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Ashby Fields Dental Centre

Inspection Report

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Overall summary

We carried out this announced inspection on 1 April 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

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

Ashby Fields Dental Practice is in Daventry, a town in western Northamptonshire. It provides NHS treatment to patients exempt from payment and private treatment to adults and children.

Services provided include general dental services, implants, orthodontics and cosmetic procedures.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including those for blue badge holders, are available in a free public car park in front of the premises.

Summary of findings

The dental team includes five dentists, three dental nurses, two trainee dental nurses, one dental hygiene therapist and four receptionists, (one of the receptionists also works as a dental nurse).

Two practice managers share administrative duties.

The practice has five treatment rooms; all of which are on ground floor level. The provider has a refurbishment plan for the premises. This includes updates to surgeries, replacement furniture and a new floor in the decontamination room.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we collected 37 CQC comment cards filled in by patients.

During the inspection we spoke with two dentists, two trainee dental nurses, two receptionists and the practice managers. We looked at practice policies and procedures, patient feedback and other records about how the service is managed.

The practice is open: Monday from 9am to 6pm, Tuesday, Wednesday and Thursday from 9am to 5.30pm, Friday from 9am to 5pm.

Our key findings were:

- The practice appeared clean and generally well maintained.
- The provider had infection control procedures which reflected published guidance. We identified exceptions as we were not assured that all staff were made aware of and complied with processes regarding dental work being disinfected prior to it being sent to a dental laboratory or before treatment was completed. Not all staff demonstrated they had completed regular update training.
- Staff knew how to deal with emergencies. Appropriate medicines but not all life-saving equipment were available such as oropharyngeal airways and some of the sizes of clear face masks for self-inflating bag. We were told these had been ordered after the day.
- The practice's systems to help them manage risk to patients and staff required review as some were ineffective. Potential hazards were not mitigated in relation to legionella.
- The provider had safeguarding processes but not all staff were aware of their responsibilities for safeguarding vulnerable adults and children and reporting procedures.
- The provider had staff recruitment procedures. We found these required improvement, particularly in relation to agency staff.
- The clinical staff provided patients' care and treatment in line with current guidelines. We noted exceptions where guidelines were not always followed.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider dealt with complaints positively and efficiently.
- Governance arrangements required strengthening. Not all risks arising from the undertaking of the regulated activities had been suitably identified and mitigated.

We identified a regulation the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review the practice's protocols and procedures for the use of rectangular collimators fitted to X-ray machines to reduce radiation dose to patients.
- Review guidance regarding basic periodontal examination (BPE) from the British Society of Periodontology.

Summary of findings

- Review the practice's protocols for domiciliary visits taking into account the 2009 guidelines published by British Society for Disability and Oral Health in the document "Guidelines for the Delivery of a Domiciliary Oral Healthcare Service".
- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice systems and processes to provide safe care and treatment were not always operating effectively. Incident reporting had recently been implemented and as a result, no incidents had been formally reported or documented. Whilst staff had reported accidents and there was evidence that they were investigated, we did not see that learning was shared amongst them to prevent their recurrence.

We did not view evidence to show that all staff had received training in safeguarding people to the recommended level to manage safeguarding concerns.

Staff were qualified for their roles and the practice completed most essential recruitment checks. The practice did not confirm that agency staff had received all relevant recruitment checks.

Not all risks were addressed, for example, fire, legionella and lone working arrangements.

Equipment was clean and properly maintained. The practice generally followed national guidance for cleaning, sterilising and storing dental instruments with some exceptions.

The practice had some suitable arrangements for dealing with medical and other emergencies. We noted that some equipment was missing.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. We noted there was scope for improvement in relation to following some aspects of best practice guidance.

Patients described the treatment they received as professional, first class and efficient. The dentists told us they discussed treatment with patients so they could give informed consent. Patient comments also supported this. Conversations about treatment between the dentist and patients were not always documented in their records however.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

Summary of findings

We found that monitoring arrangements for staff training and appraisals required improvement as we were unable to check all staff continuing professional development and some staff were overdue an appraisal.

Are services caring?

No action

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

We received feedback about the practice from 37 people. Patients were positive about all aspects of the service the practice provided. They told us staff were caring, reassuring and welcoming.

Patients said that they were given helpful and informative explanations about dental treatment, and said their dentist listened to them. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

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

The practice's appointment system took account of patients' needs. Patients could get an appointment quickly if in pain.

