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Broadway Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 20 May 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

The practice is in Woodhall Spa, a village in Lincolnshire and provides NHS and private treatment to adults and children.

The current provider has taken over the sole ownership of the practice from March 2019. Prior to this, they were in a partnership with the previous owner from October 2018.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available in the practice's car park. There is also on road public car parking directly outside the practice.

Summary of findings

The dental team includes six dentists, four dental nurses, (a previously registered nurse is also undertaking work at the practice and is waiting for their registration to be confirmed), three trainee dental nurses, (one of the dental nurses also works as a receptionist), two dental hygienists and a receptionist. A practice manager is also employed.

The practice has five treatment rooms, all on ground floor level.

Services include general dentistry and the practice has a contract with NHS England for the provision of orthodontic treatments. The practice is also a training practice for dentists new to practice. One of the associate dentists is a trainer.

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 27 CQC comment cards filled in by patients.

During the inspection we spoke with two dentists, three dental nurses, one dental hygienist, a receptionist and the practice manager. We looked at practice policies, patient feedback and procedures and other records about how the service is managed.

The practice is open: Monday to Saturday from 9am to 1pm and 2pm to 5pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available, with exception of four sizes of clear face masks that were missing.
- The practice did not have all suitable systems to help them manage risk to patients and staff. For example, the risks presented by fire, legionella and lone working required review.

- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. We did not view evidence to show that all staff had completed training in safeguarding however.
- The provider had a staff recruitment policy and procedure, but this was not always complied with in relation to the recruitment of new staff.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- 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.
- Staff felt involved and supported and worked well as a team.
- The provider welcomed feedback from staff and patients about the services they provided.
- The provider dealt with one complaint received positively and efficiently. It was not evident that learning was shared amongst the team however.
- The provider had suitable information governance arrangements.
- Governance arrangements required strengthening. Not all risks arising from the undertaking of the regulated activities had been suitably identified and mitigated.

We identified regulations 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 availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.
- Review the security of NHS prescription pads in the practice and ensure there are systems in place to track and monitor their use.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice systems and processes to provide safe care and treatment were not always operating effectively. We found that no incidents had been formally reported or documented since the provider took ownership in March 2019. Whilst staff had reported accidents, we did not see that learning was shared amongst the team to prevent their recurrence.

Staff showed knowledge and awareness of safeguarding. We did not view evidence to show that all staff had received training in safeguarding however.

Staff were qualified for their roles, but the provider had not undertaken all legislative checks required when they recruited new staff.

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

Equipment was clean and properly maintained. We noted that some of the X-ray equipment was overdue annual mechanical and electrical testing.

The practice followed national guidance for cleaning, sterilising and storing dental instruments. We noted some exceptions in relation to loose items stored in surgery drawers.

The practice had suitable arrangements for dealing with medical and other emergencies, although four sizes of clear face masks were missing from the kit.

No action



Are services effective?

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. Patients described the treatment they received as excellent, first class and impressive. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

One of the associate dentists was a verified trainer to support newly qualified dentists and a trainee dentist was working in the practice.

We did not view evidence of all staff's continuing professional development (CPD) as some of the files were not made available on the day of our inspection.

Staff appraisal was overdue prior to when the current provider took ownership of the practice. We were informed that plans were in place to hold appraisals in October 2019.

No action



Summary of findings

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

The practice had a contract with NHS England to provide orthodontic treatment.

Are services caring?

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

We received feedback about the practice from 27 people. Patients were positive about all aspects of the service the practice provided. They told us staff were polite, courteous and efficient.

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 noted that some of the patients who left comments in CQC cards had been attending the practice for many years; they spoke highly of the ongoing care received.

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

No action



Are services responsive to people's needs?

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 patients' different needs. This included providing facilities for patients with a disability and families with children. The practice did not have direct access to interpreter services; staff told us there had been no requirement for this given the practice demographic. They had arrangements to help patients hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively. We did not view evidence to show that learning was shared amongst the team.

No action



Are services well-led?

