Cambridge Smile Studio Limited

Cambridge Smile Studio

Inspection Report

27 Milton Road
Cambridge
CB4 1UZ
Tel: 0844 5769556
Website: 0844 5769556

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Overall summary

We carried out an announced comprehensive inspection on 20 December 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well led?

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was 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

The Cambridge Smile Studio is a well-established dental practice that provides mostly NHS general dentistry services to adults and children. It is situated near Cambridge City Centre and serves about 10,000 patients.

The practice has a team of five dentists, three hygienists, a practice manager, seven dental nurses and reception staff. There are six treatment rooms, a room for the decontamination of instruments, an office, and a reception and waiting area. A specialist dentist visits once a month to provide implants to patients.

The practice opens on Mondays from 8am to 7pm, and on Tuesdays to Fridays from 8am to 5pm.

The practice owner is registered with the Care Quality Commission (CQC) as the registered manager. 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.

Our key findings were:

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients received clear explanations about their proposed treatment and were actively involved in making decisions about it. They were treated in a way that they liked by staff

Summary of findings

- Staff had received safeguarding training and took good action to protect vulnerable adults and children when needed.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- Appointments were easy to book and emergency slots were available each day for patients requiring urgent treatment.
- Staff were not aware of recent safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) that affected dental practice.
- Arrangements for monitoring safety and managing risk were not robust. This included the recording of significant events, assessing potential hazards and the use of a safer sharps' system.
- The practice's recruitment process did not ensure that all relevant checks were undertaken before new staff started work.
- Communication systems within the practice were poor and not all staff felt supported or valued in their work.

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

- Ensure robust systems are in place so that care and treatment is provided in a safe way for patients. This includes implementing processes for reporting, recording and monitoring significant events; responding to national patients safety alerts; ensuring staff recruitment procedures are robust; ensuring the practice's sharps handling procedures and protocols are in compliance with national guidelines, and ensuring infection control audits are undertaken at regular intervals.
- 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 and national guidance relevant to dental practice. This includes providing staff with adequate supervision and appraisal, auditing the quality of the service provided, ensuring policies and procedures are kept up to date and followed, and providing clear leadership within the practice.

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

- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.

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?

Requirements notice

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

Staff had received safeguarding training and took action to protect people when necessary. The practice had good arrangements in place for areas such as the decontamination of instruments and clinical waste management. There were sufficient numbers of suitably qualified and competent staff to meet patients' needs, although recruitment procedures were not robust.

Significant events were not always recorded and the identification of possible hazards within the practice was poor. Fire safety and infection control needed to be strengthened to ensure patients were protected. The practice's management of sharps did not meet national guidance. Staff did not practise responding to medical emergencies and checks of emergency equipment and medicines were not recorded.

Prescriptions were not managed safely and dentists were not aware of reporting procedures for patients who experienced adverse reactions to medicines; staff were also unaware of recent safety alerts affecting dental practice

Are services effective?

No action

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines. Patients received a comprehensive assessment of their dental needs including taking a medical history. Treatment risks, benefits, options and costs were explained to patients in a way they understood and staff followed appropriate guidelines for obtaining patient consent. Patients were referred to other services as needed.

The staff were able to access professional training, although they did not receive regular supervision or appraisal of their practice.

Are services caring?

No action

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

We collected 38 completed patient comment cards and obtained the views of a further three patients on the day of our visit. Patients commented on friendliness

Summary of findings

and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed. Patients spoke highly of the dental treatment they received, and told us that staff appeared genuinely interested in their welfare and worked with their children well.

Staff understood the importance of maintaining patients' privacy and information about them was handled confidentially. Staff gave us examples of how they had actively supported patients to attend their treatment.

Are services responsive to people's needs?

No action ✓

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

The practice had good facilities and was well equipped to treat patients. Patients could access routine treatment and urgent care when required and the practice opened late one day a week to meet the needs of patients. Appointments were easy to book and patients were able to sign up for text and email reminders for their appointments. The practice had made some adjustments to accommodate patients with a disability.

There was a clear complaints' system and the practice responded appropriately to issues raised by patients.

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 governance arrangements for the day-to-day management and administration of the practice were not effective. Policies and procedures to govern the practice's activities had not been regularly reviewed or updated. Risk assessments were not sufficiently comprehensive to identify potential hazards to both staff and patients. Staff did not receive regular appraisal of their performance and did not have personal development plans in place. There were no staff meetings to discuss the running of the practice, significant events, and complaints or to share learning.

Communication systems in the practice were poor and we received mixed feedback from staff about the quality leadership.

