

Dr. Zeenat Ishak

Bridlington Dental Centre

Inspection Report

12 Prospect Street
Bridlington
Humberside
YO15 2AL
Tel: 01262678777

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Overall summary

We carried out an announced comprehensive inspection on 3 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

We found that this practice was not providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was not 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

Bridlington Dental Centre is situated in Bridlington town centre, Humberside. The practice offers NHS and a small amount of private dental treatments including preventative advice and general dentistry.

The practice has one surgery, a decontamination room, a waiting area, a reception area and patient toilets. All facilities are located on the first floor of the premises. There are also staff facilities available.

There is one locum dentist, a trainee dental and a receptionist.

The practice is open between the hours of 9am and 5pm Monday – Friday.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

On the day of inspection we received 14 CQC comment cards providing feedback and we spoke with three patients. The patients who provided feedback were not always positive about the care and attention to treatment they received at the practice. They told us they had no continuity of care and the dentist could be rough. They told us there was poor communication from the practice

Summary of findings

about the services and patients were waiting for treatment to be completed. Patients also told us the receptionist and dental nurse were excellent, helpful and friendly.

The provider has taken steps to improve following our inspection but further action is necessary.

Our key findings were:

- The practice had poor systems in place to assess and manage risks to patients and staff including infection prevention and control, health and safety and the management of medical emergencies.
- Staff had received online safeguarding training, knew how to recognise signs of abuse and how to report it. There was no in house lead for safeguarding.
- There was not sufficient numbers of suitably qualified staff to meet the needs of patients.
- Infection control procedures were not in accordance with the published guidelines.
- Oral health advice and treatment was not provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- Treatment was not well planned and provided in line with current best practice guidelines.
- Patients did not receive clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- The appointment system did not met patients' needs due to the lack of a full time dentist.
- The governance systems were not effective and not embedded.
- There were no defined leadership roles within the practice and staff did not feel supported. The registered manager worked remotely from the practice.

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

- Ensure the training, learning and development needs of staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff employed.
- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical

Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.

- Ensure the recommendations from the current legionella risk assessment are implemented including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure all practice risk assessments are implemented and reviewed including the practice sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Ensure audits of various aspects of the service, such as radiography are undertaken at regular intervals to help improve the quality of service. Practice must also ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure that all staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Ensure the storage of records relating to people employed and the management of regulated activities is in accordance with current legislation and guidance.
- Ensure every patient is treated in line with their needs and referred to other services when required.
- Ensure that a system for identifying, receiving, recording, handling and responding to complaints by patients 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:

- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Summary of findings

- 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 stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock.
- Review the practice protocols and adopt an individual risk based approach to patient recalls giving due regard to National Institute for Health and Care Excellence (NICE) guidelines.
- 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'.
- Review the practice confidentiality policy with regard to the use of CCTV cameras within the dental practice and ensure all information, assessments and signage are implemented as per the Information Commissioning Office (ICO) recommendations.
- Review the availability of a practice information leaflet.
- Review the practice's process for ensuring staff are up to date with their continuous professional development.
- Review the practice's recruitment policy and procedures to ensure immunity to Hepatitis B is requested and recorded suitably.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had some inconsistent systems and processes in place to ensure all care and treatment was carried out safely. For example, there were systems in place for clinical waste control and staff had received only limited life support training and none included a practice session or assessment in regards to management of medical emergencies. All emergency medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

Infection prevention and control was not carried out in line with recommended guidance from the Department of Health: Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practice. On the day of the inspection we found debris on several instruments, single use items which appeared to have been re processed for use and dirty gauze that had not been changed as part of a treatment kit.

Staff told us they did not feel confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). This would be reported to a remote registered manager and we did not receive reassurance this would enable an effective response.

Staff had received some online training in safeguarding patients and knew how to recognise the signs of abuse and who to report them to including external agencies such as the local authority safeguarding team. There was no in house lead for safeguarding.

Staff were not suitably qualified or experienced for their roles as only one trainee dental nurse and a new receptionist (who had not worked in dentistry before) were in place to work with a high turnover of locum dentists. On the day of inspection there was no evidence of the immunity of one member of staff to Hepatitis B.

