The Dentist In Town Limited

The Dentist in Town

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 January 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

The Dentist in Town Ltd provides private dental care and treatment. The principal dentist operates the practice as a limited company and is the sole director and registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. 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.

The dentist is supported by a dental hygienist, two nurses and one receptionist. The practice is located in a pedestrian arcade in the heart of the city centre. There is wheelchair access to the premises and the whole practice is on the ground floor. The premises consist of a reception area, waiting room, two treatment rooms, a decontamination room and accessible toilet facilities. Opening hours are 10am to 5.30pm on Monday, Tuesday, Thursday, 8.30am to 5pm on Wednesday and 8.30am to 4pm on Friday.

Forty-three patients provided feedback about the service. We looked at comment cards patients had completed before the inspection. All information we received from these patients was very complimentary. Patients were

Summary of findings

positive about their experience and they commented that they were treated with care, respect and dignity. They felt that they were listened to and not rushed and many patients travelled some distance to visit this practice.

Our key findings were:

- An infection control policy was in place and procedures followed mainly reflected published guidance. We highlighted areas for improvement and these were dealt with promptly by the dentist.
- Emergency equipment for dealing with medical emergencies mostly reflected published guidelines. We highlighted areas for improvement and these were all dealt with on the day of our visit.
- The practice had a system in place for recording accidents and adverse incidents at the practice.
- Staff demonstrated knowledge of whistleblowing and were confident they would raise a concern about another staff member's performance if it was necessary.
- Staff needed training in areas such as safeguarding and medical emergencies.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- We received feedback from 43 patients and all comments were positive about the practice. Patients felt they received an excellent service, they felt involved in their care and that staff were caring and polite.
- During our visit, we observed staff were friendly, caring and professional.
- The appointment system met the needs of the patients and waiting times were kept to a minimum.
- No complaints had been received at the practice.
- There was a lack of an effective system to assess, monitor and improve the quality of the services provided.
- There was a lack of an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- The practice was unable to demonstrate compliance with the guidance surrounding X-rays as the information was not accessible on the day of the inspection.

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

- Ensure they establish an effective system to assess, monitor and improve the quality of services provided.
- Ensure they establish an effective system to assess, monitor and mitigate the risks to the health and safety of patients, staff and visitors.
- Ensure they have a standard check on medicines, recruitment and dental care records.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review at appropriate intervals the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff.
- Maintain accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal references taken and ensuring recruitment checks, including references, are suitably obtained and recorded.
- Carry out audits of various aspects of the service, such as radiography and dental care records at regular intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.
- Review 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.
- Implement a system to ensure that certain procedures are documented, such as water temperatures and staff appraisals.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The dentist told us they felt confident about reporting incidents and accidents. Staff were aware of the whistleblowing process within the practice and there was also a policy in the staff handbook for raising concerns. The practice had processes in place to prevent the occurrence of adverse events. Not all staff were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice mostly followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. We observed that some elements of the infection control processes required improvement although most of these were rectified immediately.

The practice had systems in place to manage risks to patients, medical emergencies, whistleblowing, recruitment and complaints. However, some of these required improvement. Patients' medical histories were obtained before any treatment took place.

Prescription medicines were stored securely and were dispensed by the dentist. There was a policy present for the safe disposal of prescription drugs. Portable appliance testing (PAT) was completed in October 2015 to confirm that portable electric items used at the practice were safe to use.

Other areas required improvements relating to the safe provision of treatment. Staff needed updates on safeguarding training (the protection of children and vulnerable adults) and medical emergencies.

The dentist informed us that the practice had a radiation protection file but was unable to access it as they had membership with a company who retained this documentation. Therefore, they were unable to demonstrate that the practice was working in accordance with the ionising radiation guidance.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained.

The dentist was aware of the importance of gaining patients' consent and the relevance of the Mental Capacity Act 2005. The dentist was aware of 'The Delivering Better Oral Health Toolkit' with regards to prevention of oral disease.

