Dr. John Graham Owen

Dr Graham Owens Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

We found that this practice was 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

Dr Graham Owens Dental Surgery is located in the London Borough of Westminster. The premises are situated on the ground floor of a building where other health care providers are also situated. There is one treatment room, a dedicated decontamination room, and a reception area. There is also a shared waiting room and patient toilets on the ground floor.

The practice provides private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges.

The staff structure of the practice consists of a locum dentist and locum nurse, and a practice manager who is also a trained dental nurse. The principal dentist (and owner) was not practicing at the location, at the time of our inspection, due to an unexpected prolonged absence.

The practice opening hours are on Monday, Tuesday, and Thursday from 9.30am to 6.00pm. The practice also opens occasionally on a Wednesday.

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

Summary of findings

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 inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Seven people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances. However, not all staff had received formal training in safeguarding vulnerable patients.
- Equipment, such as the air compressor, autoclave (steriliser), and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Staff knew how to report incidents and how to record details of these so that the practice could use this information for shared learning.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice did not have effective systems to reduce and minimise the risk and spread of infection.
- There was no formal recruitment policy, and not all relevant background checks had been carried out prior to staff employment.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The practice had not identified all of the additional training required for specialist roles, such as the training required for staff involved in the provision of conscious sedation.
- Governance arrangements were not robust; audits and risk assessments were not used effectively to drive improvements in the quality of the service.

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

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure the practice's infection control procedures and protocols meet current guidelines issued by the Department of Health - Health Technical Memorandum 01-05 Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Ensure the practice's protocols for conscious sedation are suitable giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.
- Ensure the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff.
- Ensure audits of various aspects of the service, such as infection control, radiography and dental care records, are undertaken at regular intervals to help improve the quality of service. The practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.

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

- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the use of risk assessments as a process for minimising risks to patients and staff.

Summary of findings

- Review stocks of medicines and equipment and establish a system for identifying, and disposing of out-of-date stock.
- Review the information contained within the Control of Substances Hazardous to Health (COSHH) Regulations 2002 file to ensure that it is up to date and all staff understand how to minimise risks associated with these substances.
- Review the storage of dental care records to ensure they are stored securely

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

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 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).

The practice had policies and protocols related to the safe running of the service. Staff were aware of these and were following them. The practice had effective systems for the management of medical emergencies and dental radiography. Equipment was well maintained and checked for effectiveness.

However, we also found that the practice did not have effective systems to reduce and minimise the risk and spread of infection. We noted that dental instruments were not being cleaned in line with relevant guidance and environmental cleaning was not being appropriately monitored.

We also noted the practice did not have a recruitment policy in place, and had not sought appropriate Disclosure and Barring Service (DBS) checks for all of the clinical staff, or kept a record in relation to the content of verbal references, employment history, or qualifications.

There were safeguarding policies in place which staff members understood. However, appropriate training in safeguarding for clinical staff who would be in contact with vulnerable adults and children had not been completed.

Are services effective?

We found that this practice was not providing effective 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 monitored patients' oral health and gave appropriate health promotion advice. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff had engaged in continuous professional development (CPD), but the practice did not have a system in place to review what training had been completed. The practice had not ensured that all staff, including locum and other visiting health care professionals, were suitably qualified to meet people's care and treatment needs. The provider did not offer appropriate supervision and appraisal for staff as is necessary to enable them to carry out the duties they are employed to perform.

Are services caring?

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

We received positive feedback from patients through comments cards, by speaking to patients on the day of the inspection, and by checking the results of the practice's patient satisfaction survey. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. However, we found that dental care records were not stored securely, although patient confidentiality was otherwise well maintained by staff who had a good awareness around this topic.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of people with disabilities had been considered and there was a portable ramp at the entrance providing access to the treatment room on the ground floor.

Summary of findings

There was a complaints policy in place and the practice staff were aware of the complaints procedures and assured us that they would act promptly to respond to any complaints that were received. No complaints had been received in the past year.

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 at the end of this report).