We reviewed the legionella risk assessment dated December 2014. Evidence of regular water testing was being carried out on one hot water tap only and this was not in accordance with the risk assessment. The water temperature had not reached adequate temperatures for the past eight months and this had not been reported or rectified.

Requirements notice 

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 Requirement Notices at the end of this report).

Requirements notice 

Summary of findings

Patients' dental care records did not always provide detailed information about the patients' current dental needs and past treatment. We found 96 patients on a waiting list for referrals to specialist services for treatment or investigations. We asked the dentist why this was and he did not know where to refer patients to so did not refer at all.

The practice did not follow best practice guidelines when delivering dental care. These should include the Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP).

Staff were encouraged to complete online training relevant to their roles and this was not monitored by the registered manager. Due to a high turnover of staff it was difficult to ascertain if all staff were trained adequately and safely. On the day of inspection we were not provided with any information to show that the dentist was up to date with their CPD.

Are services caring?

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

We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 14 responses of which six were positive and eight raised concerns about the continuity of treatment and the dentist being rough when providing treatment. The comment cards highlighted that patients were very positive about the dental nurse and receptionist at the practice.

Current dental care records were kept securely in locked cabinets behind reception and computers were password protected. Archived records were not stored in locked cabinets.

We observed patients being treated with respect and dignity during interactions at the reception desk, over the telephone and as they were escorted through the practice. We also observed staff to be welcoming and caring towards the patients.

CCTV cameras were in place throughout the practice. No information was available to suggest a policy, risk assessment or registration with the Information Commissioning Office (ICO) had been sought. The practice did assure us they would switch all CCTV off until more information and guidance was available.

During our inspection we spoke with a patient who expressed some concerns regarding the dentist not ensuring they consented to all aspects of their treatment. We brought this to the attention of staff at the practice who told us they would follow up this issue as a complaint.

Requirements notice



Are services responsive to people's needs?

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

Requirements notice



Summary of findings

We were told every effort was made to see emergency patients the same day and if there was not a dentist on site this was provided through local sister practices. Patients commented they had difficulty accessing treatment for urgent and emergency care when required as the practice had not had a full time dentist for some time.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure. We found several complaints which had been sent to the registered manager to respond to and this has not been followed up in the required time frame and these complaints had been escalated to the local area NHS team.

Patients had access to telephone interpreter services when required and the practice provided a range of aids for different disabilities such as a hearing loop and hand rails. The practice had no disability access. Patients with mobility difficulties were signposted to a local sister practice.

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).

There was not a clearly defined management structure in place as this was provided remotely. Staff did not feel supported and appreciated in their own particular roles. The trainee dental nurse was responsible for the day to day running of the practice.

The practice did not regularly audit clinical and non-clinical areas as part of a system of continuous improvement and learning.

The practice conducted patient satisfaction surveys; there was a comments box in the waiting room for patients to make suggestions to the practice.

All staff were provided on line training but did not feel supported and encouraged to improve their skills through learning and development.

The practice held monthly staff meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues. The registered manager told us they also used an online multimedia system to have 1-2-1 conversations with staff. This was not recorded.

Enforcement action



Bridlington Dental Centre

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 led by a CQC inspector who was supported by a specialist dental adviser.

We informed NHS England area team and Healthwatch North Yorkshire that we were inspecting the practice; we received information of concern from them in regards to continuity of care of patients and accessibility to care.

During the inspection we spoke with the registered manager, the locum dentist, the trainee dental nurse and the receptionist.

To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff told us they were aware of the need to be open, honest and apologetic to patients if anything was to go wrong; this is in accordance with the Duty of Candour principle which states the same. During the inspection we told of a situation that had not been responded to in line with the Duty of Candour principal.

Staff understood the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). They did not feel confident in the reporting process as the staff would refer any RIDDOR or significant events to the remote registered manager. We were told of a significant event and found this had not been recorded.

