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A Primary Dental Practice

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection due to receiving information of concern on 10 January 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 that this practice was not providing safe care in accordance with the relevant regulations.

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

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

Are services responsive?
We found that this practice was not providing responsive care in accordance with the relevant regulations

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

Background
A Primary Dental Practice, also known as Station Road Dental Practice is a dental practice providing mostly NHS dental treatment, with private treatment options for patients. The practice is located on the High Street in Birchington, Kent.

The practice has two treatment rooms, both of which are on the ground floor.

The practice provides dental services to both adults and children. The practice provides mostly NHS treatment (90%). Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment. Dental Implants and cosmetic dentistry are available privately.

The practice's opening hours are – Monday to Friday 8.40am to 5.30pm

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the 111 NHS service.

The principal dentist/owner is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'.

Summary of findings

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 practice has three dentists; one qualified dental nurse and one student nurse.

We did not provide CQC comment cards prior to our visit as this visit was unannounced. We spoke with patients and reviewed feedback that practice had received through the NHS Friends and family test (FFT) and NHS Choices.

Our key findings were:

- The provider did not have emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Patients said staff were always friendly, polite and professional and they were treated with dignity and respect by staff.
- Patients we spoke with told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day.
- Medical oxygen held by the practice was out of date.
- Some staff had not completed training and other staff had lapsed in basic life support and medical emergencies.
- The practice had a system and processes to record, investigate, respond to and learn from significant events. However, no staff when questioned had knowledge of what a significant event was.
- The practice had not carried out effective audits in key areas, such as infection control and the quality of X-rays.
- The practice did not have sufficient safeguarding processes and staff did not understand their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff had not completed training for safeguarding vulnerable adults or children.
- The practice did not follow the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning, storing and sterilising dental instruments.
- Operational policies were out of date and contained information that was no longer relevant or followed current guidance and legislation.
- Environmental cleaning was not effective
- The practice did not hold regular staff meetings and formal staff appraisals, and the appraisals undertaken had not identified training needs.
- The practice did not handle complaints effectively or used these to help them improve the practice.
- Clinical governance activity was not sufficient, audits we reviewed did not reflect processes in the practice, and therefore no learning or improvements could be made.
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We identified regulations that were not being met and the provider must**:**

- Ensure that staff understand what constitutes a significant event, and establish systems and processes to investigate, respond to and learn from significant events.
- Ensure staff training and availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure the training, learning and development needs of staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff employed.
- Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD)
- Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum
- 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Ensure infection control audits are undertaken at regular intervals and learning points are documented and shared with all relevant staff.
- Ensure the practice's sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Summary of findings

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure that a system for identifying, receiving, recording, handling and responding to complaints by patients is established.
- Ensure dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Ensure the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Ensure audits of various aspects of the service, such as radiography are undertaken at regular intervals to help improve the quality of service. Practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure audit protocols to document learning points are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure that systems and processes are established and operated effectively to safeguard patients from abuse.
- Ensure systems are put in place for the proper and safe management of medicines.
- Ensure that all staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.

You can see full details of the regulations not being met at the end of this report. We found this practice was not providing safe care in accordance with the relevant regulations and identified regulations were not being met. We took urgent enforcement action to suspend the practice for one month to allow improvements to be made.

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 the storage of dental care products to ensure they are stored in line with the manufacturer's guidance.
- 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 staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and carry out a Disability Discrimination Act audit for the premises.
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by patients.

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 this practice was not providing safe care in accordance with the relevant regulations and identified regulations were not being met. We took urgent enforcement action to suspend the practice for one month to allow improvements to be made.

None of the staff had received training in safeguarding vulnerable adults and children. The practice did not have guidelines available for reporting concerns. Staff, when questioned did not know how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, the majority of which had expired; in 2014. The medical oxygen cylinder had expired in August 2016. The practice had an automated external defibrillator (AED). No regular checking was taking place to ensure the emergency medicines and equipment was in good working order.

The practice was using items that are marked as single use more than once on patients.

Infection control did not reflect the guidance issued by the Department of Health, Health Technical Memorandum HTM 01-05. Environmental cleaning was not recorded sufficiently and did not follow national colour coding. Processed instruments were stored unpouched and on the work surface, exposed to aerosol from patient treatments and in dirty cluttered draws before being used on patients. Clean and dirty areas were not defined in the treatment rooms.