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with each other. The practice had some clinical governance and risk management structures in place. However, a system of audits was not used to monitor and improve performance. For example, there had not been an audit of the infection control processes to identify areas for improvement. Governance policies, such as those for staff recruitment, were not available. There was no system in place for carrying out formal appraisals of staff to discuss their role and identify additional training needs.

There was a lack of a clear leadership structure as the principal dentist had been absent, due to an unexpected prolonged absence, throughout 2015. The interim arrangements had not allowed for a clear line of responsibility as regards the governance of the practice, including processes for monitoring the quality of the service and driving improvements in the quality of care.

Dr Graham Owens 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 10 December 2015. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

During our inspection we reviewed policy documents and spoke with three members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The locum dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Seven people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents. There was a written policy and protocol for staff to follow for the reporting of incidents. We discussed the recording and reviewing of incidents with the locum dentist. They described what might constitute a significant event; no such incidents had occurred at the practice in the past year.

We found that one member of staff had been affected by an accident in the past month. They were able to demonstrate that action had been taken to prevent the accident from recurring. A mat, which had caused the staff member to trip, had been replaced. Improvements could be made to ensure improved recording of such incidents and accidents in the practice's accident reporting book. Staff were aware of the process for accident reporting, and had heard of, but did not fully understand, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The staff told us that they were committed to operating in an open and transparent manner; they told us they would always inform patients if anything had gone wrong and offer an apology in relation to this. Improvements could be made to increase staff awareness of their responsibilities under the Duty of Candour [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding policy which referred to national guidance and included local authority telephone numbers for escalating concerns that might need to be investigated. This information was held in a policies file stored in the reception area.

The locum dentist was able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

However, not all staff had received training in safeguarding adults and children to an appropriate level. The practice manager had completed their training in 2011 and this was now due for renewal; they subsequently sent us an email confirming that they had booked to attend a relevant course in January 2016. The locum nurse told us she had not completed any safeguarding training. The locum dentist told us they had completed safeguarding training in the past, but did not produce any documentary evidence in relation to this, and could not recall the date that the training was completed.

The practice had carried out some risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle-stick injuries. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to needle stick injuries. There was also a written risk assessment and associated risk-reduction protocol describing how to handle sharps with a view to preventing injury. However, this risk assessment did not describe the rationale behind the reasons why dental local anaesthetic syringes were to be recapped during patient treatment in accordance with EU Directive on safer sharps (2013). We discussed the current protocol for handling sharps with the locum dentist. A rubber needle guard was not used, and needles were re-sheathed by the dentist using a one-handed scooping technique. We noted that the nurse was currently responsible for dismantling and disposing of the needles.

We also checked whether the practice followed other national guidance on patient safety. For example, we checked how the practice treated the use of instruments which were used during root canal treatment. The locum dentist told us that they rarely carried out this type of treatment, and generally referred patients to other providers for root canal treatment. They told us that when they did carry out root canal treatment they always used a rubber dam in line with guidance supplied by the British Endodontic Society. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.] However, when we viewed the rubber dam kit stored at the practice, we found that it was out of date and not fit for use. The practice manager told us this equipment belonged to a visiting endodontist who was no longer associated with the practice. They would be ordering and replacing the kit as soon as possible.

Are services safe?

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED). [An AED is a portable electronic device that analyses life-threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.] There was also an oxygen cylinder for use in an emergency. Staff were aware of the location of these and could demonstrate how they were used.

The practice held the majority of emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. However, we found that midazolam was not present, although an alternative (diazepam) was. We discussed this with the locum dentist and practice manager. They assured us that the correct medicine would be ordered for the kit.

The expiry dates of medicines, oxygen and equipment had not been appropriately monitored to enable the staff to replace out-of-date drugs and equipment promptly. We found that some items of equipment, such as the set of differently sized oropharyngeal airways, were out of date and needed replacing.

Staff told us that they had received training in responding to medical emergencies within the past year; we were only provided documents confirming this for the practice manager. The locum dentist subsequently sent us evidence via email confirming that they had completed training in responding to emergencies in November 2014, indicating that this was now due for renewal.