The registered manager received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. Relevant alerts were emailed to all practices and shared with staff. We were told by the registered manager that relevant alerts were emailed to all practices; they printed the alerts and shared them with staff. We found no supporting evidence on the day of the inspection that alerts had been actioned within the practice.

Reliable safety systems and processes (including safeguarding)

The practice had child and adult safeguarding policies and procedures in place that were not practice specific and did not have the contact details of local services. There was a flow chart in the staff room that provided staff with information about identifying, reporting and dealing with suspected abuse. They included the contact details for the local authority safeguarding team, social services and other relevant agencies. The remote registered manager was the lead for safeguarding. This role included providing support and advice to staff and overseeing the safeguarding procedures within the practice.

We saw evidence all staff had received online safeguarding training in vulnerable adults and children. Staff could easily access the safeguarding policy kept within the staff room.

Staff demonstrated their awareness of the signs and symptoms of abuse and neglect. They were also aware of the procedures they needed to follow to address safeguarding concerns.

We spoke to with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The practice had not carried out a thorough sharps risk assessment and had not implemented the use of safer sharps. This regulation was introduced to reduce the risk of contaminated sharps injuries to all staff members.

The practice had a whistleblowing policy which staff were aware of. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were not knowledgeable about what to do in a medical emergency. They had completed online training in emergency resuscitation and basic life support within the last 12 months. Two staff member's staff had received limited life support training and none included a practice session or assessment in regards to management of medical emergencies. The GDC states two members of qualified CPR trained staff should be on the premises at all time when patients are seen.

The emergency medicines, emergency resuscitation kits and medical oxygen were stored in an easily accessible location. Staff knew where the emergency kits were kept.

The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Records showed weekly checks were carried out on the emergency medicines and weekly checks were carried out on the medical oxygen cylinder and the AED. These checks ensured the oxygen cylinder was sufficiently full, the AED was fully charged and the emergency medicines were in date. We saw that the oxygen cylinder was serviced on an annual basis.

Staff recruitment

Are services safe?

The practice had a recruitment policy in place and this process had been followed when employing new staff. This included obtaining proof of their identity, checking their skills and qualifications, registration with relevant professional bodies and seeking references. We reviewed the newest member of staff's recruitment file which confirmed the processes had been followed. All personal information was stored securely in the office.

We saw all staff 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.

There was no clear evidence all staff were appropriately immunised against Hepatitis B. For example, for one member of staff titre levels were not available.

We recorded 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.

The trainee dental nurse told us they were enrolled on to a dental nurse training course. The training assessor had been to the practice to assess competencies of the dental nurse and was refused access to the surgery by the dentist.

Monitoring health & safety and responding to risks

The practice could not provide evidence 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 had been completed.

The practice had maintained a detailed Control of Substances Hazardous to Health (COSHH) folder. 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. If any new materials were implemented into the practice a new risk assessment was put in place.

We noted there had been a fire risk assessment completed for the premises in October 2016. We saw as part of the checks by the team the smoke alarms were tested and the

fire extinguishers were regularly serviced. There was evidence a fire drill had been undertaken with staff. These and other measures should be taken to reduce the likelihood of risks of harm to staff and patients.

We saw the business continuity plan had details of all staff, contractors and emergency numbers should an unforeseen emergency occur.

Infection control

There was an infection prevention and control policy in place. We found this related to old guidance and had not been kept up to date or reviewed annually.

We spoke with the trainee dental nurse about decontamination and infection prevention and control; the process of instrument collection, processing, inspecting using a magnifying light, sterilising and storage was clearly described and shown. We also saw the daily and weekly tests were being carried out by the dental nurse to ensure the sterilisers were in working order.

We found instruments were not being cleaned and sterilised in line with published guidance (HTM01-05). The trainee dental nurse was informed about the decontamination process and demonstrated some of the correct procedures. We found instruments were transported in a rigid colour coded sealed box to the instrument decontamination area. Instruments were hand scrubbed using a long handled brush under temperature controlled solution before being placed in an ultrasonic bath. Instruments were inspected under light magnification before being placed in a validated non-vacuum autoclave (a device for sterilising dental and medical instruments). Instruments were dried and stored in a date stamped bag and returned to the treatment room in a 'clean' colour coded box.