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

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.

Systems required improvement to support a good governance and management structure.

Requirements notice



Summary of findings

The systems and processes for learning and continuous improvement were in development at the practice at the time of our inspection.

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 systems to keep patients safe; we also found areas that required strengthening.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw that safeguarding was subject to discussion in practice meetings. Contact information for reporting concerns was posted on noticeboards in the practice. The principal dentist and the practice manager were joint leads for safeguarding.

We saw evidence that some of the staff received safeguarding training. Training records were not provided for three dentists and the hygienist. We were informed that the receptionist had not completed this training.

Staff we spoke with knew about the signs and symptoms of abuse and neglect and how to report concerns.

The practice had a system to highlight vulnerable patients on records e.g. where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication. Flags could be placed on patients' computerised records.

The practice had a whistleblowing policy. This included external contact information for reporting concerns. Staff felt confident they could raise concerns without fear of reprimand.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record.

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 buddy arrangements with another practice that patients could be referred to, if the premises became un-useable.

The practice had a recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation.

We looked at four staff recruitment records for staff recruited after the partnership commenced in October 2018. These showed the practice had not complied with their recruitment procedure. For example, disclosure and barring service (DBS) checks, references or other evidence of satisfactory conduct in previous employment were not held for two trainee nurses and the previously registered dental nurse. Evidence of photographic identity was also not held for the two trainee nurses. The practice manager told us that they were planning to update DBS checks held for all their staff.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

The practice had recently installed new emergency lighting and a new fire alarm system to replace an obsolete system. There were no records of previous checks conducted by staff on old equipment or of the fire extinguishers. Fire extinguishers were last serviced in January 2018 and were overdue. Fire drills had not been undertaken. A fire risk assessment was last undertaken in January 2011 and had been reviewed by practice staff since then. The practice manager told us that a new assessment was planned now that the new fire system had been installed.

The practice had some suitable arrangements to ensure the safety of the X-ray equipment, but we noted that annual mechanical and electrical testing on X-ray equipment in three of the surgeries was two years overdue. 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. We noted that one

Are services safe?

radiography audit had been undertaken in respect of an associate dentist in 2018, prior to the new ownership. We were informed that a full and comprehensive audit programme would be implemented in October 2019, a year after the current provider had joined the practice.

We were not provided with documentation to show that four of the dentists and the hygienist had completed continuing professional development (CPD) in respect of dental radiography, as their files were not held for our review on the day.

Risks to patients

There were not all of the systems required to assess, monitor and manage risks to patient safety.

The practice had health and safety policies, procedures and risk assessments to help manage potential risk. Workstation assessments had not been completed for staff. A risk assessment had not been completed for when the hygienist worked without chairside support.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The trainee dentist used the safer sharps system and other dentists used traditional needles. Matrix bands used were not the fully disposable type. A generalised sharps risk assessment was held, but this did not include reference to the specific sharps used in the practice.

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. New trainee staff did not yet have this information recorded on their records.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year. Training last took place in October 2018.

Emergency equipment and medicines were available as described in recognised guidance, with exception of four sizes of clear face masks. Staff kept records of their checks of medicines and equipment held to make sure these were available, within their expiry date, and in working order.

A dental nurse worked with the dentists but not routinely with the dental hygienist when they treated patients.

The practice manager was in the process of updating risk assessments to minimise the risk that can be caused from substances that are hazardous to health. This work was ongoing at the time of our inspection.

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 were informed that staff completed infection prevention and control training and received updates as required as part of their core training. Documentation to support this was not available for our review in respect of four of the dentists and another of the dentist's files showed a training record dated in February 2014. We also, did not see supporting documentation in some of the dental nurses' training records.

The practice utilised a dedicated decontamination nurse three days of the week. The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

We noted some slight damage on the edges of surfaces in the surgeries leading to exposed MDF. The practice manager told us that they were aware of this and plans were in place to address this as part of the practice update. We also noted some loose items in drawers in a surgery, for example, cotton wool rolls, X-ray packets, suction tips and local anaesthetic.