Staff recruitment

The staff structure of the practice consists of a locum dentist and locum nurse, and a practice manager who is also a trained dental nurse. The principal dentist was not practicing at the location, at the time of our inspection, due to an unexpected prolonged absence.

The locum dentist had started working at the practice early in 2015. The locum nurse, that we spoke with on the day of the inspection, had worked intermittently at the practice since September 2015. Other locum nurses had also been engaged to work at the practice since that time. The practice manager had been employed at the practice for over 15 years.

There was no formal recruitment policy for the practice to follow during any recruitment process. There were a limited number of checks carried out to ensure that the people being recruited were suitable and competent for their.

The practice held a copy of the terms and conditions for the agency who had supplied the dental nurse. This stated that all relevant checks for the dental nurse would be secured prior to her starting work at the practice. However, the locum dentist had been appointed directly by the owners and had not been referred through an agency, and had not been subject to a formal recruitment process prior to employment. The locum dentist had only been asked for a copy of his professional registration with the General Dental Council (GDC) and professional insurance status, and no other checks had been carried out. We saw that relevant qualifications for this dentist were displayed at the practice. The dentist told us they had met with the owners for an informal interview and that they had provided a verbal reference. A relevant check of medical history, in the form of an immunisation record, had also been obtained. However, there was no formal application form, copy of employment history, or check of identity.

We found that the practice manager had a Disclosure and Barring Service (DBS) check carried out in 2011. The recruitment agency used to supply the locum dental nurse had provided the practice with written assurance that a DBS check had been carried out. The locum dentist told us that the practice had not requested they complete a DBS check prior to employment, but that such a check had been carried out during the course of their work with other providers.

Some patients required conscious sedation (a combination of medicines to help a patient to relax (a sedative) and to block pain (an anaesthetic) during a medical or dental procedure. The patient remains awake during the whole procedure) as part of their treatment. The practice used a visiting medical anaesthetist to provide this service. The practice did not have a written agreement in place to provide assurance that the visiting professional was offering services in accordance with current guidelines. Records were not held at the practice in relation to the suitability of the anaesthetist for the role, including relevant background checks and provision of evidence regarding current qualifications.

Monitoring health & safety and responding to risks

Are services safe?

There were some arrangements in place to deal with foreseeable emergencies. The premises freeholder was responsible for assessing the premises for risk of fire, and fire extinguishers were placed throughout the building. Staff told us they were regularly engaged in fire drills. However, there had been no practice-wide risk assessment to identify and minimise health and safety risks. We noted that there had been a recent staff accident involving a trip hazard. This could potentially have been identified and prevented through the use of a regular and appropriate risk assessment process.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted that a review of COSHH substances in use at the practice had not been carried out for over a year.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice manager via email. These were disseminated to staff, where appropriate.

There were informal arrangements for the practices' patients to be seen by other dental practices in the same building, or on the same street, should the premises become unfit for use. There was also an address book with key contacts, for example, for the servicing of electrics or plumbing, which could be referred to in the event of service failures. However, not all emergency arrangements had been considered. For example, the practice relied on a paper appointments book with no other back up.

Infection control

There were systems in place to reduce the risk and spread of infection within the practice, but not all of these were in accordance with current guidance on 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)'.

There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. However, the practice had not carried out any practice-wide infection control audits; these are recommended to be carried out every six months with a view to monitoring the effectiveness of infection control protocols and driving improvements in performance.

We observed that the premises appeared clean, tidy and clutter free. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment room, and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the locum nurse to describe to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. This included ensuring that the working surfaces, dental unit and dental chair were cleaned, as well as the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

A Legionella risk assessment had been carried out by an external contractor in July 2014 (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The risk assessment found that no further actions were required to minimise the risks associated with the potential development of Legionella. However, on the day of the inspection we found that some, but not all, of the dental water lines were maintained to prevent the growth and spread of Legionella bacteria. The dental nurse described the method they used which was to flush the '3 in 1' line at the start of each day; other lines were not flushed in line with current HTM 01-05 guidelines.

