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Fishermead Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Fishermead Dental Surgery is a general dental practice situated in the Fishermead area of Milton Keynes, Buckinghamshire. The practice offers treatment to adults and children funded by the NHS or privately.

The practice is staffed by three dentists (two of whom work part time), two qualified dental nurses, and a receptionist/ practice manager. One of the dentists offered dental implants to patients. This is where a metal post is surgically placed into the jaw bone to support a tooth or teeth. Following our inspection the practice informed us that the implant service is currently under review.

The practice has two treatment rooms and is all on the ground floor making wheelchair access possible. A ramp is available for use at the front door where a step would otherwise prevent access.

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

We received comments from 26 patients by way of comment cards available at the practice for the two weeks prior to our inspection.

Our key findings were:

Summary of findings

- The practice was visibly clean and clutter free with the exception of the window blinds in the treatment rooms which were dirty and not easily cleanable. These were replaced following the inspection.
- A new patient NHS appointment could normally be secured within a week or two.
- Emergency patients would be seen where possible on the day they contacted the service.
- Infection control standards did not always meet those set out in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health.
- Clinicians used nationally recognised guidance in the care and treatment of patients.
- The practice carried medicines for use in medical emergencies in line with national guidance. Recommended emergency equipment which was missing at the time of the inspection was purchased shortly after.
- There was appropriate equipment for staff to undertake their duties and equipment was well maintained.
- The practice did not have a system in place to report and monitor significant incidents, although they did have an accident book.
- Policies and protocols were available to aid the smooth running of the service, although the practice was not always working in accordance with their policies.
- The practice used tablet computers for patients to fill out medical history forms, and sign documents. These uploaded directly to the patient care record and meant that records were entirely computerised.
- The practice did not keep sufficient records of its prescription forms in line with current guidance.
- Infection control audits did not identify the areas of concern within the decontamination process that were apparent during the inspection. This indicated that the process of audit was not as robust as it needed to be.

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

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, this includes management of infection control risks, effective systems to highlight risks and ensuring that practice policy is adhered to.

You can see full details of the regulations not being met at the end of this report.

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

- Review the systems in place to record, investigate and learn from incidents that occur in the practice.
- Review the safety systems and processes in place at the practice to protect patients undergoing root canal treatment.
- Review the practice protocols regarding records of prescription forms with reference to the NHS guidance on security of prescription forms August 2013.

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

The use of X-rays on the premises had been risk assessed and was in line with current regulation.

The practice had medicines and equipment in place to manage a medical emergency including an automated external defibrillator. The practice took immediate steps to purchase two pieces of recommended equipment that were not available.

Equipment in the practice was maintained in accordance with manufacturer's instructions.

The practice had systems in place for infection control, but these did not always meet the standards set out in national guidance. Following our inspection the practice took immediate steps to address this.

The practice did not have a system in place to report and learn from significant incidents beyond an accident book, in which previous entries' lacked detail.

Are services effective?

No action

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

The dentist made accurate, detailed and contemporaneous notes in patient dental records. They used national guidance in the care and treatment of patients.

Staff were appropriately registered in their roles, and had access to ongoing training and support.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and it's relevance in obtaining consent for patients who may lack capacity to consent for themselves.

Are services caring?

No action

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

Staff described how patients' confidential information was kept private. This included keeping password protected computer records.

Comments received from patients of the practice indicated that staff were friendly and helpful, and would always try to accommodate patients at a time that was convenient to them.

Summary of findings

Are services responsive to people's needs?

No action

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

Every effort was made to see emergency patients on the day they contacted the practice.

The practice afforded wheelchair access, and staff described various ways in which the individual needs of patients were met by the practice.

New patients to the practice could expect to secure an appointment within a week or two.

Are services well-led?

Requirements notice 

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

The practice had policies and protocols in place to assist in the smooth running of the service, although the practice was not always working in accordance with their policies.

Cross infection audits did not highlight all the concerns we identified during the inspection, and therefore were not effective in this regard.

The practice had not responded to infection control risks arising from damage to the premises and fittings, and did not ensure that all surfaces within the clinical area were cleanable.

The practice had a whistleblowing policy to guide staff members who wished to raise a concern about a co-worker. This was reviewed and replaced following the inspection as it did not guide staff in how to raise a concern externally to an independent agency.