Are services effective?

Requirements notice 

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

We could not be assured that patients received information regarding the risks and benefits and options available to them.

We were not shown sufficient evidence to be assured that staff had completed mandatory training in medical emergencies or safeguarding.

Staff had not completed training in the Mental Capacity Act 2005 (MCA) and had limited understanding and knowledge of its relevance in practice.

The practice made referrals to other dental professionals when it was appropriate to do so. However there was no system to follow up the referrals once they had been sent out.

Are services caring?

No action

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

Summary of findings

Patients said staff were always friendly, polite and professional and they were treated with dignity and respect by staff.

Patients said they received fair dental treatment and they were involved in discussions about their dental care.

Patients said they were not able to express their views or opinions.

Are services responsive to people's needs?

Requirements notice 

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

Access at the front of the premises was via a small step and ramp. The two surgeries were located on the ground floor. The practice had not conducted a disabled access audit to consider the needs of patients with restricted mobility.

There were systems and processes to support patients to make formal complaints. However, there was no information for patients to escalate their complaints should they wish too. Complaints were not always recorded, responded to and actioned in line with the practice complaints process.

Are services well-led?

Requirements notice 

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

We found a number of shortfalls in the practice's governance and leadership. Policies and procedures to govern the practice's activities were not sufficient.

Staff did not receive regular reviews of their performance and did not have personal development plans in place.

Staff training was not actively monitored and staff training was mostly completed online.

The practice did not monitor water temperatures in the building as a precaution against the development of legionella.

Audits had been undertaken for infection control, but the content had little value to drive improvement as areas marked as completed or done did not reflect the actual circumstances. Other auditing activity to measure the quality of radiographs taken and the content of dental care records had not been conducted.

A Primary Dental Practice

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

The inspection took place on 10 January 2017 and was conducted by a CQC inspector and a specialist dental advisor.

We did not request any information from the provider as this inspection was unannounced. We reviewed information we held about the practice.

During the inspection we spoke with two dentists, one student dental nurse and a relative of the provider who was covering the reception duties. We spoke with two patients on the day of our inspection and two more via telephone following our inspection.

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 had a system to manage significant events and safety concerns. However, staff could not demonstrate sufficient understanding of the procedures to follow. We had received some information of concern prior to our visit which related to a serious significant event. During our inspection we discussed the event in detail with staff who could recount the event as it unfolded and the outcome. We found that no record of this event had been made. No discussions and learning had taken place. No measures implemented to reduce the risk of an event of this kind happening again and no report made to other outside agencies as was required. Therefore we could not be assured that staff were able to respond, document or learn from significant events and this posed a risk to patients.

Staff at the practice were not aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Staff were unaware of their responsibilities with regard to reporting to RIDDOR, or how they would do this. The significant event we were informed of prior to our visit; due to the outcome, required a report to RIDDOR which was not actioned.

There was also an accident reporting book. There had been two entries in the last 12 months both of which had involved staff. There had been no record made of the event where a person had been seriously injured and this had not been reported to either RIDDOR or CQC as required.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which had been not been updated. the policies were not localised and did not contain any information of the direct contact details of the local authority safeguarding team and what to do out of hours. Staff were not aware of a procedure to follow.

No staff had completed safeguarding training. Staff we spoke with were not confident when describing potential abuse or neglect. Staff referred to a folder held at reception where they would source information should they suspect abuse. We looked at the folder staff had referred to. It was a copy of “Safeguarding and the dental team”. This folder did not contain contact details for the local authority.

Staff were not aware of the procedure for whistleblowing if they had concerns about another member of staff’s performance. Staff told us they would raise such issues with the principal dentist.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had a rubber dam kit available for use when carrying out endodontic (root canal) treatment. However, we asked to see the rubber dam kit which was incomplete. Staff told us that it was used consistently but could not locate the missing components and could not identify what was missing when asked.

Medical emergencies

The practice did not have sufficient arrangements to deal with medical emergencies. Staff had not completed recent medical emergency training. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). The practice held some of the emergency medicines set out as advised in the British National Formulary guidance; However, the majority of these had expired. The medical oxygen cylinder had expired in August 2016. However, other related items such as face masks were available in line with the Resuscitation Council UK guidelines.