The dental nurse had received conflicting information about the process of cleaning and storage of dental instruments and we found different dates methods in place on the day of the inspection. We found debris on instruments and single use instruments which appeared to have been re processed ready for reuse. The trainee dental nurse did not have any onsite support or a dental nurse mentor locally for support.

The practice had carried out an Infection Prevention Society (IPS) self-assessment audit in September 2015 relating to the Department of Health's guidance on

Are services safe?

decontamination in dental services (HTM01-05). This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. This audit should be carried out six monthly with action plans and learning outcomes in place. We found no historical action plans or learning outcomes in place.

There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

The dental surgery and decontamination room had carpeted areas. The registered manager provided a quote to replace the surgery carpet from October 2016. There was not a quote for the replacement of the carpet in the decontamination room.

Records showed the practice had completed a Legionella risk assessment in December 2014. The dental nurse was not fully aware of what processes should be undertaken to reduce the likelihood of Legionella developing. The running the dental unit water lines in the treatment room was completed only at the start of the day for 10-15 minutes but at no other time. The only monitoring of water temperatures in place was of one hot tap which for the past eight months had not reached the required temperature and had not been reported. The registered manager told us in house Legionella training had been completed but there was not supporting evidence to show this. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Air conditioning had been installed in to the surgery although there was no heating for staff in the winter and on the day of the inspection the practice was very cold and staff had to wear cardigans over their clinical wear. The surgery had a gas fire and when we asked we were told this was not used. It had not been decommissioned.

The practice stored clinical waste in a secure manner and an appropriate contractor was used to remove it from site. Waste consignment notices were not available for the inspection as these were stored centrally.

The practice staff carried out daily environmental cleaning. We observed there was different coloured cleaning equipment to follow the National Patient Safety Agency guidance.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations.

We saw evidence of servicing certificates for sterilisation equipment in August 2016.

The Portable Appliance Testing (PAT) had been completed in August 2016. (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use).

Local anaesthetics were stored appropriately.

Radiography (X-rays)

The practice did not have a radiation protection file. There was a record of all X-ray equipment including service and maintenance history. A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure the equipment was operated safely and by qualified staff only.

A new X-ray machine had been fitted in August 2016. This had subsequently been moved and no testing or change to the local rules had been put in place.

We saw radiographs had not been taken recently due to the equipment failure and replacement.

Intra-oral X-ray audits had not been completed since February 2015. Due to the failure of equipment we felt an audit process should be implemented due to continuity of care.

We did not see that the dentist was up to date with their continuing professional development training in respect of dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date electronic dental care records. The dentist carried out assessments that were not in line with recognised guidance from the Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). We found this was not always recorded in detail and due to the high turnover of staff we found continuity of record keeping was difficult to follow a patient's treatment pathway.

The dentist used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. The practice also recorded the medical history information within the patients' dental care records for future reference.

Health promotion & prevention

We found patient specific oral health and preventative advice was not being provided in line with the Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, fluoride varnish was not applied to the teeth of all children who attended for an examination and high fluoride toothpastes were not prescribed for patients at high risk of dental decay. Staff told us the dentist would not always provide oral hygiene advice to patients where appropriate.

The medical history form patients completed included questions about smoking and alcohol consumption. There were health promotion leaflets available in the waiting room to support patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included making the new member of staff aware of the practice's policies, the location of emergency medicines and arrangements for fire evacuation procedures. We saw evidence of completed induction checklists in the induction files.

Staff told us they had access to on-going training to support and advance their skill level and they were

encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). Records showed professional registration with the GDC was up to date for all staff who required to be and we saw evidence of on-going CPD. On the day of the inspection the dentist did not have any certificates present to show they were up to date with their CPD requirements.

The trainee dental nurse was not fully supported in her role at the practice and had no local support. The registered manager told us they would hold multimedia online meetings if required. There was no evidence these had taken place to date.