Staff reported an open and honest culture at the practice where staff were supported to raise concerns or give feedback to aid the growth of the practice.

Fishermead Dental Surgery

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 11 October 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with five members of staff during the 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 limited systems in place for reporting and learning from significant incidents. Accidents, such as sharps injuries were reported in an accident book, but examples we were shown lacked detail in regard to outcomes and any learning that could be fed back to prevent reoccurrence.

The practice had a significant incident policy which was dated 23 January 2016. As part of this document a template was available to record incidents which prompted staff on outcomes and learning opportunities. We were assured that this template would immediately be adopted to record incidents.

The practice had a document available for staff to reference on duty of candour; with practice guidance on the same. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff we spoke demonstrated a clear understanding of the principles of candour.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and the principal dentist shared relevant alerts with the staff. Staff were able to discuss a recent relevant alert that had been received and actioned by the practice.

The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE), although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice had a policy in place which detailed the information regarding reporting to the HSE and the CQC.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place regarding safeguarding vulnerable adults and child protection. These were available in hard copy for staff to reference. They detailed the types of abuse that staff may recognise and what action to take.

The principal dentist was the safeguarding lead for the practice and all staff had completed training in safeguarding appropriate to their role. Staff we spoke with were able to describe types of abuse and how they would go about raising a concern.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in September 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentist in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that although a rubber dam kit was available, it was not used routinely. The practice did take steps to mitigate the risk when rubber dam was not used.

The practice had a protocol in place for the safe use of sharps and re-sheathing devices were available for use by the dentist to reduce the risk of injury when re-sheathing a needle in line with the requirements of Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

A protocol was in place which detailed the actions in the event of a sharps injury as well as the contact details for occupational health.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them.

Emergency medicines were in date and in line with those recommended by the British National Formulary. However the practice only carried one dose of adrenaline in a pre-filled syringe. In the event of a severe allergic reaction

Are services safe?

this dose may have to be repeated in the time it took for emergency services to arrive. Following the inspection the practice purchased further adrenaline to cover this eventuality.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK with the exception of a full set of oropharyngeal airways (these should be available in five sizes and support the airway in an unconscious or semi-conscious patient), and portable suction (which can be used to clear the airway of secretions or vomit if the patient collapses away from the dental chair). These items were purchased immediately following the inspection.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Staff had all received training in medical emergencies and basic life support within the year preceding our inspection and staff we spoke with were able to tell us which emergency medicines would be required in specific circumstances.

Staff recruitment

The practice had a recruitment policy which indicated the pre-employment checks required prior to a new staff member starting work.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We reviewed the staff recruitment files for four members of staff and found that DBS checks were in place for all staff, however proof of identity and references were not always recorded. These were provided following the inspection.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy (which had been reviewed in January 2016) was available for staff to reference. This included details on waste disposal, mercury spillage and practice safety rules.

A general practice risk assessment had been completed on April 2016 as well as a health and safety self-assessment audit. These covered areas of risk such as electrical safety, fire risk, manual handling and autoclaves.

A fire risk assessment had been completed in April 2016. Fire alarm tests were carried out weekly and fire drills monthly. A fire inspection had determined that two fire extinguishers on the premises were not fit for purpose. This had been acted on by replacing both units. Staff we spoke with were able to describe their actions in the event of a fire, and the external muster point following an evacuation of the premises.

An X-ray report detailed unsatisfactory test results for one of the X-ray machines. The practice responded by replacing both X-ray machines on the premises, and tests on the new machines indicated they functioned within acceptable parameters.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors. Household detergents and other substances that could be hazardous to health were stored unlocked in cupboards in the patient toilet. Following the inspection we received evidence that these were now secure.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' 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 cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

Are services safe?

The practice had an infection control policy which was reviewed in January 2016.This included hand hygiene, and waste disposal, and referenced the importance of clearly defined 'clean' and 'dirty' areas, although we did not find this to be reflected in the decontamination room.

The practice had a dedicated decontamination facility with use of a washer disinfector to clean the instruments. A washer disinfector is a piece of equipment not dissimilar to a dishwasher that is designed specifically to clean dental instruments. Instruments were inspected after cleaning and sterilised in an autoclave.