The majority of the emergency medicines had expired. We found, three medicines that had expired in 2014 and two that had expired during 2016. We brought this to the attention of the principal dentist who informed us that checking of the medicines had been the responsibility of a member of staff who had been on long term sick leave for approximately five months. We questioned how the three medicines that had expired in 2014 would have been missed if these checks had taken place five months previously. We asked to see the records of the checks from before the member of staff was absent. Staff were unable to locate or provide these records to us. The medical equipment and medicines were stored in three separate locations and not all staff were aware of where they were kept.

Are services safe?

Staff had not completed medical emergency training with the exception of one, who had started at the practice the day before our visit. Staff had not received any induction or could sufficiently answer questions to indicate awareness of the storage arrangements for the medical emergency equipment or medicines.

Before our inspection we had been informed of a serious medical emergency that had occurred on the premises where a person had suffered injuries and had been taken to hospital. With the current arrangements available at the practice we could not be assured that staff were equipped or sufficiently trained to respond to a medical emergency should another occur.

Staff recruitment

The practice showed us evidence that they did not always obtain all of the required information for members of the team before they had contact with patients.

The practice's written policy for the recruitment of staff was outdated. The policy did indicate some of the required checks that would be required for new staff. The policy stated that all staff employed would be required to submit a full CV and that positions of employment would only be offered on the receipt of suitable references. Staff files we looked at did contain a CV. However, there were no records of references being obtained.

The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had obtained DBS checks for some of the staff employed at the practice. However, two clinical members of staff did not have a DBS.

Staff files contained evidence of Hepatitis B inoculation and their current cover status for some staff. We found that this information was not available for two of the dentists.

Monitoring health & safety and responding to risks

The practice had limited arrangements in place to deal with foreseeable emergencies. The practice did not have a health and safety policy for staff to refer to. The provider was responsible for assessing the premises for risk of fire, and fire extinguishers were placed throughout the building. There had been a fire risk assessment carried out by an external company in November 2016. There had been a number of actions identified, such as replacement of a door to comply with the fire regulations, fire awareness training to be completed for all staff, fire action plans to be displayed throughout the building informing people what to do in the event of a fire and a log book to be completed with dates and outcomes of checks completed of the fire alarm, fire safety equipment and fire drills executed. None of these actions had been addressed.

There were some 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 (only dental materials) were identified. Actions were described to minimise identified risks for the dental materials only. The practice did not hold any of the data sheets for the dental materials they used. We noted that there had been no risk assessment or COSHH evaluation for the cleaning products used at the practice. The cleaning cupboards were situated in the decontamination area. One cupboard stored the cleaning equipment and the other the cleaning materials. The cleaning materials cupboard was not secure and closed with a hook and eye closure. The cleaning products were stored on the floor and included bleach, floor and toilet cleaner. There was also an open box of washing powder. The cleaning cupboards were in a patient accessible area. We found two bottles of toilet cleaner in the toilet used by patients and staff which was in easy reach of children. Therefore we could not be assured that hazardous products were stored appropriately.

We were not assured that the practice received communications from the Medicines and Healthcare products Regulatory Agency (MHRA) or if any actions had been taken if needed.

There were arrangements to refer patients to another practice in close proximity, should the premises become unfit for use. There was a business continuity plan with key contacts, such as for electrics or plumbing, which could be referred to in the event of service failures.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures.

Are services safe?

We were not assured that the practice was meeting the HTM01- 05 essential requirements for decontamination in dental practices. The provider had overall lead responsibility for infection prevention and control (IPC)

The practice employed a cleaner to carry out the environmental cleaning at the practice. We looked at the equipment used to clean the premises and we saw the equipment available did not correspond with national guidance. We noted that there the equipment in use was dirty and not colour co-ordinated. Staff had completed a cleaning log, but these logs did not contain enough detail of tasks carried out so it was unclear what cleaning was completed and when or its frequency.