Staff considered some of their patients' different needs. The practice had made some reasonable adjustments for patients with disabilities. These included step free access, a magnification device at reception and accessible toilet with hand rails but not a call bell. The practice did not have a hearing loop to aid patients with hearing aids. Not all staff were aware that there was access to an interpreter service available.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

Requirements notice

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

We found that improvements were required in the management of the service. The provider did not demonstrate that they were effectively addressing all risks when delivering the service.

Following our visit, the practice demonstrated a proactive approach in rectifying some of the shortfalls we identified.

The practice had quality assurance processes to encourage learning and continuous improvement. We found there was scope to improve audit processes.

Summary of findings

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.	

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had some systems to keep patients safe; we found areas that required review.

The practice manager we spoke with demonstrated their understanding of safeguarding processes and provided a detailed example involving a patient safeguarding concern.

Not all staff we spoke with showed awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances however. One of the clinicians told us they would refer concerns to the practice managers. They said they did not recall seeing contact information for local safeguarding teams, or know where to check for this.

The practice had safeguarding policies to provide staff with information about identifying, reporting and dealing with suspected abuse. The principal dentist was the nominated lead for safeguarding.

We saw evidence that staff received suitable safeguarding training, although this was not available for all staff on the day. We were not shown evidence that one dentist had completed training to level two (the recommended level) and we were not provided with documentation to show that another dentist had completed safeguarding training, as their file was not available on the day. Following our visit, we were sent certificates for both the dentists who had recently completed the training.

Practice management were not specifically aware that notification to the CQC was required in the event of a safeguarding referral.

The practice had a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who required other support such as with mobility or communication. Pop up notes could be created on the practice's computer system to inform staff about patients with any concerns.

The practice had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. One of the dentists told us they used latex only rubber dams; we discussed with the dentist about ensuring information was obtained from the patient about any latex allergy.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. The practice had an agreement with another practice that could be used in the event of the premises becoming unusable.

The practice had a recruitment policy to help them employ suitable staff.

We looked at four staff recruitment records to ascertain if they complied with legislative requirements. We found that photographic identity was not held on one staff member's file; this was obtained later on the day of inspection and added to their file. We also found there was no evidence of references or other evidence of satisfactory conduct in previous employment on one clinical staff member's file.

The practice had not received assurance that suitable checks were made for agency staff when they worked in the practice.

We checked that clinical staff were qualified and registered with the General Dental Council (GDC) and saw that most had professional indemnity cover. One of the dentist's files we looked at did not contain evidence of up to date indemnity (expired February 2019) and another dentist did not have up to date GDC registration noted in their record. GDC registration information was obtained on the day of our visit and added to their record.

The practice ensured that equipment was safe and maintained according to manufacturers' instructions including portable electrical items and gas appliances. Evidence of five-year fixed wiring testing was not provided to us on the day, but a certificate was located afterwards and sent to us.

Are services safe?

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were serviced. We looked at documentation dated within the previous 12 months.

The practice had mostly suitable arrangements to ensure the safety of the X-ray equipment. We noted that most X-ray equipment was not fitted with rectangular collimators to reduce the dosage to patients. The practice had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation. We looked at the latest audit in January 2019; we found there was scope to improve audit to include details of each of the dentists.

We saw that clinical staff completed continuing professional development (CPD) in respect of dental radiography. One of the dentists did not provide their training record on the day of our inspection; we were provided with their certificate after the inspection; this was dated 3 April 2019.

Risks to patients

The systems to assess, monitor and manage risks to patient safety required improvement; not all risks were effectively addressed.

We noted that a fire risk assessment had not been undertaken. A generic template assessment was held; this was not specific to the practice's risks. Following our inspection, the provider sent us information to show that an external assessment had been booked for 15 April 2019.

The practice last completed a fire evacuation rehearsal around 12 months ago. Whilst staff had discussed what they would do in the event of an emergency in January 2019, the practice would benefit from undertaking a further rehearsal.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The dentists used traditional needles, these were not the safest type. We were told that the dentists used a needle guard, if they preferred to when handling needles. We were informed that qualified dental nurses might handle used needles and dismantle matrix bands.

A risk assessment had not been undertaken to identify sharps risks. The practice manager told us that they had recently placed an order for the safest type of needles and staff would attempt to use these, when received. Following our inspection, we were provided with a sharps risk assessment that was completed on 3 April 2019. The risk assessment was generic and required personalisation to practice specific risks.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked in relation to most staff. We noted that one of the dentists and the hygienist did not have the effectiveness of the vaccination recorded. A risk assessment had not been completed for these staff at the time of our inspection.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year.