A decontamination facility should have clear zoning to separate 'dirty' areas from 'clean' areas. We observed that this zoning was not clear; clean instruments were placed in the same area as the dirty instruments when they were bought directly from the treatment room. This was essentially due to the layout of the room; the 'clean' area was very small and did not allow space for multiple trays of instruments to be placed there.

Dental drills were washed manually in a dedicated sink, however the temperature of the water for this task was not monitored (the temperature should be below 45 degrees Celsius to ensure effective removal of protein contaminants). In addition a foaming cleanser was used, which could also inhibit the effective removal of contaminants. Dental drills were rinsed under running water which carried the risk of creating an aerosol of contaminated material.

Following the inspection the practice conducted training for the staff in manual cleaning and use of the washer disinfector to ensure that national standards were being met. As a result of this training the practice also processed instruments in smaller batches so that they no longer had to use a designated 'dirty' surface to place clean instruments. The practice replaced the foaming cleanser with an appropriate non-foaming alternative.

The practice arranged a cross infection training day with all staff in the practice to discuss and implement changes to ensure that all relevant guidance was met.

The practice did not have a separate bowl to clean non clinical utensils and crockery. The cleaning of mugs was taking place in the sink used for rinsing instruments before they were sterilised. Following the inspection the practice took immediate steps to resolve this.

Tests carried out on the washer disinfector and the autoclave was in line with the requirements of HTM 01-05.

The treatment rooms had fabric blinds at the window, which were not cleanable and appeared dirty, and possibly mouldy. The flooring of the treatment areas was not always impervious and easily cleanable due to gaps or tears in the flooring. We also noted tears within the fabric of the dental chair which would make adequate cleansing difficult. Following the inspection the blinds were replaced, arrangements were made to replace the flooring and a temporary seal placed over the cracks to improve the ability to effectively clean in the short term, and arrangements made to repair the dental chair.

All clinical staff had documented immunity against Hepatitis B. 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 the risk of contracting blood borne infections.

Environmental cleaning was carried out by practice staff. Cleaning equipment and materials conformed to the national guidelines for colour coding cleaning equipment in a healthcare setting, and a comprehensive cleaning log was kept for each area of the practice.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a locked bin prior to removal from the premises.

The practice had systems in place to reduce the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had completed an in house risk assessment and was checking water temperatures every three months to ensure they remained outside the range in which Legionella could proliferate. However HTM 01-05 requires that a risk assessment is completed by a competent person, following the inspection the practice arranged for a specialist external contractor to complete a comprehensive risk assessment.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice. We saw a reference in a staff meeting

to a request for more instruments to be purchased, as the use of the washer disinfector resulted in the decontamination process taking longer. This requested was noted as having been completed.

Portable appliance testing had been carried out in April 2015, and the following equipment had been serviced and validated within the year preceding our inspection: the autoclave, compressor and washer disinfector. The fire extinguishers had been replaced in September 2016.

The practice had a separate kit of instruments used for placing implants. All necessary equipment was seen, and the practice described the protocol for preparing the kit prior to placing implants.

The practice had a medicines policy dated January 2016. This detailed the appropriate disposal of medicines that had expired. Prescription pads were kept secured on the premises although no log was kept of the pads in case of loss in line with the NHS security of prescription forms guidance.

Glucagon is an emergency medicine used to treat diabetics. It is only effective until the expiry date if it is stored within a specified temperature range. Although the practice kept this medicine in the fridge they were not monitoring the temperature range and therefore could not be assured of its effectiveness until the expiry date.

Following the inspection the practice took steps to store the medicine appropriately.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice had two intra –oral X-ray machines that can take an X-ray of one or a few teeth at a time. The machines had been appropriately serviced and tested, and a risk assessment had been completed in September 2016.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was completed by patients on a tablet which uploaded directly to the patient's dental care record. A new form was completed at every examination appointment, and the updated verbally at every attendance.

This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology.

The dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks and needs and to determine how frequently to recall them. The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive.

Health promotion & prevention

Medical history forms that patients were asked to fill in included information on nicotine use; this was used by dentists to introduce a discussion on oral health and prevention of disease.