We noted that one of the treatment rooms were cluttered and unorganised. The surfaces in one of the treatment rooms were visibly dirty. During the inspection we observed that the dental nurse cleaned the surfaces, dental chair and equipment in one of the treatment rooms between each patient. We saw that the practice had a supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel available. However, as the principal dentist was working without a dental nurse on the day of our inspection, we noted that these cleaning tasks were not always carried out in between patients. We observed the principal dentist carrying out decontamination duties without wearing any gloves or other PPE. We observed the handling of dirty instruments and instruments that had been through the autoclave without any hand hygiene or gloves worn.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. We saw that dirty instruments were first placed in an ultrasonic bath in the treatment room, following use on a patient. The instruments were then transported in a dirty box to the decontamination area.

Processed instruments were stored uncovered on trays intended for use in close proximity to the head of the dental chair and were exposed to the aerosol created when carrying out treatment. We observed instruments were selected from the trays during a treatment session whilst wearing contaminated gloves. We noted that clean and dirty areas in the treatment rooms and decontamination area were not defined and there was a risk of cross contamination.

The practice had a decontamination area, where staff cleaned and sterilised instruments. We noted that the illuminated magnifying unit was positioned in a clean area rather that in the dirty area and therefore posed a cross contamination issue. However, during observation of the decontamination process we noted that the illuminated magnifiying device was not being used. Staff had undertaken some training in infection control via an online course. We did not feel that staff had been trained sufficiently so that they understood this process and their role in ensuring it was correctly implemented. The decontamination area was in a corridor which could be accessed by patients. This corridor was the only route for staff and patients to take to use the practice toilet. There had been no risk assessment conducted regarding the safety of this arrangement. Patients, including children could access the decontamination area without the supervision of staff.

We observed the full process of decontamination of instruments from the point of use to the ultrasonic bath and autoclaves (equipment used to sterilise dental instruments) to clean and then sterilise them. We noted that clean instruments following sterilisation were not packaged or stored according to current HTM01-05 guidelines. We saw that following sterilisation some instruments were left uncovered on the work surface or stored loose in draws. We noted that the drawers where the sterilised instruments were stored prior to use were dirty and cluttered. This posed a risk of recontamination. Staff could not tell us when loose instruments would expire and need to be re-processed or how long they had been stored, therefore staff did not know if these instruments were safe to use. In the treatment rooms we saw that a few instruments that were not routinely used were pouched and marked with an expiry date.

We looked at the how the practice checked that the decontamination system was working effectively. We saw maintenance information showing that the practice had maintained some of the decontamination equipment to the standards set out in current guidelines such as the autoclave. We noted that some checks for the ultrasonic baths were not always recorded.

The practice used single use dental instruments which we found had been re-used on other patients. We found

numerous rose head burs in each of the two treatment rooms with debris on them. Some were rusty and very dirty. We found that matrix bands were dirty and had visible debris on them.

We were told that a specialist contractor had carried out a legionella risk assessment for the practice in June 2015. The only document to confirm this was a certificate stating that the practice had had a legionella risk assessment conducted. We asked to see a copy of the legionella report which could not be located. We asked staff what measures they took to ensure that legionella risks had been addressed. Legionella is a bacterium which can contaminate water systems in buildings. The practice was using a continuous dosing method to prevent a build-up of legionella biofilm in the dental waterlines. However, this was not always recorded as being carried out in one of the treatment rooms. We noted that no water temperature monitoring was being carried out.

The practice had carried an audit of infection control in 2013 using the format provided by the Infection Prevention Society. We saw that on the front page of the 2013 audit, dates had been recorded for 2014, 2015, 2016, and 2017. We noted that the contents of the audit had not changed or had been amended. We looked at the audit and staff had answered yes to many sections that did not reflect the practices and processes carried out. For example, staff had answered yes to the maintenance and use of a washer disinfector. The practice had never had a washer disinfector. Staff had answered questions regarding manual scrubbing of instruments. Instruments are placed directly into an ultrasonic bath following use and no manual scrubbing was taking place.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. There were instructions for staff about what they should do if they injured themselves with a needle or other sharp dental. Instrument. We noted that three members of staff did not have their Hepatitis B status recorded. We spoke with one member of staff who assured us that they had received two vaccinations and would soon be due for the third. Another member of staff had records to show they had received a booster in 2008, but there was no serum conversion conducted following the booster to confirm the level of cover. Another member of staff had no records available with regard to their Hepatitis B status.