Are services caring?

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

Patient feedback stated that they had very positive experiences of the dental care provided at the practice. Staff behaved in a respectful, appropriate and kind manner. Patients commented that they felt involved in their treatment and that it was fully explained to them.

Summary of findings

We saw an example of notable practice that merits sharing during this inspection: the dentist was a member of The National Phobics Society which is an organisation that helps support people affected by anxiety and phobias. The dentist told us they managed the care of nervous patients at the practice using various methods. This removed the need for the dentist to refer nervous patients to external dental practices for sedation or general anaesthetic.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and considered these in how the practice was run.

The practice provided friendly and personalised dental care. Patients could access routine treatment and urgent or emergency care when required. The practice offered dedicated emergency appointments each day enabling effective and efficient treatment of patients with dental pain.

Are services well-led?

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

Staff told us the dentist was very approachable and supportive and the culture within the practice was open and transparent. Staff were aware of the practice ethos and philosophy and told us they felt well supported and able to raise any concerns where necessary. Staff told us they enjoyed working at the practice and felt part of a team. They would recommend the practice to a family member or friends.

However, the practice did not have effective clinical governance and risk management structures in place. We found a significant number of shortfalls in the practice's governance and leadership. These included some safety related matters including some aspects of infection control, equipment and drugs for medical emergencies and staff knowledge surrounding safeguarding. Regular audits are imperative for identifying any compromise in quality and/or safety. There were no audits in areas such as infection control, X-rays and record keeping.

Staff required training in areas such as safeguarding, RIDDOR and medical emergencies. The practice did not have robust processes in place to identify shortfalls at the practice such as missing medical emergency equipment.

The Dentist in Town

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 inspected The Dentist in Town on 14 January 2016. The inspection team consisted of a CQC inspector and a dental specialist advisor.

Before the inspection we reviewed information we held about the provider from various sources. We informed Healthwatch that we were inspecting the practice and did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives.

During the inspection we toured the premises, spoke with the dentist (who was the registered manager), one nurse and the receptionist. We also reviewed CQC comment cards which patients had completed. We were unable to speak with patients on the day because the dentist had rescheduled all dental appointments to provide staff with ample time to speak with the inspection team. We reviewed a range of practice policies and practice protocols and other records 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

The practice had arrangements in place to allow staff to report incidents and accidents. No accidents or adverse incidents had taken place at the practice at the time of the inspection.

Not all staff members we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

There were no systems in place to ensure that all staff members were aware and responsive to national patient safety and medicines alerts. The dentist emailed us after the inspection with evidence that they had registered with an appropriate organisation to receive updated alerts from the MHRA (Medicines and Healthcare Products Regulatory Agency).

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place with details about child protection. This provided staff with information about identifying suspected abuse and it was readily available to all staff. However, there were no protocols for reporting suspected abuse to local organisations. There were no policies for safeguarding vulnerable adults. The practice did not have a named safeguarding lead although staff told us they would approach the dentist in the event of any safeguarding queries. Not all staff had undertaken safeguarding training in the last 12 months. There had not been any safeguarding referrals to the local safeguarding team. The dentist contacted us after the inspection and explained that a staff meeting was planned in February to discuss safeguarding protocols and raise awareness with all staff members.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. Staff told us that rubber dams were used as far as practically possible.

Never events are serious incidents that are wholly preventable as guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. Staff members we spoke with were aware of Never events and had processes to follow to prevent these happening. For example, they had a process to make sure they did not extract the wrong tooth.

All staff members we spoke with were aware of the whistleblowing process within the practice. There was also a policy in the staff handbook for raising concerns. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies were not completely in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF).

The practice kept some emergency equipment but some items were missing. The dentist explained this was due to a recent error with the suppliers of the emergency medical equipment.

