

Mr. Michael T C Wong

Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 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

Mr Michael T C Wong's Dental Surgery is located in the London Borough of Richmond-upon-Thames. The premises are situated in a high-street location. There is one treatment room with a decontamination area, a reception room with waiting area, an X-ray area, a staff room, and a patient toilet. These are situated on the ground and first floors of the building.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges.

The staff structure of the practice consists of a principal dentist, a trainee dental nurse and a receptionist.

The practice opening hours are Monday to Friday from 9.00am to 5.00pm and alternate Saturdays from 9.00am to 1.00pm.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual, registered person. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Summary of findings

Fifty people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were systems in place to reduce and minimise the risk and spread of infection. However, further improvements to infection control protocols were identified during the inspection.
- The practice had safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances. However, not all staff were up to date with their safeguarding training at the time of the inspection.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- There were arrangements in place for managing medical emergencies. However, the practice did not have access to an Automated External Defibrillator (AED), in line with current guidance, on the day of the inspection.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- The practice had some governance arrangements and systems to monitor the quality and safety of the service. However, audits, such as those of X-ray and dental record keeping quality had not been carried out.
- Ensure suitable governance arrangements are in place and an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure audits of various aspects of the service, such as radiography, are undertaken at regular intervals to help improve the quality of service. The practice should also ensure that, where applicable, audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure the practice's infection control procedures and protocols are suitable taking into account 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'

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 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 its responsibilities as 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.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's recruitment policy and procedures to ensure accurate, complete and detailed records are maintained for all staff. Review its responsibilities to respond to the needs of patients with disability and the requirements of the Equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

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

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 policies and protocols related to the safe running of the service. Staff were aware of these and were following them. The practice had effective systems for the management of dental radiography. Equipment was well maintained and checked for effectiveness.

However, we found that the practice did not have suitable arrangements for managing medical emergencies as they did not have access to an Automated External Defibrillator (AED), in line with current guidance, at the time of the inspection.

We also noted that dental instruments were not being cleaned in line with relevant guidance and single-use items, like dental burs, were being re-used.

The practice did not have a formal recruitment policy and we found that some relevant background checks, such as proof of identification and references, had not been obtained.

There were safeguarding policies in place which staff members understood. Improvements were required to ensure all staff were up to date with their safeguarding training.

The principal dentist was responsive to our feedback and sent us evidence, after the inspection to show that action was being taken to improve. For example, the practice had purchased an AED and staff had completed safeguarding training. Infection control protocols had also been updated.

No action



Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff told us they were well supported and supervised by the principal dentist. Staff engaged in continuous professional development (CPD) and were working towards meeting all of the training requirements of the General Dental Council (GDC).

No action



Summary of findings

Are services caring?

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

We received positive feedback from patients through comment cards and by speaking with patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

No action



Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

The culture of the practice promoted equality of access for all. The practice was wheelchair accessible as the treatment room was situated on the ground floor. The practice had not carried out a full Disability Discrimination Act audit at the time of the inspection, but confirmed they would now do so with a view to identifying any further reasonable adjustments that could be made at the practice to improve patient access.

There was a complaints policy in place and the practice staff were aware of the complaints procedures and assured us that they would act promptly to respond to any complaints that were received. No formal complaints had been received in the past year.

No action



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 Requirement Notices at the end of this report).

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with each other.

The practice had some clinical governance and risk management structures in place. However, the practice did not have a structured plan in place to audit quality and safety beyond the mandatory audit for infection control. A radiography audit and a dental record keeping audit had not been completed. An infection control audit had been completed within the past six months, but this had not been effective as it had failed to identify areas for improvement. Risks associated with re-use of single-use instruments such as dental burs and incorrect cleaning of used dental instruments had not been recognised and suitably mitigated.

We also found areas where improvements in risk management processes were needed. For example, the COSHH file had not been reviewed recently. There were health and safety risk assessments, but these had not identified the need to store

Requirements notice



Summary of findings

an AED at the practice to protect staff and patients in the event of a medical emergency. The practice did not have a recruitment policy and we noted some gaps in record keeping related to staff recruitment. The practice did not have a system in place to identify gaps in staff training.

Dental Surgery

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

We carried out an announced, comprehensive inspection on 21 October 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with three members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Fifty people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents and accidents. There was an incident reporting policy and an accidents reporting book. Staff understood the process for accident reporting, including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been one incident recorded in the past 12 months. We noted that this had been investigated by the principal dentist and actions had been shared with staff to prevent a recurrence.

The practice did not have a system in place to receive or respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. We raised this with the principal dentist who told us that they would now sign up for MHRA alerts.

The principal dentist was aware of the Duty of Candour. They told us they were committed to operating in an open and transparent manner; they would always inform patients if anything had gone wrong and offer an apology in relation to this. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

The practice had a well-designed safeguarding policy which referred to national guidance. The principal dentist was the named practice lead for child and adult safeguarding. Information about the local authority contacts for safeguarding concerns was displayed on a practice noticeboard and held in a safeguarding policy folder.

