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# Wroughton Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 3 March 2017 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 this practice was providing safe care in accordance with the relevant regulations.

**Are services effective?**

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

**Are services caring?**

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

**Are services responsive?**

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

**Are services well-led?**

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

**Background**

Wroughton Dental Practice is a dental practice providing private treatment mainly for adults but does treat the children of registered patients.

The practice is based close to local amenities and car parking in Wroughton. The practice has one reception / waiting room, an open plan office area, two treatment rooms (although one is only used to take x-rays). There is a separate room for the cleaning, sterilising and packing of dental instruments which was also used by staff for making beverages, storing personal items and fridge storage.

Although the practice was on the ground floor, the current entrance was not configured so that it was easily accessible to patients who used a wheelchair.

The practice owner is the principal dentist and employs one trainee dental nurse and a receptionist.The practice opens Wednesday: 09:am to 1pm (only pre-booked patients), Thursday and Friday 9am to 1pm & 2pm to 5pm

There were arrangements in place to ensure patients receive urgent dental assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number patients should ring and there were notices in the reception area giving the details. Wherever possible, patients who require emergency dental treatment were seen the same day if the practice was open.

# Summary of findings

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. In addition we spoke with patients on the day of our inspection. We received feedback from 19 patients.

Feedback from patients was positive about the quality of care, the caring nature of all staff and the overall high quality of customer care. They commented staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained to them so they could make an informed decision which gave them confidence in the care provided.

**Our key findings were:**

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Leadership was provided by the principal dentist.
- There were systems in place to check all equipment had been serviced regularly, including the autoclaves and the X-ray equipment.
- Patients could access treatment and urgent care when required.
- Patients gave us a positive picture of a friendly, caring and professional service.
- The practice dealt with complaints according to their practice protocol.
- The principal dentist was the safeguarding lead professional and processes were in place for safeguarding adults and children but the provider was unable to demonstrate two members of staff had undertaken training in child or adult safeguarding
- There were policies and procedures in place but these had not been reviewed for a significant period of time and did not always reflect current guidance and practice requirements.
- The principal dentist had undertaken training and continual professional development, although arrangements for identifying the ongoing learning and development needs and the on-going assessment and supervision of the trainee dental nurse and receptionist had not been established.
- The dentist provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines, although they did not routinely use a rubber dam for root canal treatments.
- Staff had been trained to handle emergencies and appropriate medicines were in place. Although some life-saving equipment was readily available in accordance with current guidelines, some of the equipment was outside of its expiry date and there was no Automated External Defibrillator (AED) on the premises. There was no documented operational policy relating to the management of such emergencies.
- Premises appeared maintained and visibly clean, although cleaning equipment seen was not in line with current guidelines.
- The infection control policy had not been reviewed and therefore some information, risk assessments and practices were not available or in line with guidance issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05). This included a current legionella risk assessment, carried out by a competent person.
- Quality monitoring such as by undertaking regular audit of the infection control process had not been completed and there was no annual statement available in relation to infection prevention and control as required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Dental care products and medicines requiring refrigeration were stored with food in a domestic fridge. Some products were out of date and the fridge temperature was not regularly monitored or suitably recorded.
- The practice had not carried out pre-employment recruitment checks for one staff member.

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

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking the regulated activities.

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

# Summary of findings

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification and other checks are requested and suitably recorded.
- 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 access to interpreter services for consultations with patients whose first language is not English.
- Review the practice of leaving treatment room doors open when patients are receiving or discussing treatment during consultations

# 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?

No action

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

The practice had arrangements in place to help ensure the safety of staff and patients. This included for essential areas such as the disposal of clinical waste and dental radiography (X-rays). Although some aspects of infection control were not in line with current guidelines.

There were emergency medicines available in line with current guideance in order to deliver care safely and in an emergency. However improvemenst were required as regards the management of medicines requiring refrigeration.

There was no Automated External Defibrillator (AED) on the premises or operational policy or protocol for the management of medical emergencies should one occur. Some equipment used for a medical emergency had passed its use by date date and needed to be replaced. There were no procedures or records regarding the checking of the emergency equipment.

We found the equipment used in the dental practice was well-maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying and investigating patient safety incidents.

The principal dentist had received safeguarding training and was aware of their responsibilities regarding safeguarding children and vulnerable adults. However, they were unable to demonstrate the trainee dental nurse or receptionist had undertaken any training in safeguarding.

### Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The principal dentist used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice, although they did not routinely use a rubber dam for root canal treatments.

We saw examples of positive teamwork within the practice and evidenced good communication.

The principal dentist had undertaken professional training and development appropriate to their role, learning needs and in line with General Dental Council (GDC) requirements for registrants.

There was no record of induction completed for a recently appointed member of the clinical team and the arrangements for identifying the ongoing learning and development needs of staff employed was not established.

# Summary of findings

The practice held electronic and paper records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. Records showed patients were recalled in line with national guidance and screened appropriately for gum disease and oral cancer.

The principal dentist monitored any changes in the patient's oral health and made referrals as appropriate to other primary and secondary care providers such as for specialist orthodontic treatment or hospital services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition. (DBOH).

**Are services caring?**

**No action** ✓

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

We reviewed feedback from 19 patients about the care and treatment they received at the practice.

Patients commented the quality of care was very good. Patients commented on the friendliness and helpfulness of the staff and told us the principal dentist was good at explaining the treatment that was proposed.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

**Are services responsive to people's needs?**

**No action** ✓

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

Patients could access treatment and urgent and emergency care when required.

The practice had experienced very few requests for treatment by patients whose first language was not English but provided patients with written information in a language they could understand but did not have arrangements for interpreter services if required.

The practice had not carried out an assessment under The Equality Act 2010. Although the practice is situated at ground level, the entry was not easily accessible for patients using a wheelchair. The practice howver had made alternative arrangements for these patients to be seen in other services.

Although there was no hearing loop available, information and forms were available and could be printed in large print when required.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

# Summary of findings

**Are services well-led?**

We found 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).

We found leadership was provided by the principal dentist. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice. Staff told us they felt well supported and could raise any concerns with the principal dentist.

The practice maintained a system of policies and procedures however these had not been reviewed for some time and needed to be updated to reflect current guidance and practice.

The practice had not established an effective system for assessing, monitoring or mitigating risks to patients. It had not carried out a programme of audits as part of a system of continuous improvement and learning.

The practice did not have systems in place to seek and act upon feedback from patients who used the service.

**Requirements notice** 

# Wroughton Dental Practice

**Detailed findings**

## Background to this inspection

This inspection took place on 3 March 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector, and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

We informed the NHS England area team we were inspecting the practice and we did not receive any information from them.

During the inspection, we spoke with the principal dentist, trainee dental nurse and receptionist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment.

We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records.

We also reviewed policies, procedures and other documents. We reviewed 17 CQC comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

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

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

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice had an incident reporting system in place to use when something went wrong; this system also included the reporting of minor injuries to patients and staff.

Records showed that no incidents or accidents had occurred during the last 12 months. We were told by staff they any incidents if they occured be managed in accordance with the practice reporting policy.

We discussed with staff the action they would take if a significant incident occurred. They detailed a process that involved a discussion and feedback with any patient that might be involved which indicated an understanding of their Duty of Candour. (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].

Procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

There was no procedure for when and how to notify CQC of incidents which cause harm but staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice could not provide any evidence to demonstrate receipt of national 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. The principal dentist took action to remedy this during the inspection by emailing the CAS.

**Reliable safety systems and processes (including safeguarding)**

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments).

We spoke with a trainee dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current management of sharps regulations 2013 and the EU directive with respect to safe sharp guidelines, thus protecting patients and staff against blood borne viruses.

The systems and processes we observed were in line with the current EU directive about the use of safer sharps. The practice used a safe system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The dentist was responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur.

We asked how the practice treated the use of instruments that were used during root canal treatment. The principal dentist explained these instruments were usually for single patient use only. We observed some of these instruments had been re-packaged with a patients name written on the packaging but it was not clear if all patients were still undergoing root canal treatment. This meant that the re-packaged instruments were retained when they didn't need to be and should have been disposed of.

We were told and observed that a rubber dam was not used in all root canal treatments and therefore did not follow the guidance issued by the British Endodontic Society in relation to it's use during such treatment for the safety of the patient. We discussed this with the principal dentist because only one of six records reviewed where patients had received root canal treatment had reference to a rubber dam being used. The principal dentist explained that the use of a rubber dam was dependent on whether the patient could tolerate this but it was not clear what alternatives were discussed or what other precautions were taken to protect a patient's airway during the treatment. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams 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 the patient's dental care records giving details as to how the patient's safety was assured).

