

Dr. Renata Redka

Queens Terrace Dental Practice

Inspection Report

26 Queen's Terrace
Southampton
Hampshire
SO14 3BQ
Tel: 023 8033 5005

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Overall summary

We carried out an announced comprehensive inspection on 11 October 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was 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

Queen's Terrace Dental Practice is a dental practice providing NHS and private treatment for both adults and children. The practice is based in a converted domestic dwelling in Southampton, a town situated in south Hampshire.

The practice has two dental treatment rooms, one of which one is based on the ground floor and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The ground floor is not accessible to wheelchair users, prams and patients with limited mobility without support from staff due to the physical make-up of the building. Patients who require level access are referred to a nearby practice.

The practice employs a dentist (the practice owner), a decontamination nurse and a receptionist who is also a dental nurse.

The practice's opening hours are 8.30am to 1pm and 1.30pm to 5.50pm Monday to Friday.

Summary of findings

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

Dr Renata Redka is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008. 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.

We obtained the views of 10 patients on the day of our inspection.

Our key findings were:

- The practice ethos was to achieve high quality patient centred care, a feature that was captured on the 71 comments cards completed by patients prior to our inspection.
- Feedback from 10 patients during our inspection gave us a completely positive picture of a friendly, professional service.
- Appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and maintained.
- Infection control procedures followed published guidance although the governance systems underpinning infection control procedures required strengthening.
- The practice owner was the dedicated safeguarding lead and there were processes in place for safeguarding adults and children living in vulnerable circumstances.
- The service was aware of the needs of the local population and took those into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- We found that the practice owner did not provide effective leadership due to the difficulties of combining their roles of lead clinician and registered manager in an effective way. This resulted in weak clinical governance across the practice as a whole.

- Management files contained out of date and generic operating practice policies, procedures and protocols that were not practice specific.
- We noted that the building was not fully mitigated in terms of fire risk prevention. A fire risk assessment was since carried out.
- Training in some areas had not been carried out for some considerable time and there was no system in place for recording staff training.
- Staff we spoke with were committed to providing a quality service to their patients.
- Regular staff meetings had not taken place since 2014.
- There were some clinical and non-clinical audits in place but these related to previous years and could not be considered as current.

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

- Ensure practice records are accurately maintained and written policies and procedures are practice specific and reviewed regularly.
- Ensure the training, learning and development needs of staff members are collated and reviewed at appropriate intervals.
- Ensure an effective process is established for the on-going assessment and supervision of all staff employed.
- Ensure that a system of regular staff meetings is established.

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:

- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Review its responsibilities to the needs of disabled people and the requirements of the Equality Act 2010

Summary of findings

and ensure a Disability Discrimination Act audit is undertaken for the premises. Specifically, the availability of a hearing loop for patients who are hearing aid wearers.

- Review staff understanding of Gillick competency and ensure all staff are aware of their responsibilities.
- Review the current legionella risk assessment and implement the required actions of the assessment carried out by the competent person, specifically an internal management review on a regular basis by the practice owner.
- 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 protocols for recording in the patients' dental care records the use of a rubber dam.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had arrangements in place for essential areas such as infection control procedures, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that the dental equipment used in the dental practice was maintained in accordance with current guidelines.

The practice had in place systems for identifying, investigating and learning from patient safety incidents, however we were not assured that all incidents were being recorded as often as they should. The system for receiving national alerts had lapsed.

Staff had previously received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults although their knowledge around Gillick competency was limited.

No action



Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

The staff had received professional training and development appropriate to their roles and learning needs previously but now required updating.

No action



Are services caring?

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

We obtained the views of 71 patients prior to our inspection and 10 patients on the day of our visit. These provided a positive view of the service the practice provided.

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

No action



Are services responsive to people's needs?

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

No action



Summary of findings

The service was aware of the needs of the local population and took these into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

Are services well-led?

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

Although the practice owner provided good clinical care from the patient's perspective, there were shortfalls in the clinical governance systems and processes underpinning the clinical care.

These shortfalls related to managing fire safety risks and the systems that mitigated further risks to patients and staff in the event of a fire. Specifically, this related to including means of escape, the maintenance of emergency lighting and fire signage. We referred the practice to the local fire service who undertook separate action and a professional fire risk assessment since been undertaken. A legionella risk assessment review was overdue.

Other areas of concern included files containing out of date and generic operating practice policies, procedures and protocols that were not practice specific. We found that the practice owner could not provide effective leadership due to the difficulties of combining the roles of lead clinician and registered manager in an effective way. This resulted in weak clinical governance across the practice as a whole.