The practice was not conforming to the clinical and dental waste guidelines from the Department of Health. Their management of sharps waste was not in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were filled way beyond the maximum fill line. We also noted that they were not correctly labelled with the point of use. We noted that there were many empty sharps containers available for use.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary required waste consignment notices.

Equipment and medicines

We looked at the practice's maintenance information which demonstrated that equipment used to sterilise instruments, and X-ray equipment. Electrical equipment that required a test had not been PAT tested by an appropriate person. PAT is the abbreviation for 'portable appliance testing'.

Prescription pads held by the practice were not securely stored. We saw prescription pads on an open shelf in one of the treatment rooms. We noted that all were stamped with the practice stamp. There were no written records of prescription pads to ensure that the use of these was monitored and controlled.

The batch numbers and expiry dates for local anaesthetics were not routinely recorded in the clinical notes.

Temperature sensitive medicines had been stored in a fridge along with food and dental materials. The fridge temperature was not monitored.

Radiography (X-rays)

The practice had a Radiation Protection file which contained most of the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays are small images taken inside the mouth).

The local rules for the use of each X-ray machine were available in each area where X-rays were carried out. The local rules are bespoke operating procedures for the area where X-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each X-ray set on the premises. The local rules set out the dimensions of the controlled area. This is a set parameter around the dental

Are services safe?

chair/patient and the lowest dose possible. Applying the local rules to each X-ray taken means that X-rays are carried out safely. However we noted that there was no information recorded for who was the radiation protection advisor (RPA) or diagrams of the controlled area.

The Radiation Protection file and the local rules identified who was the radiation protection supervisor (RPS) this being the principal dentist. The provider had not identified an external radiation protection advisor (RPA). An RPA is someone who is available for expert advice regarding the machinery and radiation safety. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS to be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and only by qualified staff. The RPS must be somebody who has a radiography qualification and is on the premises whilst X-rays are being conducted. The RPS has oversight of radiation safety in the practice.

Records showed the X-ray equipment had last been checked by an engineer in September 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years to ensure it is safe and working correctly.

All patients were required to complete a medical history form and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. The practice did not have risk assessments for pregnant mothers or women of child bearing age.

Patients' dental care records showed that information related to X-rays was not recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. We saw that X-rays taken had been graded; we looked at a sample of X-rays taken and saw that they had all been graded as 1. The images did not present a grade 1 image. All were grade 2 or 3. One X-ray taken to investigate pain was coned so that parts of the teeth were obscured. Also the images had a lot of scratches which again obscured areas of the teeth, gums and supporting structures. As no auditing or correct grading of image quality was being conducted we could not be assured that deficiencies were being addressed or that patients were being re-exposed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice did not have robust policies and procedures for assessing and treating patients. This posed a risk to patients as X-rays could be taken at inappropriate intervals and not in accordance with the patient's risk of oral disease.

The dentist told us that they discussed each patient's diagnosis and treatment options. Although options were provided, there was no evidence that possible risks or benefits, advantages or disadvantages of each choice had been discussed.

We noted that dental care records lacked detail and were not in line with, the National Institute for Health and care Excellence (NICE) guidance or the, Faculty of General Dental Practice record keeping guidance. This would support the dentists in maintaining appropriate dental care records. As there were limited policies and procedures for promoting the maintenance of good oral health; we were not assured that the practice gave due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'

We spoke with two patients on the day of our inspection and two more on the telephone, a few days after out visit. Patients commented they were happy with the treatment they had received and felt that their treatment had been explained to them.

Health promotion & prevention

There was information displayed in the waiting and reception area that explained the services offered at the practice.

Staff told us how they advised patients on how they could maintain they oral hygiene. They also told us how they would discuss the impact of diet, tobacco and alcohol consumption on oral health. However we did not see any evidence in the dental care records we examined with regard to this advice given. Patients we spoke with stated that they had been given advice with regard to brushing their teeth and using mouthwash, but had not been asked or advised about their diet of tobacco or alcohol consumption.

Staff told us they advised patients of the importance of regular check-ups to maintain good oral health. We noted that of the dental care records we examined, none had any information regarding a patient's oral health status, no information recorded with regard to the health of their gums and no risk assessments for oral hygiene, caries or recall time frames.