Emergency medicines were available as described in recognised guidance. We noted some exceptions in relation to equipment held. For example, sizes 0, 4 oropharyngeal airways and some sizes of clear face masks for self-inflating bag were not held. We were told after the inspection that these had been ordered.

The portable oxygen cylinder integral valve cylinder contained 340 litres (l) and not 460 (l) which would ensure an adequate flow rate. The practice manager showed us an order that had been placed just prior to the inspection for a new portable oxygen cylinder 460 (l). We were not provided with servicing documentation for the emergency oxygen cylinder.

We also noted that syringes might not be suitable for use, due to their large size.

Staff kept records of their checks of medicines and equipment on a monthly basis and oxygen and AED were checked daily.

A dental nurse worked with the dentists and the hygiene therapist when they treated patients in line with GDC Standards for the Dental Team.

Are services safe?

The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. Whilst the practice had a file that contained information, we found this was not structured and information required might not be found quickly in the event of an incident occurring. Cleaning products that were used by the cleaner did not have risk assessments recorded. The cleaner worked alone in the premises, a lone worker assessment had not been completed. A lone worker risk assessment was completed and provided to us after the day.

The practice occasionally used agency staff. We noted that these staff received an induction to ensure that they were familiar with the practice's procedures.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. We saw that some staff completed infection prevention and control training and updates. We noted that two of the dentists did not have sufficient evidence of this CPD training on their records. Another of the dentists had not provided their training file for us to view on the day; evidence of this dentist's training in this area was sent to us after the inspection, and was undertaken on 4 April 2019.

The practice had generally suitable arrangements for transporting, cleaning, checking and sterilising instruments in line with HTM 01-05. Staff undertaking decontamination duties had use of a foam cleaning solution; this presented a risk of needlestick injury as the solution restricted staff vision.

We found storage arrangements for some items required review. We found some were stored loosely in surgery drawers, for example, local anaesthetic, cotton wool rolls and prophy brushes, which risked aerosol contamination.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

The practice needed to ensure that all dental nurses were aware of the processes to follow regarding lab work being disinfected prior to it being sent to a dental laboratory or before treatment was completed. Our discussions with two dental nurses showed that they had not followed appropriate decontamination procedures. A copy of the infection control policy was displayed in each surgery that contained this information.

The practice had limited procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A risk assessment had been completed in September 2017. We noted that recommendations made had not been actioned. For example, assigning a lead for legionella, producing a written scheme and undertaking water temperature testing. Following our inspection, we were provided with logs that had started to be completed for water temperature testing in April 2019. The record showed that the hot water tap in two surgeries was dispensing at 49 degrees. The practice manager advised us after the inspection that a plumber had been booked to attend the premises to provide advice to them.

The practice did not undertake dip slide testing as recommended in national guidance. The practice manager told us that dip slides had been ordered after the day. Dental unit water line management was in place. However, there were inconsistencies in the processes staff were following.

One of the members of staff undertook cleaning of the general areas of the practice. We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored in line with guidance.

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards. We identified issues not shown in the audit such as flooring in the surgery rooms not being satisfactorily sealed at the edges and a spittoon that appeared unclean.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and

Are services safe?

managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The provider had mostly reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The practice stored and kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines. The practice dispensed antibiotics and we found that the practice name and address were not included on the boxes dispensed.

Track record on safety and Lessons learned and improvements

The provider did not demonstrate that they had undertaken appropriate risk assessments in relation to a number of safety issues, for example, legionella, sharps and lone working.

There was an accident book held in the practice. We noted three accidents reported in the previous 12 months. Whilst the records demonstrated that action had been taken to report and investigate the issues, we did not view formal records to demonstrate that lessons learned were shared amongst all staff. The practice manager communicated with staff using a social media application. We saw some information on the app to demonstrate that preventative measures had been deployed following a staff member slipping on the floor.

There was a newly implemented procedure regarding significant events. This had not yet been subject to discussion with staff. The practice manager told us that they had not identified any incidents within the past 12 months. During our discussions with the practice manager, they stated that they could think of some incidents that had occurred but had not been formally reported or investigated.

There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. These were acted upon if required, but not discussed with all staff to make them aware.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received positive comments from patients about the effectiveness of treatment and information provided to them during the course of their care received.