The practice used a decontamination room for instrument processing. We observed the locum nurse carrying out the process for decontamination of instruments. The dirty instruments were transported in an open tray into the decontamination area, which was adjacent to the dental

chair. However, improvements could be made by undertaking a risk assessment and completing an associated written protocol to ensure that all staff were aware of the correct procedures to follow.

Items were then placed in solution in a 'dirty' box in the decontamination room. Instruments were then manually scrubbed in the solution in the dirty box. The temperature of the water was not checked. We also noted that a wire brush was used for manual cleaning as well as a soft-bristle brush. There was only one sink in the decontamination room, precluding the use of a separate rinsing sink. We observed the nurse carrying out the cleaning process and noted that a separate bowl for rinsing items was not used.

Items were inspected under a light and magnification before being placed in an ultrasonic cleaner. The items were not rinsed in a separate bowl after being removed from the cleaner. They were also not dried with a cloth. Items were pouched prior to being placed in a vacuum autoclave (steriliser). When instruments had been sterilized, they were stored appropriately, until required. All pouches were dated with a date of sterilisation and an expiry date.

We discussed this process with the locum dentist and practice manager. They agreed to implement the correct procedures immediately and sent us a follow-up email to confirm that this was the case.

We saw that there were systems in place to ensure that the autoclaves were working effectively. These included the automatic control test and steam penetration test. However, it was observed that the practice needed to ensure that the first autoclave test was carried out without instruments. We also found that the protein test check for the ultrasonic cleaner had not been appropriately recorded since October 2015, but there was some indication that the tests had been carried out without a date record.

The segregation and storage of dental waste was mostly in line with current guidelines laid down by the Department of Health. We observed clinical waste bags and municipal waste were properly stored. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection. Improvements could be made to ensure the sharps bins were appropriately labelled, giving the details of who had assembled the bin and the date. These are required for the purpose of backwards tracing and identification, if necessary, by the waste contractor.

Environmental cleaning was carried out at the end of each day. There was a checklist protocol in the staff policy file. The locum nurse was responsible for environmental cleaning. They were not aware of this protocol and had followed their own procedures. This had led to some confusion as to what was required to be cleaned and when.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the autoclave had been serviced and calibrated in June 2015. The pressure vessels had been checked and serviced in September 2015. Certificates for this equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) for all electrical appliances had also been carried out in January 2014.

We checked a sample of dental care records to confirm our findings and noted that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients.

We found that a range of out-of-date products had been kept in a store cupboard. There was no system in place for the regular monitoring of stock expiry dates. However, we noted that the out-of-date items were clearly not in use as there were also in-date items stocked in the treatment room. The out-of-date items were appropriately disposed of on the day of the inspection.

Radiography (X-rays)

Documentation related to radiation protection was available in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This paperwork included the details of an external company who were acting as the

Are services safe?

Radiation Protection Advisor. However, there was no named Radiation Protection Supervisor at the practice on the day of the inspection. The locum dentist subsequently agreed to act in this role and was qualified to do so.

The other documents seen included the critical examination packs for the X-ray set along with the three-yearly maintenance logs. The maintenance log was within the current recommended interval of three years. The locum dentist told us that they had completed X-ray training as part of their continuing professional development, and sent us confirmation via email that they had renewed their training in the week after the inspection. There was a copy of the local rules, although this was incomplete on the day of the inspection due to the lack of a Radiation Protection Supervisor.

The practice had kept a record of quality check for each X-ray taken to demonstrate that the dental X-rays were graded and quality assured every time. However, there was no audit, for example, of image quality, which systematically analysed the quality of X-rays and identified areas for improvement. We checked some dental care records and found that these contained a written justification for why X-rays were being taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist working at the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The dentist described to us how they carried out their assessment. The assessment began with the patient providing a verbal update to their medical history and completing a written update on an annual basis. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A letter was subsequently sent to the patient which described the consultation and proposed treatment plan, as well as the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out where appropriate during a dental health assessment.