Emergency oxygen was available at the practice and the provider also ordered an additional oxygen cylinder during the inspection. Missing items included oropharyngeal airways, self-inflating bags and single-use syringes. An oropharyngeal airway is a device used to maintain a patient's airway. A self-inflating bag is a device used to provide ventilation to patients who are not breathing or not breathing adequately.

We noted that the emergency medicines kit did not contain buccal midazolam in line with BNF guidance. Buccal midazolam is a medicine used to control seizures. The kit contained emergency adrenaline but the dosage was appropriate for a child and not an adult. Adrenaline is used in the treatment of serious allergic reactions and otheremergency situations.

The practice did not have an automated external defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Are services safe?

Within two working days of our visit, we received documentary evidence from the dentist that showed they had ordered an AED, buccal midazolam, a larger oxygen cylinder, adult dose adrenaline, airways and the self-inflating bags.

Staff we spoke with were all aware of the location of the emergency equipment and drugs. Records showed that staff carried out regular checks to ensure the equipment and emergency medicines were safe to use. The emergency medicines were all in date and stored securely.

Staff had not undertaken basic life support training within the last year at the practice. The dentist contacted us after the inspection and told us that they were due to have this training at the practice in February 2016.

Staff recruitment

The practice did not have a specific written policy for the safe recruitment of staff. We looked at the recruitment records for two members of the practice team. Other staff records were not available and the dentist told us they kept these at their home. The records we saw contained evidence of DBS checks, Immunisation status (where relevant), employment contracts and curricula vitae. Some of the files also contained references (but some were verbal and not documented), staff I.D., and copies of their General Dental Council (GDC) registration certificates. We checked the GDC website and saw that all clinical staff members were registered. We did not see any evidence that clinical staff had medical indemnity.

Monitoring health & safety and responding to risks

The practice had limited arrangements in place to monitor health and safety. Risk management policies were in place. For example, we viewed risk assessments for handling sharp instruments, X-rays and electrical wiring. We also reviewed a policy on health and safety at work.

Fire extinguishers were present and were serviced in March 2015. We were told that the fire alarms were tested on a weekly basis and the fire drills every three months. The practice did not keep records of these tests because the landlord was responsible for fire safety. The dentist told us that fire safety training was carried out when the practice first opened (over five years ago).

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. The practice identified how they managed hazardous substances in their health and safety and infection control policies, for example in their blood spillage procedure.

The practice did not have a structured business continuity plan which described situations which might interfere with the day to day running of the practice. The dentist told us they had access to all emergency contact details, if required. However, all staff should have access to these details in the event of an unforeseen situation affecting the practice.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. These included hand hygiene, managing waste products and decontamination guidance. The practice mostly followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We saw that the staff files available at the practice contained evidence that clinical staff had received immunisations against blood borne viruses (such as Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be generally clean and hygienic. Several patients commented that the practice was clean and hygienic. Work surfaces and drawers were clean and free from clutter. There were handwashing facilities in each treatment room and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. The practice was computerised and the keyboards in the treatment rooms had easy to clean water-proof covers.

Decontamination procedures were carried out in a dedicated decontamination room as advised by HTM 01-05. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room, minimising the risk of contamination. The clinical areas had sealed flooring which was in good condition. Staff used the

same sink in the decontamination room for handwashing and instrument decontamination. HTM 01-05 recommends that separate, dedicated sinks should be used for handwashing and decontamination.

Sharps bins were appropriately located and out of the reach of children. We observed waste was separated into safe and lockable containers for regular disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. Discussions with staff members confirmed they were aware of items that were single use and that they were being disposed of in accordance with the manufacturers' instructions.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. The practice had an illuminated magnifying glass to improve the value of the inspection process. Staff wore appropriate personal protective equipment during the process and these included heavy duty gloves, disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and should be replaced on a weekly basis in line with HTM 01-05 guidance. Staff told us they were being replaced every two weeks.

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There appeared to be sufficient instruments available to ensure the services provided to patients were uninterrupted. Staff also confirmed this with us.