Cambridge Smile Studio

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 20 December 2016 and was conducted by a CQC inspector and a dental specialist advisor.

During the inspection we spoke with the owner, one dentist, two dental nurses, a hygienist and two receptionists. We received feedback from 38 patients who had completed our comment cards prior to our visit, and spoke with another three during our visit. We reviewed policies, procedures and other documents relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff were aware of the requirement to record and report accidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and used appropriate accident record forms. However, the records of three accidents we reviewed in the book were a little sparse in detail and did not contain any information of the action taken in response.

There was no significant event form or policy within the practice and staff we spoke with had a limited understanding of what might constitute a significant event. Staff told us of one particular incident when a person had entered the practice pretending to be a gas engineer. No formal record had been made of this and there was no evidence that learning from the event had been shared with staff. One member of the reception team told us she had heard about the incident but was not aware of any measures put in place to prevent its reoccurrence.

Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. Records showed that all staff had received appropriate safeguarding training for both vulnerable adults and children provided by the local safeguarding team. The principal dentist was the lead for safeguarding and had undertaken level three training in child protection. Staff we spoke with demonstrated their awareness of the different types of abuse, and understood the importance of safeguarding issues. We were given specific examples of where staff had acted to protect people. One dentist had reported their concerns in relation to a child whose injuries had not matched what they had been told by the parents, and staff had contacted the manager of a local care home as they had concerns about a staff member who had accompanied a resident to their dental appointment.

Staff spoke knowledgeably about action they would take following a sharps' injury and a sharps risk assessment had been completed. However, sharps' protocols were not on display where they were used, and accident records of two sharps injuries gave no information if medical advice had been sought, or if the patients' medical history had been checked. Both nurses and dentists handled used needles, and some dentists manually resheathed them. This was not in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps bins were not always sited safely in the treatment rooms and their labels had not been completed to show the date the bin had been assembled and by whom.

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. All the dentists used rubber dams and we noted that several rubber dam kits were available in the practice.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff had received training in basic life support including the use of an Automated External Defibrillator (An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff did not regularly rehearse emergency medical simulations so that they had a chance to practise what to do in the event of an incident.

The emergency equipment and oxygen were stored in central locations known to all staff, although a number of essential items were missing including portable suction, self-inflating bags, airways equipment, a spacer device and syringes to administer adrenalin. However all these items were ordered during our inspection.

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Glucagon (a medicine used to treat hypoglycemia) was kept in a fridge, although the fridge temperature was not monitored to ensure it was operating effectively. Staff told us that the medicines were checked regularly; however no log of this was kept.

Bodily fluid spillage, eyewash and mercury spillage kits were available to deal with any incidents.

Staff recruitment

Are services safe?

The practice's staff recruitment policy stated that references and a disclosure and barring check (DBS) must be obtained for potential employees, that job descriptions must be available and that there should be an interview panel of two people. However, staff files we checked showed that staff were not following this policy. For example, no references or DBS check had been obtained for one nurse and there was no record of their interview to demonstrate it had been conducted fairly. The practice manager told us that none of the nurses or administrative staff had received a DBS check to ensure they were suitable to work with vulnerable adults and children. However, evidence that the checks had been applied for was sent to us shortly after our inspection.

A specialist visited the practice to provide implants to patients. Other than proof of his indemnity, the practice did not hold any other information about him such as his GDC registration, training certificates and hepatitis status to ensure he was suitable to work with patients. However evidence of his DBS check was sent to us following our inspection.

There was no formal induction programme in place for new staff joining the practice to ensure they had the knowledge and skills for their role.

Monitoring health & safety and responding to risks

There was no general risk assessment for the practice to help identify potential hazards, despite us viewing several including the fact that people could enter the building without being seen by reception staff. A fire risk assessment had been completed in December 2016 but this was very basic and had failed to identify a number of hazards we saw such as the storage of oxygen.

Firefighting equipment such as extinguishers was regularly tested. However, evacuation drills were not completed to ensure staff knew what to do in the event of a fire and none of the staff had received fire safety training. The practice manager told us that the practice's smoke alarms were tested, but a log of the checks was not kept.

The practice had not carried out a legionella risk assessment but the practice manager told us that an external company had been commissioned to undertake one in February 2017. Regular flushing of the water lines was carried out in accordance with current guidelines and the practice used an appropriate biocide in the water line to reduce the risk of legionella bacteria forming. However staff did not monitor hot and cold water temperatures regularly.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for most materials used within the practice, and missing data sheets were downloaded during our inspection.

The practice did have a business continuity plan in place for major incidents such as the loss of utilities or natural disasters, although a copy of the plan was not kept off site to ensure it was accessible in the event of an incident.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice.