We checked the dental care records for one patient who had recently undergone conscious sedation. We found that the patient had had important checks prior to, and during, sedation. The processes carried out were in line with current good practice guidelines demonstrating that sedation was carried out in a safe and effective way. However, the dental nurse assisting in this procedure had not had additional relevant training in assisting during conscious sedation required for this type of procedure.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and dietary advice. The dentist also carried out examinations to check for the early signs of oral cancer.

The waiting room and reception area at the practice contained some literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The dentist told us they also referred their patients to online information about managing their oral health.

Staffing

Staff told us they received appropriate professional development and training. We viewed documents available on the day of the inspection, and staff sent us some further evidence via email after the inspection related to training courses. The locum dentist, locum nurse and practice manager told us that the training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, infection control and X-ray training.

There was no systematic induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. There were some informal processes which ensured that new staff were aware of some policies and protocols. However, we found that these had not been fully effective. For example, the locum nurse was not aware of the environmental cleaning checklist or the appropriate equipment to use for this process.

The practice manager was the only full-time member of staff at the time of the inspection. They had not been engaged in an appraisal process which reviewed their performance and identified their training and development needs.

An anaesthetist visited the practice to provide conscious sedation, but the practice had no formal contract with the visiting health professional, and had not requested information or assurance as regarding their continuing professional development. We also found that neither the practice manager or the locum nurse had relevant training in conscious sedation which would enable them to safely assist during any treatments done under sedation.

Are services effective?

(for example, treatment is effective)

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals were made to other dental specialists when required.

The dentist explained how they worked with other services, when required. They were able to refer patients to a range of specialists if the treatment required was not provided by the practice. For example, the practice referred patients for specialist endodontic and implants treatments. They also had systems in place for accessing emergency care for cases of suspected oral cancer. Copies of referral letters were kept with the patient's dental care records. The dentist kept a written log of all referrals that had been made so that they could monitor whether the treatment had been received and provide all necessary post-procedure care in a timely manner.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

The dentist was aware of the requirements under the Mental Capacity Act 2005. 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. The dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from seven patients. They described a positive view of the service. The practice had also carried a patient survey throughout 2015 and received twenty-five responses. The results of the survey indicated a high level of satisfaction with care. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly. The staff we spoke with were mindful about treating patients in a respectful and caring way.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment room was situated away from the main waiting area. Conversations between patients and dentists could not be heard from outside the treatment area, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and described strategies for ensuring that patients' dental care records were not seen by other people. For example, they were face down on the reception desk when in use, or filed away behind the desk. Patients' dental care records were stored in a paper format. We observed that the notes were not stored in a locked filing cabinet to further reduce the risk of patient data being inappropriately accessed.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the private dental charges or fees. There were a range of information leaflets available at the practice which described the different types of dental treatments available.

We spoke with the locum dentist, locum nurse and practice manager on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, through speaking with patients on the day of the inspection, and reviewing the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The dentist decided on the length of time needed for their patients' consultation and treatment. The dentist told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

During our inspection we looked at examples of information available to people. Improvements could be made to ensure suitable information was made available to help people understand the services on offer. There was a display in the waiting area concerning the fees for different treatment. However, at the time of the inspection, there was no up-to-date leaflet, or other printed document, available for new patients to refer to. We discussed this with the practice manager who told us they provided a more personalised approach to providing information. They regularly phoned patients to discuss any queries or concerns about the services offered by the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice manager told us the service provision was predominantly to an English-speaking population. However, some patients had attended with their own translators, and they could offer to arrange for translation services, if necessary. They were also able to provide large print, written information for people who were hard of hearing or visually impaired. The practice was wheelchair accessible with portable ramp in use at the entrance. There was also a disabled toilet on the ground floor.

Access to the service

The practice opening hours were on Monday, Tuesday, and Thursday from 9.30am to 6.00pm. The practice also opened occasionally on a Wednesday.

The practice manager told us that there were always appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could get an appointment when they needed one. The practice manager told us that they aimed to respond to their patients' needs in terms of timings of appointments and would arrange to see patients at a time suitable for them.

The dentist told us they always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case. The appointment schedules showed that patients were given adequate time slots for appointments of varying complexity of treatment.