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice was staffed by three dentists, two qualified dental nurses, and a practice manager who also covered reception.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council and did not have any conditions on their registration.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves.

Templates were available to standardise the referral process, and referrals made were scanned onto the patient care records. A referral policy dated January 2016 indicated the importance of keeping copies of referrals made, and recorded that patients are made aware that they could request copies of referrals made on their behalf.

Referrals made for suspicious pathology were faxed to the hospital for speed, and followed up with a telephone call to ensure that the referral had been received.

The practice was not keeping a log of referrals to monitor whether they had been actioned in a timely manner.

Consent to care and treatment

The clinicians described the process of gaining full, educated and valid consent to treat. This involved detailed discussions with the patients of the options available and the positives and negatives of each option. We saw details of these discussions documented in the dental care record.

If a patient was interested in having dental implants we were shown a leaflet that was given to them to consider

Are services effective?

(for example, treatment is effective)

their options. Although the leaflet described the process of placing an implant and had diagrams of what to expect, there was limited information pertaining to the risks and limitations of this treatment option.

Discussions took place with the clinician, but we were not shown any further written information afforded to patients prior to undertaking the surgery. Following our inspection the practice informed us that they were reviewing the provision of dental implants at the practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment.

Similarly staff demonstrated an understanding of the situation in which a child under the age of 16 could legally consent for themselves. This is termed Gillick competence, and it relies upon an assessment of the child in question indicating that they have sufficient understanding of the procedure in question, and the consequences of having/ not having the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments we received from patients indicated that they were very happy with the level of care they received from the practice, with some commenting that they were good at putting nervous patients at ease.

Patients referred to the staff as polite, friendly and professional. We witnessed patients visiting the practice being treated in a pleasant and helpful manner.

Staff we spoke with explained how they ensured information about patients using the service was kept confidential. The computers were password protected and positioned below the level of the counter so that it could not be overlooked by a patients stood at the counter.

The practice did not keep paper records, reducing the opportunity for confidential information to be overseen. These measures were underpinned by the practice's confidentiality policy which was dated January 2016.

We noted that the treatment rooms were linked by an interconnecting door, but did not find that patients could be easily overheard from one treatment room to the next.

Involvement in decisions about care and treatment

The practice had a patient involvement policy dated January 2016. This detailed measures employed by the practice to ensure they remained patient focussed. For example: all treatment options explained to the patient, choices and preferences of the patients to be reported and noted and consider the results of patient satisfaction surveys.

All patients received a written treatment plan, and patients commented that they felt listened to.

The practice displayed NHS and private price lists in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

At the time of our inspection a new patient appointment could be secured at the practice within a week or two. Patient comments indicated that reception made every effort to secure an appointment at a time that was convenient.

We looked at the appointments scheduling and found that appropriate time was given for an examination and a discussion of the patient's needs.

The practice had access to an interpreting service to assist those patients for whom English was not their first language.

Tackling inequity and promoting equality

The practice had an equality and diversity policy which indicated the practice's intention to welcome patients of all cultures and backgrounds. This was dated January 2016.

The practice was situated on the ground floor and wheelchair access was possible with the assistance of a ramp to negotiate a step at the front door.

Reception staff explained how they assisted patients with limited mobility. In order to facilitate this, a door had been fitted directly from the reception area to the waiting room so that the receptionist could be on hand to help immediately should the situation arise. Fitting this door was arranged by the practice at the request of the reception staff so that they would be able to assist patients attending the practice.

Patient comments indicated that appointments scheduling was flexible depending on the patients' individual needs, with extra time being afforded to those patients who needed it.

Access to the service

The practice was open from 9 am to 5.30 pm Monday to Friday.

Outside normal working hours patients were directed to the NHS 111 service for advice or treatment.

During working hours patients of the practice with an emergency would normally be fitted in for an emergency appointment the same day. We received comments from patients confirming that they were seen for emergency appointments on the day they contacted the service.

Concerns & complaints

The practice had a complaints handling policy which had been reviewed in July 2016. This indicated the methods by which a patient could raise a complaint and listed external agencies to which they could raise the complaint. This was displayed in the waiting area.