The practice had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice did not have all suitable procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. A risk assessment had been completed in December 2017, prior to new ownership. It was not clear if recommendations had been completed as there was no written evidence regarding this. We found that records of water temperature checks had not been completed since the end of February 2019. The practice had not implemented a management structure regarding legionella.

Are services safe?

The practice was visibly clean when we inspected, but staff checklists for cleaning were not held.

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

The practice carried out infection prevention and control audits twice a year. The latest audit undertaken in November 2018 showed the practice was meeting the required standards. An annual infection prevention and control (IPC) statement had not been completed by the practice.

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 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.

The practice had not implemented a protocol for locSSIPs. These are local safety standards for invasive procedures and are relevant for dental teams involved in dental extractions.

Safe and appropriate use of medicines

The provider had 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 records of NHS prescriptions as described in current guidance. The practice did not monitor individual prescription pad numbers to mitigate the risk of them being taken inappropriately.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety and Lessons learned and improvements

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

There was an accident book held in the practice. We noted two accidents reported since the provider took ownership of the practice. Whilst the records demonstrated that action had been taken to report and investigate the issues, we did not view records to demonstrate that any lessons learned were shared amongst all staff. Two of the dental nurses and another member of the team we spoke with did not recall any reported accidents.

There was a policy and procedure for significant events. We were informed that there had not been any incidents identified since the provider took ownership. Staff we spoke with showed awareness of the incident reporting policy and the type of issue they would report to management.

The system for receiving and acting on safety alerts required strengthening. It was not clear how the practice learned from external safety events as well as patient and medicine safety alerts. We were informed by the practice manager that one of the dentists received alerts and passed these, if relevant to the principal dentist. Our review of documentation held showed one alert was dated in January 2019 and prior to this, October 2017 and October 2013.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We received many positive comments from patients about the effectiveness of treatment and information provided to them during the course of their care received. We noted that some of the patients had been attending the practice for many years. Patients described the treatment they received as excellent, first class and impressive.

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.

The practice held a small contract with NHS England to provide orthodontic treatment. Orthodontics is a specialist dental service concerned with the alignment of the teeth and jaws to improve the appearance of the face, the teeth and their function. Orthodontic treatment is provided under NHS referral for children, except when the problem falls below the accepted eligibility criteria for NHS treatment. Private treatment was available for these patients.

The practice had suitable policies and procedures for assessing and treating patients. An associate dentist had a special interest in orthodontics and worked to The British Orthodontics Society (BOS) guidelines in delivering care to patients.

The practice kept detailed dental care records containing information about the patients' current dental needs in respect to orthodontic treatment, past treatment and medical histories in the sample of records we reviewed.

The practice was an approved training practice for dentists new to general practice. Ongoing support and supervision was provided to the foundation dentist by one of the associate dentists who was the trainer.

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 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 over the age of three years.

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a small selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The clinicians 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.

Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice. The practice utilised two dental hygienists; one of these had recently been recruited. If needed, referrals to the hygienist were made.

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 and recording patients' consent to treatment. The dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions.

The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

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

Are services effective?

(for example, treatment is effective)

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw that the practice had audited patients' dental care records in 2018 under the previous ownership. The practice manager told us that they would complete a new audit in October 2019.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. A mixed skill-set of staff worked in the practice that enabled them to be a training practice, provide orthodontics and general dentistry. One of the dentists had a special interest in complex endodontics. Support was also provided from dental hygienists. The practice benefitted from a dedicated decontamination lead on the days they worked in the practice. The practice manager was qualified as a dental nurse and was experienced in management when recruited to their role. We saw examples of CPD undertaken by some of the dental nurses. This included oral cancer, impression taking and radiography.

Staff who were directly employed by the practice had a period of induction based on a structured programme. We were not provided with records to show that inductions had been completed by dentists new to working in the practice.

We were unable to confirm that all clinical staff completed the continuing professional development required for their registration with the General Dental Council as some of the clinicians' files were not made available to us on the day of our inspection.