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. We did however note some exceptions where guidance had not always been followed.

The provider occasionally undertook domiciliary visits for patients who were physically unable to attend the premises. Whilst treatments provided were low risk, the provider was not specifically aware of guidelines as set out by the British Society for Disability and Oral Health. For example, risk assessment of premises and equipment to take.

The practice offered dental implants. These were placed by one of the dentists at the practice who had undergone appropriate post-graduate training in this speciality. The provision of dental implants was in accordance with national guidance.

The practice had access to some technology available in the practice for example, an intra-oral camera to enhance the delivery of care.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. The provider was committed to providing preventative oral hygiene advice and support; they utilised the skills of a dental hygiene therapist.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay.

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice was aware of national oral health campaigns in supporting patients to live healthier lives. Those patients seeking smoking cessation support were referred to their GP or to NHS stop smoking services.

The practice provided health promotion leaflets to help patients with their oral health.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. Two dentists we spoke with told us that they undertook basic periodontal examinations for young people from the age of 12 or 14 to 15 and not the age of seven, as recommended in guidance. Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining patients' consent to treatment. We were provided with an example of a patient consent form for their direct access with the dental hygienist.

The sample of patients' records that we reviewed did not always demonstrate that they were given information about treatment options and the risks and benefits of these so they could make informed decisions, however. Patients told us that their dentist listened to them and gave them clear information about their treatment. One patient comment included that their dentist was detailed in their responses to questions asked and this made them feel valued and respected.

The practice's consent policy did not include information about the Mental Capacity Act 2005. We found there was scope to improve the team's understanding of their responsibilities under the Act when treating adults who might not be able to make informed decisions. Following the inspection, we were sent an updated patient consent policy which referred to the Act, although it was not specifically mentioned.

We found there was scope to improve the team's awareness of Gillick competence, and the need to consider this when treating young people under 16 years of age.

Are services effective?

(for example, treatment is effective)

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept generally detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories.

We saw the practice audited patients' dental care records to check that the clinicians recorded the necessary information.

Effective staffing

We noted examples whereby staff had the skills, knowledge and experience to carry out their roles. For example, one of the dentists was skilled to place dental implants. Two of the dentists had undertaken training in restorative dentistry.

Staff new to the practice had a period of induction based on a programme. We confirmed that most clinical staff completed the continuing professional development required for their registration with the General Dental Council. On the day of inspection, one of the dentist's training records were not held for our review.

We were informed that staff discussed their training needs at annual appraisals and one to one meetings. We found that some staff were overdue an appraisal. For example, two receptionists had last received an appraisal in June 2016, three dental nurses had last received an appraisal in July 2016 and a record was not provided to us for another dental nurse who started work in the practice in 2011. One of the practice managers was also due an appraisal; a record was not provided to us to show when they last received an appraisal.

We saw evidence of completed appraisals for some of the team and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. We noted that patients did not receive a copy of their referral letter.

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were caring, reassuring and welcoming. We saw that staff treated patients respectfully and appropriately and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. Patients could choose whether they saw a male or female dentist when they first attended the practice.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

A selection of magazines and toys was provided for patients and families.

We looked at feedback left on the NHS Choices website. We noted that the practice had received five out of five stars overall based on patient experience on two occasions. Both reviews were positive about the caring nature of the dentists.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and the waiting areas provided some privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff told us they could speak with them in a private area. We were provided with an example of when this had occurred recently. There was a room at the rear of the reception area and staff had been provided with a portable headset so they could speak with patients on the telephone without being overheard.

The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

Staff told us how they helped patients make decisions about their care. We looked at how the practice complied with the requirements under the Equality Act and Accessible Information Standard. (A requirement to make sure that patients and their carers can access and understand the information they are given):

- Not all staff were aware of interpreter services available. A staff member told us that google translate was used and a patient who did not speak English might bring a friend or family member. This could present a risk of miscommunications / misunderstandings between staff and patients.
- Staff told us they tried to communicate with patients in a way that they could understand. Clini-pads were used by patients, the screen could be expanded to help those with sight problems.

Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them.

The practice's website provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, models, X-ray images and an intra-oral camera. These helped the patient/relative better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of most patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care. We were provided with specific examples of how the practice met the needs of more vulnerable members of society such as patients living with dementia, autism and other long-term health conditions.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made some reasonable adjustments for patients with disabilities. These included step free access, a magnification device at reception and accessible toilet with hand rails but not a call bell. The practice did not have a hearing loop.