The practice's waiting area, stairway and staff areas were clean and uncluttered. The toilet was clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked two treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had modern sealed work surfaces so they could be cleaned easily. However hand wash sinks did not meet national guidance and one sink appeared dirty. There was a build-up of lime scale around the taps and plughole, making them difficult to clean. Drawer insets in one room were dusty and sticky and we noted loose and uncovered items such as suction tips, X-ray packets and burrs in some treatment room drawers. These were within the splatter zone and therefore risked becoming contaminated in the long term. Dental instruments were kept in specific dirty boxes in the treatment room but were not kept moist before processing.

We noted that three dental chairs areas had small rips in their upholstery and no action had been taken to repair them. Patient chairs in one treatment room were of a design, which made them difficult to clean effectively.

The practice had undertaken an infection control audit just before our inspection: prior to this none had been completed. National guidance recommends that these audits be completed every six months. The audit had identified a number of shortfalls but there was no action

plan in place stating how these would be addressed, by whom and the date for completion. Therefore it was not clear how the practice was going to implement improvement.

Equipment used for cleaning different parts of the practice was colour coded to reduce the risk of cross contamination, although it had not been stored in line with national guidance.

The practice had a separate decontamination room for the reprocessing of dirty instruments which were mostly set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01- 05), decontamination in primary care dental practices.

The head nurse was the lead for infection control within the practice but she had not received any additional training for this role, and she was not fully aware of relevant guidance in relation to the decontamination of dental instruments. A dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. We noted that she wore appropriate personal protective equipment during the procedure including heavy-duty gloves, visor and apron.

The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. The dental nurse used a system of manual scrubbing for the initial cleaning process, and the water temperature was checked to ensure it was below 45 degree Celsius. Following inspection with an illuminated magnifying glass, instruments were placed in an autoclave (a device used to sterilise medical and dental instruments). All pouches were dated with an expiry date in accordance with current guidelines.

The dental nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively.

All dental staff had been immunised against Hepatitis B. We noted that staff uniforms were clean, long hair was tied back and staff's arms were bare below the elbows to reduce the risk of cross infection.

The practice's arrangements for segregating, storing and disposing of dental waste reflected current guidelines from the Department of Health. The practice used an appropriate contractor to remove dental waste from the practice, which was stored in locked bins outside the practice.

Equipment and medicines

Staff told us they had suitable equipment to enable them to carry out their work and that repairs were undertaken quickly. One of the hygienists reported that a new scaling machine had been purchased for her, as the previous one had been getting old.

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of decontamination cycles to ensure that equipment was functioning properly. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, the autoclaves had been serviced in May 2016, the washer disinfector in September 2016 and portable appliance testing had been completed in November 2015. At the time of our inspection the washer disinfector was not in use, and it was not clearly marked as having been decommissioned to ensure it was not used accidently.

The practice did not have a separate fridge for medicines, which required cool storage, and we found medical consumables stored alongside food in the staff kitchen. The temperature of the fridge was not monitored to ensure it operated effectively.

We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' clinical notes. A detailed log of all other medicines issued to patients was kept. Individual prescriptions were were not locked away or tracked to ensure their security. Dentists we spoke with were not aware of on-line reporting systems to the British National Formulary and of the yellow card scheme to report any adverse reactions to medicines.

We were told that relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority were emailed to the head nurse who actioned them. However staff were unaware of recent alerts affecting dental practice and there was no evidence to show that appropriate action had been taken in response to them.

Are services safe?

Radiography (X-rays)

At the time of our inspection the practice's radiation protection file was with its radiation protection advisor who was based in Leeds and therefore not available for our review. However, we found that staff who operated the equipment had undertaken appropriate training and that rectangular collimation to reduce the dose of X-rays patients received was used in all but one treatment room. Staff told us that no annual mechanical and electrical testing of the x-ray units had ever been completed: national guidance states that this should be undertaken annually.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

All new patients to the practice were asked to provide their medical history including any health conditions, current medication and allergies via the practice's i-pads. This was updated every 12 months and patients were asked to verbally confirm any changes in their health in between. This ensured the dentists were aware of patients' present medical condition before undertaking any treatment.

Our discussion with two dentists and review of dental care records demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines. Assessments included an examination covering the condition of the patient's teeth, gums and soft tissues. Antibiotic prescribing, wisdom tooth extraction and patients' recall frequencies also met national guidance. Patients' basic periodontal examinations were recorded with appropriate referrals made to the practice's hygienist if needed. Where relevant, preventative dental information was given in order to improve the outcome for the patient.