Staffing

The practice was understaffed. One of the three dentists was on long term sick leave. A locum dentist had started the day before our inspection to cover this shortfall. Another dentist who had started at the practice in May 2016 worked occasionally. The principal dentist was working without a dental nurse on the day of our inspection. We asked why and were told the member of staff had phoned in sick that day and it had not been possible to get a cover nurse at such short notice. Staff we spoke with confirmed that the absent member of staff had a planned day of leave for the day of our inspection. Patients we spoke with told us that the principal dentist often worked without a nurse.

There was a lack of training for staff in key areas. We could not establish if staff were encouraged and supported to maintain their continuing professional development (CPD) to maintain their skill and competency levels. We were concerned that staff had not maintained their CPD throughout the five-year cycle as recommended in the GDC guidance. We noted that some staff had not completed training for medical emergencies, radiography and safeguarding both vulnerable adults and children. Some members of staff could not demonstrate sufficient training in infection control.

Records demonstrated and staff confirmed that no inductions were carried out and staff did not receive appraisals.

Working with other services

The practice had a system for referring and recording when patients were sent to other dental professionals for more complex treatments that were not provided by the practice. We looked at referrals to the hospital for the extraction of wisdom teeth, referrals for patients who were anxious and required treatment under sedation and patients who required orthodontic treatment. However there was no system to monitor referrals and their progress once they had been sent out.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We saw evidence that patients were given a treatment plan to sign, which detailed their proposed treatment. Staff were aware of the need to obtain consent from patients including patients who lacked the capacity to make decisions for themselves, however staff understanding was limited. Staff had not received Mental Capacity Act 2005(MCA) training and were not fully conversant with its relevance to the dental practice. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Staff demonstrated limited knowledge of gillick competency. There was no practice policy for obtaining consent from young patients. The Gillick competency is used to assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients we spoke with were mostly happy with the care and treatment they received at the practice. Some highlighted that they had been patients for many years. Patients commented that they knew the principal dentist well. However, they told us that they had difficulty obtaining an appointment as the other two dentists were frequently not available and their appointments were cancelled. Patients commented that they had difficulty getting through on the telephone and that it could be engaged for a long period.

We observed the staff provided a personable service. They were welcoming and helpful when patients were called into the treatment rooms.

Patients indicated that they were treated with dignity and respect at all times. We noted that the door of treatment room one was left open whilst patients were receiving treatments and during their consultations. Patients who were being seen in treatment room two would have to walk past the open door and could see and hear details relating to patients in treatment room one. Patients we spoke with told us that they had no concerns with regard to confidentiality apart from the door being open in treatment room one; we noted that there had been no complaints or incidents related to confidentiality.

Involvement in decisions about care and treatment

We looked at dental care records and saw that information about the explanations they had provided to patients about the care and treatment they needed had not been recorded.

Patients told us that they felt involved in their care and they were given information about their treatment and fees.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS dental treatment and some treatment options such as implants privately. We noted that there was no patient information leaflet available in the waiting room. We asked to see the patient information leaflet and were provided with an appointment card. This did contain some information such as, disability access and NHS treatment and charges. We were given an information leaflet which staff printed off from an electronic record on the computer. The information it contained was out of date and still referred to the now disbanded primary care trust PALS for the escalation of complaints. However, this leaflet was not available to patients.

The dentists had devised their own time frames for different treatments and procedures. Staff told us that although they were busy they had enough time to carry out treatments however, this often resulted in the over running.

We found that the practice would accommodate emergency appointments. Patients we spoke with confirmed this and told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day.

Tackling inequity and promoting equality

Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had access to a translation service, but rarely had the need to use it.

The practice was accessible to wheelchairs and patients with pushchairs via a small step and ramp on entering the front door. This area was very small and had a partition wall reducing the entrance space at the front door. Staff explained how they would help anyone in a wheelchair or with mobility problems. Both treatment rooms were on the ground floor via a single step. There was one toilet in the practice which was at the rear to the building; this was not accessible for a wheelchair user and staff and patients could access the toilet through the decontamination area that was situated in a corridor. The practice had not conducted a disability access audit.

