ensure that the persons providing care and treatment to service users had the qualification, competence, skills and experience to do that. The registered provider failed to do all that is reasonably practicable to mitigate any such risks. • The registered person had not completed an audit of the risk posed from Legionella. The registered provider failed to ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. • The registered person was not completing pressure vessel certification and service for the compressor. • The registered Provider failed to ensure the X-Ray equipment was serviced. The last service was in 2010. No Radiation Protection Advisor was appointed and not local rules were in place. Regulation 12 (1)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance The registered provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. • The register person had not completed audits annually for x-rays. Regulation 17 (1)(2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing The registered provider failed to provide appropriate support, training, professional development, supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to Perform. • The registered person failed to monitor or support staff to train and develop. Staff had not completed mandatory training in line with the guidance, this includes No Medical emergency CPR or AED training. No Infection prevention and control training. No safeguarding adults or children training. Regulation 18 (1) (2)