The dentist informed us that all general cleaning such as treatment room floors and other rooms in the building was carried out daily by the dental nurses. The practice followed the national colour coding scheme to some extent for cleaning materials and equipment in dental premises. This ensures that equipment used for cleaning is specific to the area that is being cleaned. However, the practice was using the same mop to clean the toilet and clinical areas. The dentist contacted us within two working days of the inspection to confirm that they had resolved this issue.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The dentist had not carried out any infection control audits. Without auditing their infection control processes, the practice could not assure themselves that they were fulfilling the requirements of HTM 01-05. The dentist sent us an action plan and this stated that the practice was due to complete an audit soon after the inspection.

Staff members were following the guidelines on running the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A risk assessment process for Legionella was carried out in December 2011 by an external agency. The risk assessment categorised the premises as low risk for developing Legionella. The dentist told us they were checking the water temperature on a weekly basis to check the temperature remained within the recommended range; however this was not documented. The risk assessment undertaken in 2011 did not specify a review date; however, this is usually two years for most premises. The provider contacted us within 48 hours and told us that another risk assessment had been carried out by an external contractor after our visit. We were told that the practice was safe with regard to Legionella but the report was not made available to us at the time of writing this report.

Equipment and medicines

Prescription medicines were stored securely and were dispensed by the dentist. Records of these were recorded in a log book and in patients' dental care records. This would allow a particular batch of medicine to be traced to a particular patient in the event of a safety recall or alert. There was a policy present for the safe disposal of prescription drugs.

The dentist told us they had maintenance contracts for essential equipment such as X-ray sets and the autoclave. However, these were unavailable to view around the time of the inspection. This is because the dentist paid fees for

an external company to manage the practice's contracts and online access to the contracts was not available. We saw evidence that the dentist held this contract and their subscribed membership included service contracts.

Portable appliance testing (PAT) was completed in October 2015 to confirm that portable electric items used at the practice were safe to use.

The practice protocol for ensuring that dental materials were within their expiry date required improvement as we found some dental materials had passed their expiry date. We were told that the dentist no longer used these dental materials as they had been replaced with others. However, the expired materials had not been disposed of to prevent their accidental use. We also found some instruments in the surgery drawer that had been used and sterilised although HTM 01-05 recommends they are single use items. We discussed this with the dentist and they were aware of the guidance. They assured us they had not used these instruments for years and that they were obsolete. They told us these instruments would be removed from the treatment rooms.

The batch numbers for local anaesthetics were recorded in dental care records.

Radiography (X-rays)

The dentist informed us that the practice had a radiation protection file but was unable to access it as they had membership with a company who retained this documentation. Therefore, they were unable to demonstrate that the practice was working in accordance with the ionising radiation guidance. The dentist contacted us within two working days after the inspection and sent us evidence of their contract with this company and this showed that their membership included a radiation protection service contract and X-ray inspections. The radiation protection service contract was valid until April 2017.

As a result, we were unable to review the service and maintenance history of the X-ray equipment. In addition to this, we did not see any evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

The provider told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the treatment room for all staff to reference if needed.

The practice had not carried out any X-ray audits prior to our visit. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. The dentist contacted us after the inspection and we saw evidence they had commenced an audit on X-rays immediately after the inspection. We saw evidence that X-rays were now being audited to ensure consistent good quality.

We saw that the X-ray equipment was fitted with a part called a collimator which is good practice as it reduces the radiation dose to the patient.

We did not see any evidence that the dentist was up to date with the required continuing professional development on radiation safety.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date comprehensive electronic dental care records. They contained information about patients' current dental needs and past treatment. The dentist carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in patients' oral health.

We talked to the dentist about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at dental care records. Clinical records included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. Medical history checks were updated every time patients attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was following the recommended guidance in adults and children. The dentist did not always record patients' individual risk to dental disease.