Access to the service

The practice was open Monday to Friday 8.30am to 5.30pm. Patents told us that access had been difficult due to two of the dentist not being consistently available and that they had difficulty reaching the practice by phone, as it was sometimes constantly engaged. Patients also said that one of the reception staff had difficulty understanding them in person and over the telephone.

Concerns & complaints

There was information available for patients giving them details of how to complain displayed in the waiting room. However, there was no information for patients to escalate their complaints and concerns. We reviewed the practice complaints policy which was out of date. The information it contained was also incorrect such as the external organisations patients could complain to should they feel that their complaint has not been rectified to their satisfaction. We could not be assured that patients would be signposted to the correct organisation should they need to take a complaint further.

There had been one complaint logged in the preceding 12 months. This complaint had been dealt with in line with the practice complaints policy and the patient had been refunded. However, we found a complaint logged in a patients dental care record. There was no information logged in the complaints folder with regard to the issues raised. Also we could not be assured this complaint had been responded to or rectified.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was the registered provider and had responsibility for the running of the practice including its finances and personnel functions.

The practice had conducted some governance activity, although it did not result in any improvements or remedies as a result. We found significant shortfalls in the practice's governance arrangements. Although there were a few basic policies for staff to refer to and to support the management of the service, these were out of date and not wholly implemented. There was no system to show that staff had read, understood and agreed to abide by the policies. There were limited systems or processes to ensure that quality and safety was appropriately monitored or actions taken to address issues. As a result, staff were not adhering to HTM 01-05 guidance, not monitoring water temperatures, auditing information collected was incorrect and we found some materials and medicines that had expired. We found equipment that was damaged and not fit to use which was still in use.

The practice did not have team meetings to discuss the running of the practice or share learning. Staff communicated daily on an informal basis.

Recruitment procedures were not robust, although some staff had undergone a DBS check, references were not obtained and checks in past employment had not been conducted. Staff did not receive an appraisal and had their performance reviewed or have any clear objectives. The practice did not monitor training for staff.

Leadership, openness and transparency

We found there was a lack of leadership provided by the principal dentist who is the registered provider and responsible for the management of the practice. We were concerned that skills had lapsed and in some areas no training had been completed. During our inspection we noted that there were gaps in knowledge pertaining to infection control, radiography, the GDC standards, safeguarding, clinical governance, risk assessment, significant events and medical emergencies.

The practice had a whistleblowing policy which was out of date and did not contain up to date information for staff to refer to. Staff when questioned were unsure of what would constitute a whistleblowing or what their duties were under their professional registrations.

Learning and improvement

The practice did not have a structured plan to audit quality and safety. The only audits that had been conducted contained incorrect information or did not conclude to show any outcomes which could be measured or actions to be taken. There was no evidence that learning was shared or that improvement of the service was prioritised.

There was little evidence to show that staff working at the practice were supported to maintain their CPD. There had been no training for safeguarding vulnerable adults and children and medical emergencies. One member of staff had sourced and completed some training independently. Therefore we could not be assured that training completed was effective, pro-active, implemented change and improvement or would be completed in the appropriate timescales.

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

Patients gave verbal feedback to staff at the practice at each appointment; however this information was not collated and they did not collect any written feedback. Therefore patients were not able to influence how the service was run.

Staff at the practice told us that they could discuss things with the principal dentist and gave feedback on a casual basis. Staff informed us that they had mentioned concerns regarding processes and current legislation in regard to infection control, medical emergencies, training and personal development to the provider on many occasions but little had arisen from these discussions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HCSA 2008 Regulations 2014.** **Good governance.** How the regulation was not being met: • Operational policies were dated 2013 and contained out of date information for staff to refer to. • There had been no audit activity to drive improvements in the service • Patient dental care records were incomplete and did not contain information about discussions and choices given to patients. • The practice did not seek feedback from patients and staff

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HCSA 2008 Regulations 2014.** **Staffing.** • Staff did not receive training in core subjects such as, Medical emergencies, infection control and safeguarding.

This section is primarily information for the provider

Requirement notices

- The provider did not always ensure all staff members received appropriate support, training and supervision necessary for them to carry out their duties.

- Staff did not receive regular appraisal of their performance in their role from an appropriately skilled and experienced person.