Working with other services

The dentist confirmed they had not referred patients to specialists in primary and secondary care if the treatment required was not provided by the practice. The dentist told us they did not know where to refer patients to and was not aware of which templates to use in order to make these referrals. We found there was a list with 96 patients awaiting dental treatments and referral for treatment and this had not been followed up.

The dentist told us any urgent referrals would be completed but they were not aware where the patients would be sent. We reviewed the waiting list of 96 patients and could not see any evidence anyone on this list required an urgent referral. We asked the staff to review the referral waiting list to ensure this was the case. An urgent referral would be used for referring of a suspicious lesion under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks.

Consent to care and treatment

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. Staff explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. The patient would sign this and take the original document. A copy would be retained in the patients' dental care record.

Are services effective?

(for example, treatment is effective)

Staff were not clear on the principles of the Mental Capacity Act 2005(MCA) and the concept of Gillick competence. The MCA is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.

During the inspection we were told there had been an incident where a patient had asked the dentist to stop and this had not been done. No record of this incident had been recorded in the patients care record or within the practice and only when we requested the patient be followed up by a phone call was this initiated.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from patients was a mixture of positive and negative experiences. We observed the dental nurse and receptionist always interacted with patients in a respectful, appropriate and kind manner and were friendly and respectful towards patients during interactions at the reception desk and over the telephone.

Due to a high turnover of staff, continuity of patient care was not being provided. The locum dentist was only providing limited treatments for patients. We found a waiting list for patients to be seen for treatments including fillings, gum treatments, dentures, root canal treatments and staff told us some patients were in pain and had not been seen.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection.

Dental care records were not visible to the public on the reception desk. Patients' electronic care records were password protected and regularly backed up to secure storage. Current paper records were securely stored in a locked cabinet in accordance with the Data Protection Act.

We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

CCTV cameras were in place throughout the practice. No information for was available to suggest a policy, risk assessment or registration with the Information Commissioning Office (ICO) had been sought. The practice did assure us they would switch all CCTV off until more information and guidance was in place.

Involvement in decisions about care and treatment

The practice did not provide clear treatment plans to their patients due to the high turnover of staff. There was no continuity of care and conflicting treatment plans from six dentists in six months were difficult to follow. Patients were not given the opportunity to have treatment plans completed as the locum dentist did not know how long they were going to be working there and did not want to start something they could not finish. We found this included general dentistry including fillings and gum treatments.

Posters showing NHS and private treatment costs were displayed in the waiting area.

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 appointment system in place to respond to patients' needs when the practice had a dentist. We were told the patients were given sufficient time during their appointment so they would not feel rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

We were told patients were rearranged at short notice due to the timekeeping of the dentist and no explanation was given. We reviewed a complaint where by a patient had been kept waiting due to a phone call the dentist had taken which the patient overheard in the waiting room.

The practice did not have an information leaflet. The information leaflet should include details of the staff, dental treatments, out of hour's services, how to complain and a description of the facilities.

Tackling inequity and promoting equality

The practice had equality and diversity, and disability policies to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises however the practice could not accommodate patients with restricted mobility. The staff worked closely with a local practice and would refer patients to them.

We saw the consent forms could be made available in a large print version and the practice had access to translation services for those whose first language was not English.

Access to the service

The practice did not display its opening hours in the premises and they did not have a practice information leaflet

The opening hours are:

Monday – Friday 9am –5pm.

The practice had not been fully open over the past six months due to difficulty employing a full time dentist.

The patients told us they were kept waiting for their appointment and had appointments cancelled whilst they had been waiting. Where treatment was urgent staff told us patients would be seen the same day here or at other locations. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed. Patients commented they had difficulty accessing treatment for urgent and emergency care when required as the practice had not had a full time dentist for some time.

Concerns & complaints

The practice had a complaints policy which provided guidance to staff on how to handle a complaint. The policy was detailed in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and as recommended by the GDC.

Information for patients was available in the waiting areas. This included how to make a complaint, how complaints would be dealt with and the time frames for responses.

The registered manager was responsible for dealing with complaints when they arose. Staff told us they would raise any formal or informal comments or concerns with the registered manager to ensure responses were made in a timely manner. Staff told us they aimed to resolve complaints in-house initially.