The practice had information and a procedure in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team,

social services and other agencies. The principal dentist was the point of referral should members of staff encounter a child or adult safeguarding issue. Training records seen showed the principal dentist had received appropriate safeguarding training for both vulnerable adults and children and had been trained to Level two in child protection. However they were not able to demonstrate other staff had received appropriate training although they had an awareness of safeguarding, actions to take and who to contact.

The principal dentist reported there had been no safeguarding incidents that required further investigation by appropriate authorities.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

One of two staff files did not contain evidence of immunisation as recommended by Public Health England (PHE) but the principal dentist had followed this up and was waiting for the information. For example, against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva). Staff 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. One member of staff was awaiting a copy of their immunisation status.

There were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

**Medical emergencies**

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice.

The practice had access to medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines.

The practice did not have an automated external defibrillator (AED) on its premises, in line with Resuscitation Council UK guidance and the General Dental Council (GDC) standards for the dental team. [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]. The practice had not undertaken and documented a risk assessment with regard to its absence. However the principal dentist told us he would review this.

Some products such as airways, oxygen tubing and mask, had passed their use by date and there were no checks being undertaken regularly.

When asked the staff told us there was no documentary evidence which demonstrated regular checks were carried out to ensure the equipment and emergency medicines were in date and safe to use. There was no policy or procedure in place to guide staff in the handling of such emergencies.

Although the practice did not treat many children there were no child masks. The emergency medicines and oxygen we saw were stored in a central location known to all staff.

The practice held training sessions each year for the team so they could maintain their competence in dealing with medical emergencies. Records showed all staff had completed training in emergency resuscitation and basic life support.

**Staff recruitment**

The practice had a policy in place for the safe recruitment of staff which included seeking references, proof of identity, checking qualifications, immunisation status and checking professional registration. However there was no reference to obtaining a Disclosure and Barring service (DBS) check for clinical staff. These 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. These processes and checks had not been followed for a recent appointment. However the principal dentist told us he thought a recent check had been made via an external organisation but if not he would follow that up to ensure a check was requested.

The principal dentist could evidence they had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are

appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and ongoing. We also saw up to date Employers Liability Insurance.

**Monitoring health & safety and responding to risks**

The practice had limited systems in place to monitor health and safety and deal with foreseeable emergencies. There were health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. Records showed that fire detection and firefighting equipment such as fire extinguishers were regularly checked but there was no up to date fire safety risk assessment.

The practice had a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as legionella, blood, saliva, acid etch gel, x-ray processing chemicals, ionising radiation and amalgam. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. However, this required review. It was also noted that the rear fire exit was locked and bolted whilst there were persons on the premises.

**Infection control**

There were some systems in place to reduce the risk and spread of infection. We saw there was an infection control policy but it had not been reviewed for some time and did not fully reflect the essential requirements as stated in the national guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05).'

We asked for a recent audit of infection control processes to demonstrate compliance with HTM 01-05 guidelines however the practice had not completed one.

We saw the dental treatment room currently in use, waiting areas, instrument processing area, reception and toilets were visibly clean, tidy and clutter free. There was no zoning signage demarking clean from dirty areas apparent in either the treatment or instrument processing room, although the trainee dental nurse described how this was managed. Hand washing facilities were available including alcohol gel and paper towels in the treatment room but no liquid soap was available in line with current guidelines for handwashing. Bare below the elbow working was observed.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

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

The dental water lines were not maintained to prevent the growth and spread of Legionella bacteria in line with current HTM 01 05 guidelines as they were not routinely flushed through after each use. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We asked to see that a recent Legionella risk assessment had been carried out at the practice by a competent person. The principal dentist and staff confirmed such an assessment had not been completed. There were no records to show monitoring of water temperatures and microbiological testing of samples of the water supply to help ensure patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination area for instrument processing but this was also used by staff for storage of their personal items, although this was away form the instrument processing area. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a system of zoning from dirty through to clean.

The practice used a process of manual scrubbing of instruments for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). However, we observed the use of a product for manual scrubbing of the instruments which is not in line with current guidelines.

When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated

with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. We saw the data sheets used to record the essential daily, weekly and quarterly validation of this equipment were complete and up to date. These checks included details of the sterilisation cycles and steam penetration tests for the autoclave..