Shortfalls in clinical governance included policies that were not reviewed on a regular basis, clinical audits that had not been carried out for over a year and training in recommended areas such as infection prevention control and safeguarding not having been carried out within recent times. We also found that a system for maintaining training records was absent and there was no evidence that staff appraisals had taken place. Staff meetings had not been undertaken to facilitate shared learning within the practice team.

Requirements notice



Queens Terrace Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 11 October 2016. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We spoke with three members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of 71 patients prior to our inspection and 10 patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We found documents that demonstrated that the practice was aware of RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). The practice had incident reporting forms in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

Records showed that one accident had occurred during 2015-16 which was managed in accordance with the practice's accident reporting policy. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) previously. However, the system of receiving alerts appeared to have lapsed. The last alert that we observed was for a dental radiography alert from 2014.

Reliable safety systems and processes (including safeguarding)

We spoke to the decontamination technician about how the practice dealt with and prevented needle stick injuries. They explained how the practice managed sharps waste thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We saw that the practice had in place instruments and accessories for the placement of a rubber dam. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. There appeared to be an ample stock of root canal instruments which were treated as single use by the practice. We noted that dental care records we saw where root canal treatment was carried out did not contain reference to placement of a rubber dam. Rubber dams should be used when endodontic treatment is being provided.

The practice owner was the safeguarding lead and was the point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place which required reviewing along with a protocol for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that staff had previously received training for both vulnerable adults and children but this training was several years ago and not current. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. All of the medicines and emergency equipment were in date.

Staff received training in dealing with medical emergencies in the dental chair in January 2016.

Staff recruitment

The dentist had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

Are services safe?

We looked at one staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy.

The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely to protect the confidentiality of staff personal information.

We saw that all staff had received appropriate checks from the Disclosure and Barring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

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

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice had policies which included radiation, fire safety, general health and safety and those pertaining to equipment used in the practice but these were not practice specific and were not always in date and regularly reviewed. Examples of policies not being regularly reviewed and dated included COSHH procedures, safeguarding, health and safety, business continuity plan and sharps policy.

We noted the fire safety risk assessment was not fit for purpose and were concerned with the lack of emergency lighting, a blocked escape route and incomplete monitoring checks. We immediately referred the practice to the local fire service. A representative attended the practice during our inspection and issued the owner with an action plan. We have since been supplied evidence to confirm a professional fire safety risk assessment has been carried out.

Infection control

Infection control procedures followed published guidance although the governance systems underpinning infection control procedures required strengthening. This included the audit process of infection prevention control procedures and the production of an annual infection control statement as specified under The Health and Social

Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. Although we saw completed audit sheets they were not dated and therefore we were not assured that they had been completed during 2016. An annual infection control statement had not been completed.

There appeared to be effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy and was dated but it was a generic policy and not practice specific. The decontamination technician described the method for processing contaminated instruments. It appeared that HTM 01 05 (national guidance for infection prevention and control in dental practices) Essential Quality Requirements for infection control was being met.

We saw that the dental treatment room, waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent. Hand washing facilities were available including liquid soap and paper towels. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of one treatment room were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The decontamination nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2011. The recommended procedures contained in the report had been carried out such as the checking of sentinel water tap

Are services safe?

temperatures and biological slide tests, but the risk assessment had not been reviewed by the practice since. The original risk assessment required an internal review by the practice in 2012.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging of processed instruments. The decontamination technician we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of manual scrubbing and an ultra-sonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). The autoclave was brand new. When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

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

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the compressor had been serviced in May 2016. The autoclave was brand new and did not require servicing until 2017. The practice's X-ray machine was due to be serviced and calibrated as specified under current national regulations in November 2016.

Portable appliance testing (PAT) had been carried out in May 2015.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The documentation contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Also included were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

Although an audit of radiographs had been carried out for the period 8/12/2014 to 15/04/2015, there was no audit carried out from this time. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice, apart from audit, was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dental care records we saw showed that the dentist carried out consultations, assessments and treatment that were generally in line with recognised general professional guidelines.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. Written treatment plans and associated costs were given to NHS patients only when complex work, such as crowns or dentures, was provided. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

Health promotion & prevention

Dental care records we saw demonstrated that advice given to patients included tooth brushing techniques,

dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Records also demonstrated that optimum fluoride exposure was facilitated where appropriate, this included the dentist prescribing high concentrated fluoride tooth paste and the placement of fluoride varnish applications.

Staffing

We observed a friendly atmosphere at the practice. The clinical staff had current registration with their professional body, the General Dental Council.

Seven of the 10 patients we asked told us they felt there was enough staff working at the practice. The practice employed one dentist (the practice owner), a decontamination technician and a receptionist who started the day before our visit.

There was a structured induction programme in place for new members of staff.

Working with other services

The dentist explained how they worked with other services and was able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

The dentist explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan, although the use of written treatment plans for NHS patients was not in accordance with the standard NHS contractual requirements. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

The dentist went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent

Are services effective?