The practice manager also told us that the practice phone line was redirected to a member of staff's mobile phone when the practice was shut. Therefore, they could respond to patients who had urgent care needs at any time. They either arranged for them to see an alternative provider or organised to open the treatment room for an emergency appointment.

Concerns & complaints

The practice manager told us that if patients wanted to make a complaint then they printed out the formal complaints policy to describe the process. We checked the complaints policy. This described how the practice handled formal and informal complaints from patients. There had not been any complaints recorded in the past year. We noted that the policy stated that a record would be kept of what had occurred and actions taken at the time to address the problem; a timeline for responding to complaints was also provided. Staff told us that they would discuss complaints as they arose with a view to learning and preventing further occurrences.

Are services well-led?

Our findings

Governance arrangements

The practice did not have a clear management structure at the time of the inspection due to the principal dentist's absence, due to an unexpected prolonged absence, throughout 2015.

There were relevant policies and procedures in place. Staff were usually aware of these policies and procedures and acted in line with them. However, we found examples where staff were unaware of relevant protocols, such as those for environmental cleaning.

There were also limited arrangements for identifying, recording and managing risks through the use of risk assessments, audits, and monitoring tools. For example, staff could not find any evidence of an infection control audit having been carried out in the past year. Typically infection control audits are completed every six months in order to monitor the effectiveness of infection control protocols with a view to keeping staff and patients safe. There had also not been an X-ray audit or an audit of the dental care records. This meant that systems for identifying potential problems and concerns were not robust.

There was a COSHH Regulations (2002) file available at the time of the inspection, but this had not been kept up to date meaning that the actions needed to minimise the risks associated with hazardous substances had not been disseminated effectively amongst staff. Although there was a written sharps protocol, the dentist was not aware of it, and it did not explain why dental local anaesthetic syringes were to be recapped during patient treatment instead of safer sharps being used.

There was also no written recruitment policy, and we found that relevant background checks for new members of staff had not been carried out. All of these documents and assessments relate to minimising risk with a view to keeping patients and staff safe.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty.

The dental nurse told us they were comfortable about raising concerns with the locum dentist. They felt they were listened to and responded to when they did so. They told us they enjoyed their work and were well supported by the dentist.

The principal dentist had not been working at the practice throughout 2015, and had not notified the Care Quality Commission (CQC) of their prolonged absence. We noted a lack of a clear leadership structure and it was unclear who was responsible for monitoring the good governance of the practice and driving improvements in the quality of the service provision. As a result, systems for monitoring quality and managing staff were not effective. For example, there was no system of staff appraisals to identify career goals and aspirations, or for managing concerns with staff performance.

Learning and improvement

Staff told us they engaged in continuing professional development (CPD), in line with standards set by the General Dental Council (GDC). However, we found that there were not effective systems for monitoring whether or not staff had completed such training or for improving the quality and safety of the service through a process of staff induction, monitoring of performance, use of audit or staff meetings.

There was a provisional plan for improving the management of the service via the sale of the practice to a new provider. However, the interim arrangements during the provider's absence had not allowed for a process of continuous improvement to take place.

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

The practice gathered feedback from patients through the use of a satisfaction survey which ran throughout the year. The majority of feedback had been positive and did not require further action. Staff feedback was also obtained on an ad hoc basis throughout the daily work at the practice. More formal staff meetings, with written minutes, were not held. Due to the lack of clarity regarding governance arrangements, it was unclear who staff should refer their feedback to.

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: The provider did not have systems to enable them to continually monitor risks, and to take appropriate action to mitigate risks, relating to the health, safety and welfare of patients and staff. This included, but was not limited to, the procedures in place for infection control. The provider had also not ensured that their audit and governance systems were effective. Regulation 17 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure that staff were suitably qualified to meet people's care and treatment needs. The provider did not offer appropriate supervision and appraisal for staff as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider did not have an effective recruitment procedure in place to assess the suitability of staff for their role. Not all the specified information (Schedule 3) relating to persons employed at the practice was obtained.

Regulation 19 (1) (2) (3)