Staff described an example of a patient who was not registered at the practice and found it unsettling to wait in the waiting room before an appointment. The staff member reassured them prior to their appointment, which was allocated for them on the same day of their initial visit.

Staff contacted patients two weeks and two days before their appointment to remind them to attend.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their information leaflet and on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were triaged and seen the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept unduly waiting.

The staff took part in an emergency on-call arrangement with some other local practices for patients who received treatment privately. NHS patients were re-directed to contact NHS 111 outside of usual opening hours.

The practice's website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily and were not often kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The practice managers were responsible for dealing with these. Staff would tell the practice managers or principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The practice managers aimed to settle complaints in-house and told us they would invite patients to speak with them in person to discuss these, if appropriate. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received within the previous 12 months.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The clinical team had the capacity and skills to deliver high-quality, sustainable care. We found that improvements were required in the management of the service. The provider did not demonstrate that they were effectively addressing all risks when delivering the service.

Following our visit, the practice demonstrated a proactive approach in rectifying some of the shortfalls we identified.

Leaders at all levels were visible and approachable. They worked closely with staff and others.

Vision and strategy

There was a vision and set of values. The statement of purpose included the practice's aims to provide dental services of clinical excellence for all their patients.

The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. Patients included NHS fee exempt patients and those seeking private dental treatment.

Culture

Staff stated they felt respected and valued. They said they were part of a team.

Openness, honesty and transparency were demonstrated when responding to complaints. For example, an administrative error resulted in a patient being overcharged. The patient was apologised to with an explanation and refund given. We found that incident reporting processes required review as no incidents had been formally identified. Documentation relating to accidents reported did not support that lessons learned were shared amongst staff to prevent recurrence.

The provider was aware of the requirements of the Duty of Candour.

Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

We found that staff training requirements required ongoing monitoring as we were not provided with evidence to show how this was being overseen. We noted that some staff appraisals were not regularly completed and were overdue. Systems required improvement to support a good governance and management structure.

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice managers were responsible for the day to day running of the service. They received support from the rest of the team.

The provider had a system of clinical governance in place which included policies, protocols and procedures; however, this also required strengthening. Not all documentation was accessible to us on the day of inspection. We noted that some policies required review such as the practice's consent policy, as this did not include information regarding the Mental Capacity Act. A policy or procedural document regarding the Act was not held separately.

There were not always clear and effective processes for managing risks, issues and performance. For example, recommendations in a legionella risk assessment had not been acted upon, a sharps risk assessment had not been undertaken and a fire risk assessment was not personalised to the practice risks.

Appropriate and accurate information

Processes to address and respond to patient complaints and feedback were working efficiently.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice had not undertaken any recent patient surveys to obtain their feedback. We were told that the last survey had been held around 2015 to 2016. There was a suggestion box made available for patients to leave their comments.

We were told that staff could feedback informally during meetings or through approach to the practice managers. Examples of feedback left by staff included the requirement for an additional clini-pad in the reception area and for one

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root canal treatment to be booked in for each dentist in the mornings, to minimise delays if the dentist was running behind schedule. We were told that these had been acted upon.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

Continuous improvement and innovation

There were some systems and processes for learning and continuous improvement.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. We found there was scope to improve audit processes. For example, there was scope to improve infection and prevention control audit to identify issues and radiography audit could be strengthened to include detail regarding all dentists.

Records made available to us showed that those staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

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 Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • An effective policy and procedure framework was not in operation to enable staff to report, investigate and learn from untoward incidents. • Ineffective monitoring for staff training requirements. • Not all staff had received formal appraisals or some were overdue. • The provider had not ensured that those who worked within the practice had a comprehensive understanding of the principles of the Mental Capacity Act and how those principles related to their role. There were limited systems or processes established to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The provider had not sought to ensure themselves that all staff were aware of safeguarding processes. • The risks presented by legionella had not been mitigated.

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Requirement notices

- The provider did not mitigate risk in relation to all staff being made aware of processes to follow regarding lab work being disinfected prior to it being sent to a dental laboratory or before treatment was completed.
- The provider had not identified or assessed the risks presented by fire.
- The provider had not implemented a sharps risk assessment specific to the practice risks.
- The provider had not sought to ensure that there were suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.
- The provider had not sought assurance that agency staff had received clearance to work in accordance with legislative requirements.
- The provider had not sought to ensure themselves that one of the clinicians had up to date indemnity cover.