The dentist used other guidelines and research to improve their system of clinical risk management. For example, the dentist was fully aware of the National Institute for Health and Care Excellence (NICE) guidelines in relation to the referral of patients for the extraction of wisdom teeth. However, they needed to update their knowledge in respect of antibiotic prescribing and FGDP guidance on X-ray grading.

Patients were given a written treatment plan with clear estimate of costs to take away and sign before treatment commenced.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentist we spoke with and the patient records showed that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were posters and oral health promotion leaflets available in the practice to support patients look after their health. Examples included information on gum disease, children's teeth, diabetes and oral hygiene instructions.

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive fluoride applications to their teeth. Patients were given advice regarding the maintenance of good oral health and, if appropriate, were recalled at earlier intervals for hygiene treatment and support regarding general dental hygiene procedures. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Staff we spoke with confirmed they had been fully supported during their induction programme.

Staff told us they had good access to ongoing 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 and dental technicians. All clinical staff were registered with the GDC; however, the practice did not hold current GDC certificates for all staff.

The dentist monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that the part-time staff members were flexible and would carry out additional hours to cover duties for their colleagues when they were on annual leave.

Dental nurses were supervised and supported on a day to day basis by the dentist. Staff told us the dentist was readily available to speak to at all times for support and advice.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and

Are services effective?

(for example, treatment is effective)

specialist dental services for further investigations or specialist treatment. We viewed a referral letter and noted it was comprehensive to ensure the specialist service had all the relevant information required.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began.

Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) and how it was relevant to ensuring patients had the capacity to consent to dental treatment. The practice had a policy for the clinical management of adults who lack the capacity to consent. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. The 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 confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Patients were given time to consider and make informed decisions about which option they preferred. We saw evidence of customised treatment plans in the dental care records we reviewed.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Forty-three patients provided feedback about the practice. We looked at comment cards patients had completed before the inspection. The information from patients was very positive. Patients were positive about their experience and they commented that they were treated with care, respect and dignity. During the inspection, we saw and heard staff supporting patients on the telephone. In each case, staff were very friendly and respectful. Staff told us that many of the patients were longstanding and had built strong professional relationships over the years.

We were told that privacy and confidentiality were maintained at all times for patients who used the service. For example, the doors to treatment rooms remained closed during appointments. We observed staff were helpful and discreet to patients when speaking with patients on the telephone. Staff we spoke with were aware of the importance of providing patients with privacy. Staff said if a patient wished to speak in private an empty room would be found to speak with them. We were told that all staff had individual passwords for the computers where confidential patient information was stored. Staff told us they all logged out of the system whenever the computers were unattended.

The provider was a member of The National Phobics Society which is an organisation that helps support people affected by anxiety and phobias. The dentist told us they managed the care of nervous patients at the practice using various methods. This removed the need for the dentist to refer nervous patients to external dental practices for sedation or general anaesthetic. Conscious sedation involves techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The dentist's management of nervous patients is notable practice because it demonstrates compassionate care.

The computer system at the practice had a feature that enabled nervous patients to be identified quickly by all staff. This would enable staff to adapt their approach, if deemed appropriate and necessary.

We saw that patients were very complimentary and grateful to the practice for the dental care they received. We saw several cards addressed to the practice which thanked staff for their kindness and support. We also reviewed a book which contained patient testimonials.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available.

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 we found the premises and facilities were appropriate for the services that were planned and delivered. The premises were on the ground floor and there were toilet facilities for patients with disabilities.

We found the practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointment slots to accommodate urgent appointments. The practice would remain open until late evening, if required, to treat patients with emergency dental needs.

All patients could contact the dentist on their mobile telephone in the event of an emergency when the practice was closed. The dentist also had an arrangement with another local dental practice whereby patients could be seen for emergency dental treatment. Patient feedback confirmed they had sufficient time during their appointment and didn't feel rushed.

Feedback confirmed that patients were rarely kept waiting beyond their appointment time. Staff told us that most patients worked in the local business district and had very busy schedules. Therefore, the practice arranged the appointments accordingly.