The practice did not have any written complaints in the year preceding our visit, and discussed with us how verbal concerns were addressed and dealt with. We discussed the merits of recording verbal complaints as a process by which learning for the practice staff could be derived.

We discussed with the practice manager how a formal complaint would be handled, and the response was in line with the practice policy, and included giving and full and frank feedback to the complainant with apologies if appropriate.

Are services well-led?

Our findings

Governance arrangements

Aspects of the premises needed remedial work in order to become easily cleanable. The flooring in the treatment rooms had tears and gaps creating areas that were impossible to clean effectively. The window blinds in the treatment rooms were not cleanable and were found to be dirty and the dental chairs had tears within the fabric.

Following the inspection the practice arranged for the flooring to be replaced, and conducted a short term repair of the floor in the interim to improve the ability to clean effectively. Window blinds were replaced and a plan put in place to address the ability to effectively clean the dental chairs.

Concerns that we noted within the decontamination process, particularly in regard to the manual cleaning of hand pieces were not reflected in the results of the infection control audits we were shown. This demonstrated that the audit process was not effective in this regard.

The principal dentist took responsibility for the day to day running of the practice. We noted clear lines of responsibility and accountability across the practice team. The principal dentist was the named cross infection lead in the practice at the time of the inspection, although the intention was to delegate this responsibility to a dental nurse.

Staff meetings were arranged every two to three months, we saw minutes of these meetings as well as actioned points of business that the meetings generated.

The practice had policies and procedures in place to support the management of the service, and these were available for staff to reference in hard copy form and were arranged with an index sheet at the beginning of the folder to assist in locating policies.

Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, information governance, significant events and whistleblowing. All policies had been reviewed in the previous year, however in regard to infection control and significant event recording the practice were not acting in accordance with their policies.

The practice systems had not recognised that equipment for use in a medical emergency was not in line with published guidance.

The practice were not keeping records of significant incidents, and accident reports that had been filled out lacked detail. The practice did have templates available to log incidents alongside their significant events policy and we received assurances that these would be implemented immediately following the inspection.

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist.

A whistleblowing policy was available which had been reviewed in January 2016. It directed staff to raise concerns about a colleague's poor performance internally, but did not give any information regarding how a concern could be raised with an external agency. Following the inspection the practice implemented a new whistleblowing policy which informed staff that they could raise their concern externally. To that end contact numbers of external agencies were supplied.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audits were used to identify areas of practice which could be improved. An infection control audit had been carried out in October 2016 an action plan had been generated which highlighted some concerns for example: a bin in the decontamination room was not foot operated, the treatment room flooring and the dental chair headrest needed upholstering. At the time of the inspection these had not yet been actioned as the audit was completed two days before our visit. However these concerns were addressed following our visit.

The audit did not reflect the concerns we had having inspected the decontamination process. This demonstrated that the audit process was not as robust as it needed to be.

Are services well-led?

Prior to this an infection control audit had been completed in May 2015. The recommended frequency of infection control audits should be six monthly as set out in HTM 01-05. The action plan of this audit did not reference any concerns regarding the decontamination process.

An audit on the quality of X-rays was completed in January 2016, and although the scores were in line with those set out by the National Radiological Protection Board the analysis had been across the practice, rather than a separate analysis for each clinician.

This may have had the effect of masking concerns with clinicians as overall the scores may be pulled up by the others. The audit had generated an action plan, and results of the audits were discussed at staff meetings, although clinicians didn't always receive the feedback.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that all clinical staff were up to date with the recommended CPD requirements of the GDC.

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

The practice asked for feedback from patients by way of the friends and family test. This is a NHS test that was designed to give patients a quick and anonymous was of providing feedback about the service they received.

The practice team indicated their opinions and feedback would always be welcomed by the principal dentist and were able to describe ways in which suggestions they have made have elicited change in the practice to the benefit of the staff and 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: · Risks to the health, safety and welfare of patients were not assessed and actions taken to mitigate these. For example infection control audits did not identify all failures within the decontamination process, or the ability to effectively clean the treatment areas. · There was no assessment of risk or other measures to identify and mitigate the risks associated with the absence of emergency equipment. · Practice policies were not always adhered to. For example significant events monitoring and infection control. **Regulation 17 (1)**