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an external contractor to remove clinical waste from the practice. Clinical waste was stored in a locked bin at the rear of the property prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured they were protected from the risk of infection from contaminated dental waste.

We also saw general environmental cleaning was carried out but cleaning materials and equipment used to clean the premises were not stored suitably nor were they in accordance with current guidelines.

**Equipment and medicines**

There were systems in place to check all equipment had been serviced, with the exception of the compressor. Records seen showed contracts were in place to ensure annual servicing and routine maintenance. Equipment checks were carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in February 2017. The practice had two X-ray machines which had been installed in 2005 and there were critical examination and acceptance test reports for both. They had been serviced and calibrated as specified under current national regulations, the most recent checks were in December 2016. Portable appliance testing (PAT) had been carried out in January 2017.

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

We observed that medicines were stored in a fridge within the decontamination room. The fridge also contained items of food and there was no monitoring or suitable recording of any checks being carried out to ensure medicines were stored within the manufacturer's guidance for efficacy and safety. We observed there was a maximum-minimum thermometer available and in use. We found out of date medicines in the fridge and the provider agreed to dispose of these.

**Radiography (X-rays)**

We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment.

Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

The dental care records seen where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. These findings showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records which showed the principal dentist had received training for core radiological knowledge under IRMER 2000 Regulations.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The principal dentist carried out consultations, assessments and most treatment in line with recognised general professional guidelines. The principal dentist described to us how they carried out their assessment of patients for routine care.

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

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

**Health promotion & prevention**

The practice was focused on the prevention of dental disease and the maintenance of good oral health. The practice mainly treated adults but did treat the children of adult patients free of charge.

The dentist explained that adults at high risk of tooth decay were identified and were offered the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines about prevention of dental decay, known as 'Delivering Better Oral Health'. (Delivering Better Oral Health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England).

Dental care records we reviewed demonstrated the dentist had given oral health advice to patients. The practice also sold a small range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

The waiting room and reception area at the practice contained a small range of leaflets about how to carry out effective dental hygiene and how to reduce the risk of poor dental health. There was information about making patients aware of the early detection of oral cancer.

Patients reported they felt well informed about their dental care and treatment pertaining to the health of their teeth and dental needs.

**Staffing**

We observed a friendly atmosphere at the practice. The principal dentist had current registration with their professional body, the General Dental Council (GDC) and professional indemnity was up to date. The principal dentist was supported by one trainee dental nurse who had recently been appointed and a receptionist.

We were shown evidence of completed training for staff in the last 12 months which included basic life support but there was no established plan to ensure any future training provided would meet ongoing staff needs and the needs of the practice.

Staff had access to policies and procedures but these had not been reviewed and updated for some time to ensure they reflected current professional guidance.

# Are services effective?

## (for example, treatment is effective)

**Working with other services**

The dentist could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by them. The dentist used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

**Consent to care and treatment**

We spoke with the principal dentist about how they implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options. The dentist told us patients should be given time to think about the treatment options presented to them and explained that in certain situations patients would be brought back to the practice to discuss complex treatment options. This process demonstrated their understanding that a patient could withdraw consent at any time.

The dentist explained how they would obtain consent from a patient who suffered with any cognitive impairment that may mean they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. The principal dentist was familiar with the concept of Gillick competence in respect of the care and treatment of children under 16 years. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The practice consent policy provided staff with some guidance and information about when consent was required but not how it should be recorded. There was no reference in the policy to the Mental Capacity Act 2005 or assessing whether a child under 16 years is Gillick competent.

We reviewed dental care records to corroborate our information. Feedback in CQC comment cards confirmed patients were provided with sufficient information to make decisions about the treatment they received.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

We received feedback from 19 patients. These gave a positive view of the service the practice provided. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

Treatment rooms were situated close to the main waiting area and we saw doors were sometimes left open when patients were receiving or discussing treatment during consultations. Conversations between the patient and dentist could not be heard from outside the treatment rooms when the doors were closed which protected patients' privacy.

The dental care records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in a locked filing cabinet behind the reception desk but not accessible by the public. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception.

The provider was registered with the Information Commissioners Office.

During the inspection, we observed staff in the reception area were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

The provider told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

**Involvement in decisions about care and treatment**

The principal dentist provided clear treatment plans to patients that detailed possible treatment options and indicative costs.