Dental records we were shown were detailed of a good standard generally.

Health promotion & prevention

Patients were asked about their smoking habits and alcohol intake when they completed their medical histories; although there was no information or leaflets available for patients wanting to give up smoking and staff were unaware of local smoking cessation services. Knowledge of guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' was variable amongst dental clinicians, although we found evidence of oral hygiene instruction given to patients in the dental care records we reviewed.

One of the practice's dental hygienists had visited a local primary school to provide oral hygiene training to the pupils there.

Staffing

Most staff told us they were enough of them for the smooth running of the practice. Each dentist saw about 20 patients a day and both staff and patients told us they did not feel rushed during appointments. However, the practice manager told us she had not enough time to complete all her managerial responsibilities and some essential record keeping and checks had been affected as a result.

A dental nurse always worked with each dentist and an additional nurse was usually available each day to help with decontamination procedures. The dental hygienists worked alone and without support of a dental nurse. The General Dental Council (GDC) recommends that dental staff are supported by an appropriately trained member of the dental team at all times when treating patients.

Files we viewed demonstrated that clinical staff were appropriately qualified, trained and where required, had current professional validation and indemnity in place, although it was not clear what training and qualifications the practice's visiting implantologist had.

None of the staff had received an appraisal so it was not clear how their performance was assessed or their training needs identified. No system was in place to monitor the continuing professional registration of staff and their fitness to practise .

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. A log of the referrals made was kept so they could be could be tracked and urgent referral for suspected malignancy were fast tracked by fax, and followed up with a phone call to ensure they had been received.

Patients were not routinely given a copy of their referral for their information.

Consent to care and treatment

The Mental Capacity Act 2005 (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 we spoke with had a satisfactory understanding of patient consent and MCA issues. The principal dentist had completed an in-depth course in relation to patient consent issues and had held a training session for all the associate dentists in the practice.

Patients' consent to treatment had been recorded in the dental care records we reviewed, along with evidence that treatment options had been discussed with them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients told us they were treated in a way that they liked by staff and many comment cards we received described staff as professional, caring and empathetic to their needs. One patient told us that staff appeared genuinely interested in their well-being, another that the dentists had excellent rapport with their children and one patient stated that they were listened to with time and understanding.

We observed the receptionists interact with about 8 patients both on the phone and face to face and noted they were consistently polite and helpful towards them. Reception staff told us they regularly helped patients park in the very small space in front of the practice and rang patients who were waiting for an appointment if there had been an unexpected cancellation.

Staff were aware of the importance of providing patients with privacy and maintaining their confidentiality. Treatment rooms doors were closed at all times when patients were with dentists and conversations between patients and dentists could not be heard from outside the rooms. The practice manager talked about the need to ask patients about their benefit entitlement sensitively.

The main reception area itself was not particularly private and those waiting could easily overhear conversations between reception staff and patients. However, staff assured us they could offer a separate room to any patient who wanted to speak privately and that they were careful not to give out patients' personal details when speaking on the phone.

Involvement in decisions about care and treatment

Patients told us that they were provided with good information during their consultation and that they had the opportunity to ask questions before agreeing to a particular treatment. One patient told us that they had greatly valued seeing their X-rays as it had helped them better understand their treatment. Another reported that they received useful and helpful information both before and after their wisdom tooth removal. One patient stated that they received good feedback about how to clean their teeth.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a web site that provided patients with helpful information about the staff team, the treatments available and the fees for private treatment. In addition to general dentistry, the practice offered a number of cosmetic treatments, including implants, teeth whitening and facial aesthetics. The practice also employed three hygienists to support patients with the management of their gum disease.

All dental clinicians at the practice had business cards, which were given to new patients. These contained their specific telephone numbers so that they could be contacted directly by patients.

The practice opened on Mondays from 8am to 7pm, and on Tuesdays to Fridays from 8am to 5pm. It occasionally opened on a Saturday by appointment. Patients commented that appointments were easy to get, and they rarely waited long once they arrived. They told us that reception staff worked hard to find them appointments at suitable times and they particularly valued the text and email appointment reminder service offered. Two emergency slots were available each day for patients experiencing dental pain and two of the patients we spoke with during our inspection told us they had rung that morning and were able to get an urgent appointment later in the day. Some patients told us that parking at the practice was very limited however, and they often had to park a long way away.

Information about emergency out of hours services was available on the practice's answer phone message, however none was available on the front door should a patient come to the practice when it was closed.

Tackling inequity and promoting equality

The practice had made some adjustments to help prevent inequity for patients that experienced limited mobility and there was level access entry to the practice via a ramp. There was a downstairs treatment room and toilet, although the toilet was not accessible to wheelchair users. There was no wide seating or chairs of different height in the waiting room to accommodate those with mobility problems and no portable hearing loop to assist patients who wore hearing aids.