Staff were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

However, staff had not completed training in safeguarding adults and children to an appropriate level. The principal dentist had previously completed such training, but it was

due for renewal. The receptionist had not completed safeguarding training. The principal dentist sent us evidence via email, after the inspection, confirming that this training had now been completed.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. There was a written protocol for staff to follow in the event that they did experience a needle stick injury. The practice also followed a protocol to minimise needle stick injuries during the administration of local anaesthetics. The dentist re-sheathed needles using a single-handed scooping technique; only the dentist handled the needles and they disposed of them promptly in a sharps bin. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. Further improvements could be made through the use of a written risk assessment, in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 was available.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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. Rubber dam should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in patients' dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had oxygen and other related items, such as manual breathing aids and portable suction, in line with the Resuscitation Council UK guidelines.

However, staff did not have access to an automated external defibrillator (AED), in line with current guidance, and had not undertaken and documented a risk assessment as regards its absence. [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].

Are services safe?

We raised this issue with the principal dentist who sent us confirmation via email, on the same day as the inspection, that an AED had been ordered for the practice.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

Staff received annual training in using the emergency equipment.

Staff recruitment

The staff structure of the practice consists of a principal dentist, a trainee dental nurse and a receptionist.

Two members of staff had been recruited by the practice within the past year. We reviewed the staff recruitment records and found evidence that checks such as a review of employment history, formal interview and check of registration with the General Dental Council, where appropriate had been carried out. Clinical staff were asked to provide information about their immunisation status in relation to Hepatitis B.

The practice did not have a formal recruitment policy. We found that some relevant checks had not been completed or recorded. For example, a proof of identification record and evidence related to conduct in prior employment had not been obtained. The principal dentist assured us that references and proof of identification would now be obtained consistently prior to employing new members of staff.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check prior to employment. (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).

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There was a business continuity plan in place. There was an arrangement in place to refer patients to another practice in the local area for emergency appointments in the event that the practice's own premises became unfit for use.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, the contents of the COSHH file had not been reviewed since 2010 and now required updating.

Infection control

There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment room, decontamination area and toilets. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. However, we found evidence that single-use items such as dental burs were being reused. We discussed this with the principal dentist who ensured the items were disposed of suitably on the day of the inspection.

The treatment rooms had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use. We observed that these were regularly in use throughout the day.

Are services safe?

We asked the trainee dental nurse to demonstrate 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.

We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. The water lines were being flushed at the start of each session, but were not regularly treated with detergent in line with the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The practice used a decontamination area to the side of the treatment room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment room and the decontamination area which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned. All items were then inspected under a light magnification device. Items were then pouched and then placed in an autoclave (steriliser), used on the vacuum cycle, and stored appropriately, until required. All of the pouches we checked had a sterilisation expiry date. However, the manual cleaning protocol did not follow HTM 01-05 guidance. Items were cleaned above the water and rinsed under a running tap which increased the risk of aerosol contamination. We discussed the protocol with the principal dentist; they subsequently confirmed via email that the trainee dental nurse had received additional instruction in the manual cleaning process to ensure the decontamination procedures were in line with the HTM 01-05 guidance.

We saw that there were systems in place to ensure that the autoclave was working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of dental 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 segregated. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme. There was a cleaning schedule for staff to follow which described daily, weekly and monthly tasks.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

A Legionella risk assessment had been carried out by an external contractor. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis. (Legionella is a term for particular bacteria which can contaminate water systems in buildings).

The practice had carried out practice-wide infection control audits every six months and found high standards throughout the practice. However, the audit system had not identified the concerns associated with the re-use of single-use instruments and incorrect instrument cleaning procedures.

The principal dentist was responsive to our feedback in this area and assured us that the correct instrument cleaning processes would now be implemented.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected

Are services safe?

and serviced. A pressure vessel certificate for the dental compressor and autoclave had been issued within the past year, in accordance with the Pressure Systems Safety Regulations 2000.

Portable appliance testing (PAT) had been completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The practice stored small numbers of prescriptions pads for NHS treatment and each dentist also wrote out private prescriptions. There was a system for tracking the NHS prescription numbers at the practice for enhanced security.

The use-by dates of medicines, oxygen cylinder and equipment were monitored using weekly and monthly check sheets which enabled the staff to replace out-of-date drugs and equipment promptly.

Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules.

We saw evidence in the staff records which showed they had completed radiography and radiation protection training.

Audits on X-ray quality had not been undertaken. We noted that improvements in the recording of the grading of X-rays in patients' notes or elsewhere was also not being undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. The principal dentist described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire covering 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed 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 were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies.

The principal dentist was aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting).