Patient feedback confirmed that the practice was providing a service that met their needs. The practice offered patients a choice of treatment options to enable them to receive care and treatment to suit them. The practice sent appointment reminders by text message and email to all patients.

Tackling inequity and promoting equality

The practice had policies on disability and equal opportunities to support staff in understanding and meeting the needs of patients. The practice appeared to recognise the needs of different groups in the planning of its services. There were accessible toilet facilities and the reception desk was at a low level to make it more accessible for any patients using wheelchairs.

The practice did not have a hearing induction loop or information in Braille. The practice accommodated patients with hearing and visual impairments using alternative methods.

Access to the service

The practice's opening hours were from 10am to 5.30pm on Mondays, Tuesdays and Thursdays; from 8.30am to 5pm on a Wednesday; and from 8.30am to 4pm on a Friday.

The practice displayed its opening hours in the premises and on the practice website. Patients could access care and treatment in a timely way and the appointment system met their needs.

Concerns & complaints

No complaints had been received at the practice within the past 12 months.

The practice had a complaints process and staff were knowledgeable about how to handle a complaint. Staff told us they would raise any formal or informal comments or concerns with the provider to ensure responses were made in a timely manner.

The practice did not display their complaints policy in a prominent position for patients to view. Information on how to complain was available on request.

Are services well-led?

Our findings

Governance arrangements

During the course of the inspection we identified a number of issues where improvements were needed and which the practice's own systems had not identified. These included some safety related matters including some aspects of infection control, equipment and drugs for medical emergencies and staff knowledge surrounding safeguarding.

Regular audits are imperative for identifying any compromise in quality and/or safety. There were no audits in areas such as infection control, X-rays and record keeping.

The dentist was in charge of the day to day running of the practice. We saw there were some systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had some governance arrangements in place to ensure that those risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant. All staff were aware of whom to raise any issue with and told us the dentist was approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as an infection control lead.

Learning and improvement

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC).

We were told that all staff had appraisals where learning needs, concerns and aspirations could be discussed. These were ongoing and informal so the practice did not have any documentation of this.

Regular staff meetings were held where matters were discussed relating to the daily running of the practice. We noted that topics such as infection control had been discussed. We saw that these meetings took place every four weeks. Meetings were usually minuted and comprehensive. The minutes of the meetings were made available for all staff. This meant that staff members who were not present also had the information and all staff could update themselves at a later date.

At the time of the inspection, the practice had not carried out any recent audits in areas such as infection control, X-rays or record keeping. The dentist contacted us after the inspection and sent us evidence that they had commenced an X-ray audit immediately after the inspection. They also sent us an action plan with dates and details of when they would carry out audits in infection control and record keeping. The dentist had prioritised these and the action plans stated that all audits would be up to date within five weeks of the inspection.

The dentist did carry out audits in other clinical areas such as clinical waste audits and an ongoing audit of the causes for patients re-attending following treatment. This was good practice as it helped to identify any possible recurring problems. The dentist also logged actions taken to resolve issues and how to prevent problems from occurring in future.

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

Staff we spoke with told us that they felt supported and involved at the practice. The practice had systems in place to seek and act on feedback from patients. Examples included providing a particular magazine for the waiting room and the introduction of a private dental insurance plan. The practice website and social media sites also gave patients the opportunity to leave feedback. The practice did not undertake its own patient survey and there was no suggestion box available. The practice did carry out patient satisfaction surveys a few years ago but all comments have been either verbal or online (practice website) since then.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance How the regulation was not being met: The practice did not have effective systems in place to:- · Assess, monitor and improve the quality of the services provided by undertaking regular audits and formal appraisals of staff. · Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors by effective safeguarding protocols, annual training in medical emergencies and all medical emergency equipment and drugs are in line with current guidance. Regulation 17(1)(2)(a)(b)