(for example, treatment is effective)

to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. The dentist had

limited knowledge of the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The ground floor treatment room was situated along a corridor next to the reception room. We saw the door to this was wedged open and patients could be seen and heard from the corridor. In this situation conversations between patients and dentists could be heard from outside the treatment room and the patient's privacy would be compromised. We pointed this out to the decontamination nurse who immediately addressed the issue.

Patients' clinical records were stored electronically and in paper form. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; with paper records stored in an area of the practice not accessible to unauthorised members of the general public.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 71 patients prior to the day of our visit and 10 patients on the day of our visit. These provided a wholly positive view of the service the practice provided. All of the patients commented that the dentist was good at treating them with care and concern. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. Information was displayed in the waiting area that detailed the costs of both NHS and private treatments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist.

The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice was situated on the ground and first floor of the building. The ground floor waiting area and treatment room was accessed by steps up and down. We were told patients who found steps and stairs a barrier were sign-posted to nearby dental services with level access.

Practice staff spoke eight languages and told us they would arrange translation services if it was clear that a patient had difficulty in understanding information about their treatment.

The practice did not provide a hearing loop for patients who used a hearing aid.

Access to the service

The practice's opening hours were 8.30am to 1pm and 1.30pm to 5.50pm Monday to Friday.

We asked ten patients if they were satisfied with the hours the surgery was open; all but one patient said yes. This patient said they did not have an opinion.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised on NHS Choices website and on the telephone answering machine when the practice was closed. We asked to see the practice information leaflet but told it was out of date and needed to be updated.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. This policy was generic and not practice specific.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. We asked nine patients if they knew how to make a complaint if they had an issue and seven said yes, one said no and one was not sure.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within three working days and a full response would be given in 28 days. We were told the practice had not received any complaints in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

There were shortfalls related to the organisation, management and operation of a number of policies and protocols. Policies tended to be generic in nature and not practice specific and were not always current and regularly reviewed. Policies and protocols were not stored in a logical way with documentation pertinent to a particular process stored in several unrelated files. An example of this was in the checking of expiry dates for emergency medicines. One file we looked at showed that it was last carried out in January 2016 and by accident a sheet was found in an unrelated file which showed that regular checking was being carried out. We also noted that the sharps injury protocol related to a Primary Care Trust area of an unrelated area of the country.

Leadership, openness and transparency

The practice owner (dentist) articulated openly and honestly the difficulties they had in running the practice.

Although the practice owner provided good clinical care from the patient's perspective, there were shortfalls in the clinical governance systems and processes underpinning the clinical care. This was because of the difficulty of combining the roles of lead clinician and registered manager in an effective way in a small dental practice.

Having said this, the practice ethos was to achieve high quality patient centred care, a feature that was captured on the comments cards completed by patients prior to our inspection. Information from 71 completed Care Quality Commission (CQC) comment cards gave us a completely positive picture of a friendly, professional service.

Learning and improvement

We found that training in some areas had not been carried out for some considerable time and there was no system in place for recording staff training. Areas where training had lapsed and was not considered as current included fire safety, safeguarding and infection control.

We found there was no system in place for appraising staff.

We saw that the systems and process around clinical audit required improvement. For example, infection control audit sheets were completed but not dated and we were not assured that these audits had been carried out bi-annually as stated in HTM 01 05. The frequency of audit in relation to the quality of dental radiographs according to current professional guidelines should be at least on an annual basis. The last radiography audit related to a period ending April 2015.

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a complaints procedure in place, with details available for patients in the waiting area.

The practice was listed on NHS Choices website and information was mostly up to date. Information missing referred to patient access into the practice building.

Results of the most recent practice survey carried indicated that 92% of patients, who responded, said they would recommend the practice to a family member or friend.

There were two members of staff and the dentist who worked at the practice. One member of staff had started the day before our visit and the second was the partner of the dentist. As a result of this we were unable to obtain information about what it was like for staff to work at Queen's Terrace.

We found records to confirm staff meetings had taken place but the most recent meeting recorded was over two years prior to our visit.

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 17 HSCA (RA) Regulations 2014 Good governance</p> <p>We found the provider did not have effective systems in place to maintain securely such records as are necessary to be kept in relation to:</p> <ol style="list-style-type: none">1. The management of the regulated activity2. Persons employed in the carrying on of the regulated activity. <p>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <ul style="list-style-type: none">• Practice records were not accurately maintained and written policies and procedures were not reviewed regularly.• Training, learning and development needs of staff members were not maintained and the provider was unable to demonstrate that relevant training had been undertaken by all relevant staff.• There was no process in place for the on-going assessment and supervision of all staff employed.• Regular staff meetings did not take place.