The practice provided us evidence of three complaints in the last 12 months. On the day of the inspection we were given a complaint which had not been responded to and had now been escalated the local area team. As the complaints were responded to remotely by the registered manager the records in the practice were not complete and we were unsure if these complaints had been responded to. It was not clear what actions the registered manager had taken with these complaints.

Are services well-led?

Our findings

Governance arrangements

The trainee dental nurse and receptionist were responsible for the day to day running of the service. There was a range of policies and procedures in use at the practice. These were poorly organised and when asked no-one could easily find a policy when requested. We found some policies were not practice specific, had not been updated recently and referred to out of date guidance.

We found the safeguarding policy did not contain the names of the safeguarding leads. The two internal contacts within the whistleblowing policy were husband and wife therefore could potentially not be deemed to be impartial.

The practice did not have an approach for identifying where quality or safety was being affected and addressing any issues. Risk management policies were not in place to ensure the safety of patients and staff members. There was no risk assessment in place for the safer use of sharps, display screen equipment or other general risk assessments required for a dental practice.

There was not an effective management structure in place to ensure the responsibilities of staff were clear. Staff told us they did not feel supported and were not clear about their roles and responsibilities.

The practice did not have a patient information leaflet. This leaflet should contain details of the dental team, services available, opening hours, out of hours care and the complaints procedure. We discussed this with the area manager and we were assured a patient information leaflet would be produced.

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 and it was evident the receptionist and trainee dental nurse worked as a team and dealt with any issue in a professional manner.

The practice held monthly staff meetings involving all staff members. If there was more urgent information to discuss with staff then an informal staff meeting would be organised to discuss the matter with the registered provider. We saw evidence of written minutes.

All staff were aware of whom to raise any issue with and told us the registered manager would listen to their concerns.

We observed there was a blame culture at the practice. During the inspection we discussed at length, training and responsibilities of staff. The registered manager and dentist blamed the employed staff for the practice failings even though they were in training.

Learning and improvement

Quality assurance processes were not used at the practice to encourage continuous improvement. The practice did not audit areas of their practice as part of a system of continuous improvement and learning. This should include clinical audits such as X-rays and infection prevention and control.

The last X-ray audit had been completed on February 2015 and since then issues with the X-ray machine had been found. The last dated infection prevention and control audit was completed on September 2015 with no action plans or learning outcomes in place. This should be completed six monthly.

Staff told us they had access to online training which helped ensure mandatory training was completed each year; this included medical emergencies and basic life support.

All staff had appraisals at which learning needs, general wellbeing and aspirations were discussed. Evidence of completed appraisal documents were not available on the day of inspection.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and had comment cards in the waiting rooms. We could not confirm when the last survey had been completed. The satisfaction survey included questions about the patients' overall satisfaction, the cleanliness of the premises, accessibility and length of time waiting.

Staff and patients were encouraged to provide feedback on a regular basis either verbally or using the suggestion boxes in the waiting rooms. Patients were also encouraged to complete the NHS Friends and Family Test (FFT). This is a

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national programme to allow patients to provide feedback on the services provided. There was no evidence on the practice NHS choices website this had been completed as the page was not up to date.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: Person centred care The registered provider failed to ensure the care and treatment of service users are (a) be appropriate, (b) meet their needs, and (c) reflect their preferences. We found a list of 96 patients was found during the inspection with no availability of a dentist to follow these patients up in a responsive time frame. Regulation 9 (1)
Regulated activity	Regulation
	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 provider failed to do all that is reasonably practicable to mitigate any such risks. The registered provider failed to ensure that persons providing care or treatment to service users have the required qualifications, competence, skills and experience to do so safely. 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.

This section is primarily information for the provider

Requirement notices

The registered provider failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Regulation 12 (1)

Enforcement actions

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 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 registered provider failed to ensure continuity of patients and the provision of basic dental care and referral of patient to secondary dental care was in place. The registered provider failed to ensure all policies and protocols were current and in line with recommended guidelines. The registered provider failed to maintain an accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1)