They told us they held discussions with their patients, where appropriate, around effective tooth brushing, smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials available for staff. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked all of the staff files. We noted that the training covered most of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, and radiography and radiation protection training. However, staff had not completed relevant safeguarding training at the time of the inspection. The principal dentist sent us evidence, via email, after the inspection confirming that such training had been completed.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

The staff employed at the practice had worked there for under a year. They had not yet been engaged in a formal appraisal process. Staff noted that in a small, dental team there were regular opportunities to discuss performance and request additional supervision or training.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The principal dentist explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complex orthodontics.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their

Are services effective?

(for example, treatment is effective)

treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

We spoke with the principal dentist about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. They used a written treatment plan for more complex treatments. 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.

However, the dentist did not always use written consent forms or consistently record in patients' notes when verbal

consent had been obtained. We discussed this with the principal dentist who told us they would now review the guidance on consent provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

All of the staff we spoke with were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves).

The dentist we spoke with could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received, and the patients we spoke with, all made positive remarks about the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. Patients who were nervous about dental treatment indicated that their dentist was calm, worked with them, listened to their concerns, and gave them reassurance throughout the processes of the dental treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. Conversations between patients and the dentist could not be heard from outside the treatment room, which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format and kept in locked filing cabinets.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the NHS and private dental charges or fees.

Staff told us they worked towards providing clear explanations about treatment and prevention strategies.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentist could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and practice policy documents. The practice had a website which reinforced this information. New patients were given a practice leaflet which included advice about appointments, opening hours and the types of services that were on offer.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. There was an equality and diversity policy which staff were following.

Staff spoke a range of different languages, which supported some patients to access the service. The practice had access to a telephone interpretation service, when required.

The practice was wheelchair accessible as the treatment room was on the ground floor of the building. However, an accessible toilet was not available.

The practice had not carried out a full Disability Discrimination Act audit at the time of the inspection to identify what further reasonable adjustments could be made at the practice to support equality of access for all. The principal dentist told us that such an audit would now be carried out and acted on.

Access to the service

The practice opening hours are Monday to Friday from 9.00am to 5.00pm and alternate Saturdays from 9.00am to 1.00pm.

We asked the principal dentist and reception staff about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details about how to access out-of-hours emergency treatment. There were arrangements in place to redirect patients to another, local NHS dental practice when the principal dentist was on holiday.

The receptionist told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentists in the event of needing emergency treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the waiting room and in the practice information leaflet. The staff we spoke with were aware of the contents of the complaints policy. No formal complaints had been received by the practice in the past year.

The practice collected patient feedback through the use of the NHS 'Friends and Family Test'. Each patient was given a form to complete at the end of their visit. The practice collected around 100 forms each month. The majority of these showed that people were likely to recommend the practice to other people.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements and a management structure. There were also relevant policies and procedures in place. Staff were aware of these policies and procedures and acted in line with them. There were regular staff meetings where policies and protocols were reviewed.

However, there were limited arrangements for identifying, recording and managing risks through the use of risk assessments, audits, and monitoring tools. Not all of the expected assessments and audits had been carried out. For example, there was a COSHH file at the time of the inspection, but this had not been reviewed since 2010. Similarly, although there was a safeguarding policy, staff had either not received, or not kept up to date with, appropriate training.

There were health and safety risk assessments, but these had not identified the need to have an AED at the practice to protect staff and patients in the event of a medical emergency.

The practice did not have a recruitment policy and we noted some gaps in record keeping related to staff recruitment.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. The principal dentist was aware of the Duty of Candour. They told us they were committed to operating in an open and transparent manner.

Staff told us they were comfortable about raising concerns with the dentist. They felt they were listened to and responded to when they did so. Staff told us they enjoyed their work and were well supported by the management team.

We found staff to be hard working, caring and committed to their work and overall there was a strong sense that staff worked together as a team. Staff told us they were well supported by the principal dentist in relation to career and training goals.

Learning and improvement

The practice did not have a structured plan in place to audit quality and safety beyond the mandatory audit for infection control. A radiography audit and a dental record keeping audit had not been completed. We found examples of where improvements could be made in both these areas. An infection control audit had been completed within the past six months, but this had not been effective as it had failed to identify areas for improvement that were identified during the inspection.

The clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by GDC. However, not all staff had completed relevant safeguarding training at the time of the inspection.

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

The practice gathered feedback from patients via the NHS 'Friends and Family Test'. The principal dentist also recorded any informal feedback. They had reviewed and acted on one instance of negative feedback received in the past year.

Staff told us that the principal dentist was open to feedback regarding the quality of the care. The staff meetings provided appropriate forums for staff to give their feedback.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The provider had not ensured that their audit and governance systems were effective.• The provider did not have systems to enable them to continually monitor risks, and to take appropriate action to mitigate risks, relating to the health, safety and welfare of patients and staff. <p>Regulation 17 (1)</p>