Information about the practice was not available in any other languages or formats such as large print, braille or audio. Staff had not undertaken any training in equalities and diversity to help them better understand the diverse needs of patients. Reception staff were not aware of any translation services that should be used for patients who could not speak English, despite having a number of Polish and Bangladeshi patients. One member of the reception team told us she had rung a personal friend to help translate for a patient who could not speak English. Although she was clearly trying to be helpful, this was not appropriate or professional.

Concerns & complaints

The practice had a policy and a procedure that set out how complaints would be addressed, although there was no information on the practice's web site or waiting area informing patients how they could raise concerns. However, the practice manager understood the importance of dealing with patients' concerns swiftly and thoroughly, and showed us the paperwork in relation to three recent complaints received by the practice. We found that they had been managed effectively, empathetically and to the patient's satisfaction.

Are services well-led?

Our findings

Governance arrangements

We identified a number of shortfalls in the practice's governance arrangements. The principal dentist, who was also the registered manager for the practice, had been absent from the practice for the previous six months and there had been no clear delegation of management responsibilities in his absence.

The practice had a number of policies and procedures in place to guide staff however, many of these had not been reviewed in the last two years. Others had not been dated at all so it was not clear if they were up to date and still relevant to the practice. The practice did not always follow its own policies. For example, the recruitment policy stated that staff references and DBS checks would be sought for prospective employees but we found this had not been done.

None of the staff had received an annual appraisal so it was not clear how their performance was assessed. None had a training or personal development plan in place, and the practice did not keep a record of training that staff had completed. There was no mechanism for assessing the performance of the associate dentists or hygienists, and no system to monitor the professional registrations of clinicians.

There had been no staff meetings in the previous 12 months to discuss the running of the practice, significant events, and complaints or to share learning. It was not clear how information was shared with the staff team.

Risk assessment within the practice was generally poor and a number of hazards we found on the premises had not been identified by staff.

Audit systems were limited and it was not always clear if action had been taken to address highlighted shortfalls. An infection control audit had only been undertaken for the first time just prior to our visit and a radiography audit had only been completed for some of the dentists at the practice. The practice had not completed the yearly information governance audit tool so it was not clear if it was meeting the requirements of legislation in how it managed patient information.

Leadership, openness and transparency

We received mixed feedback from staff about leadership within the practice. Some stated they received good support and enjoyed their work, others told us that their morale was low and that communication systems were very poor. One staff member told us they had not been informed that a new member of staff had started working at the practice, and only discovered this when they met them in the corridor and had wondered who they were. Another stated that staff's achievements and additional work were rarely acknowledged or valued, and another that staff concerns 'fell on deaf ears'.

The practice had recently implemented a policy in relation to its requirements under the Duty of Candour, although not all staff were aware of it. We found staff to be open and honest about the difficulties the practice faced, and they were clearly keen to address the issues we found during our inspection. This demonstrated they understood duty of candour requirements.

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

The practice had introduced the NHS Friends and Family test as a way for patients to let them know how well they were doing. Results of the test for October 2016 showed that 98% of the 246 respondents would recommend the practice. There was also a suggestion box in the waiting room with forms available for patients to complete. In response to feedback from patients, the registered manager told us that he had installed bike locks outside the practice so that patients could secure their bikes. The practice also monitored patient feedback left on NHS Choices and invited people who submitted comments to contact them to discuss their concerns. The practice had been rated three out of five stars, based on 18 reviews.

Not all staff felt that the practice manager and owner listened to suggestions, although an additional I-pad had been purchased so that patients could complete their medical histories more easily. It was not clear how the practice collected formal feedback from staff given there were no staff meetings, no staff appraisal or staff survey.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12- Safe Care and Treatment** How the regulation was not being met: The provider did not have robust systems in place to ensure that care and treatment was provided in a safe way for service users. • Significant events were not always recorded and the identification of possible hazards within the practice was limited. • Fire safety and infection control needed to be strengthened to ensure patients were protected. • The practice's management of sharps did not meet the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 . • Staff did not practise responding to medical emergencies and checks of emergency equipment and medicines were not recorded. • Systems for recruiting staff were not robust to ensure they were suitable to work with patients.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The registered person did not have effective systems in place to ensure that the regulated activities were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This included:

- providing adequate staff supervision and appraisal
- ensuring suitable auditing of the service
- regularly updating the practice's policies and procedures and checking staff adhere to them
- providing robust leadership and management within the practice.