The principal dentist paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we reviewed that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

Patients were given time to consider options before returning to have their treatment. Patients usually signed their treatment plan before treatment began.

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentist and felt listened to and respected.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice provided patients with information about the services they offered in the practice leaflet.

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times. We saw that an elderly patient who attended the practice a week before their booked appointment was still seen by the principal dentist without having to return the following week. The principal dentist adjusted his diary to accommodate this and the patient needs.

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

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

**Tackling inequity and promoting equality**

The practice had not carried out an assessment under the Equality Act 2010 to consider whether any reasonable adjustments could be made to help prevent inequity for patients that experienced limited mobility or other barriers which may hamper them from accessing services. Although the practice is situated at ground level, the entry was not easily accessible for patients using a wheelchair. The practice however had made alternative arrangements for these patients to be seen in other services.

The practice had only treated a few patients whose first language was not English but told us if it became clear that a patient had difficulty in understanding information about their treatment, they would access interpreter services.

The practice did not have access to a 'hearing loop' which would assist patients with hearing issues.

**Access to the service**

There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. The number was available on the practice ansaphone and in the reception area.

The 17 CQC comment cards seen reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

**Concerns & complaints**

The practice had a complaint policy displayed in the reception area which provided guidance about how to make a complaint. The policy explained the process to follow.

The practice had not received any complaint in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and provide a satisfactory outcome for the patient. The principal dentist told us that complaints made would be investigated and the outcome discussed amongst the team and implemented for the safety and well-being of patients.

Requirements notice

# Are services well-led?

## Our findings

**Governance arrangements**

The practice had limited governance arrangements in place to ensure risks were identified, understood and managed appropriately. The governance arrangements were managed by the principal dentist who was responsible for the day to day running of the practice. Policies included guidance about confidentiality, record keeping, inoculation injuries, radiation protection, infection control and patient safety. However, there was no clear process in place to ensure all policies and procedures were reviewed and updated to support the safe running of the service. All of the policies and procedures required review to ensure they reflected current practice and guidelines.

Staff we spoke with were aware of their roles and responsibilities within the practice. The principal dentist was the lead professional for infection prevention and control.

We saw some risk assessments and the control measures in place to manage risks but most of these had been completed some years ago and had not been reviewed or updated to reflect current regulations and national guidance.. For example in respect of infection control and substances hazardous to health there was no comprehensive risk assessment for legionella carried out by a competent person.

**Leadership, openness and transparency**

Leadership was provided by the principal dentist. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards seen and the patients we spoke with reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal dentist.

There was a no blame culture within the practice. Staff felt they were listened to and responded to when they did raise a concern. Staff were motivated and enjoyed working at the practice and felt supported.

The practice had a statement of purpose that described their vision, aims and objectives.

The service was aware of and complied with the requirements of the Duty of Candour. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

**Learning and improvement**

We were told there was no structured plan in place to audit quality and safety at the practice such as by undertaking audits for infection prevention and control. X-ray quality In discussion with the principal dentist they told us they would implement a structured audit plan to ensure audit cycles were completed in accordance with national requirements and guidance.

The principal dentist had undertaken a range of continuing professional development as required by the General Dental Council. Records showed their professional registration was up to date. However, there was no established plan for the learning and development needs or supervision, of other staff in place.

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

The practice did not have systems in place to seek and act upon feedback from patients who used the service. The practice gathered verbal feedback only from patients.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**The registered person did not have effective systems or processes in place to ensure that the regulated activities at Wroughton Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**<br><br>How the regulation was not being met:<br><br>The provider did not have effective systems in place to:<br><br>• Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity<br>• Ensure that their audit and governance systems remain effective.<br>• ensure that a risk assessment for not providing an AED in the practice had been carried out or that other risk assessments were regularly reviewed and updated.<br>• ensure that all of the regular checks that should be performed in respect of the effectiveness of infection control measures were implemented, monitored or evidenced as required by HTM01-05 or that these were suitably documented and recorded.<br>• **ensure that operational policies and procedures in place had been reviewed or updated to reflect current guidelines and the needs of the practice**<br>• **ensure that a recent recruitment process followed the practice policy and met the requirements for the safe recruitment of staff.**<br>• ensure supervision and appraisal of staff to enable them to fulfil their responsibilities.<br><br>Regulation 17 (1) |