We noted that staff appraisals were overdue prior to when the current provider took ownership of the practice. One of the dental nurses recalled they had last received an appraisal in 2017. The practice manager told us that they had plans to hold appraisals in October 2019. There was therefore, no written documentation to support how the practice met the training needs 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.

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 polite, courteous and efficient. We saw that staff treated patients respectfully, appropriately and kindly 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.

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

An information folder was available for patients to read. There was also a selection of magazines and a TV in the waiting area whilst patients waited to be seen.

We looked at feedback left on the NHS Choices website. We noted that the practice had received four out of five stars overall based on patient experience on eight occasions. Reviews left since the new provider took over were positive regarding treatment received and the staff.

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 area provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff told us they could take them into another room.

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):

- The practice did not have direct access to interpretation services. Staff told us they had not identified a need for these due to the practice demographic.
- Staff communicated with patients in a way that they could understand and communication aids, information in large print and easy read materials were available, if required.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example, models, software, screens, websites and written information.

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 patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care. We were provided with examples of how staff met the needs of more vulnerable members of society. These included allocating longer appointment times and providing suitable appointment times for those with particular needs such as early in the morning or straight after lunch. Other measures taken in response to patient requests included ensuring a window was always open for them in the surgery and speaking with another patient away from the reception desk.

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. Patients with mobility problems had access to surgeries which were all on ground floor level.

The practice had made reasonable adjustments for patients with disabilities. These included step free access, a hearing loop and accessible toilet with hand rails and a call bell. They did not have a magnifying glass or spare reading glasses at the reception desk.

Staff contacted patients in advance of their appointments, using their preference of text message or telephone call 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 seen the same day, although

appointments were allocated on a first come first served basis. Patients had enough time during their appointment and did not feel rushed. Appointments appeared to run smoothly on the day of the inspection and patients were not kept unduly waiting.

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. The provider had an out of hours on call arrangement with other practices to see their privately registered patients and those on a payment plan. NHS patients were re-directed to NHS 111.

Patients confirmed in CQC comment cards that they could make routine and emergency appointments easily.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and had a system to respond 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 manager was responsible for dealing with complaints. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so that patients would receive a quick response.

The practice manager 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 one complaint the practice received since the change in ownership in March 2019.

This showed the practice responded to the concern appropriately and discussed outcomes with the staff member involved for training purposes. Our discussions with the practice manager showed it was not clear that the issue was also discussed with other staff members to share learning.

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.

Leaders at all levels were visible and approachable. They worked closely with staff and others. We noted positive comments from staff regarding the practice manager who started working for the practice in October 2018, when the new provider joined the practice.

Vision and strategy

There was a vision and set of values. The statement of purpose included the promotion of good oral health with patient involvement and the provision of high quality examination and treatment procedures. The statement also included the aim to invest in the premises, equipment and technology and to innovate processes.

The practice planned its services to meet the needs of the practice population. Patients included NHS and those paying on a private basis. The practice also held an orthodontics contract with NHS England.

Culture

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

The provider was aware of the requirements of the Duty of Candour. We saw that openness and transparency were demonstrated when responding to the one complaint that had been received. We did not view evidence to support that the complaint and accidents reported had been discussed amongst the team to share learning and prevent their recurrence.

Staff could raise concerns or issues and were encouraged to do so.

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 staff appraisals

were overdue prior to the new provider joining the practice. We were told that plans were in place for these to be undertaken in October 2019.

Systems required continuous 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 manager was 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. It was not clear that there were effective processes for managing risks. For example, a risk assessment had not been completed for when the hygienist worked without chairside support and it was not clear that the risks presented by legionella had been mitigated.

Appropriate and accurate information

The practice had not always acted on appropriate and accurate information. We noted that annual mechanical and electrical testing on X-ray equipment in three of the surgeries was two years overdue.

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 involved patients, staff and external partners to support high-quality sustainable services.

The current provider had not yet undertaken a patient survey. This was last completed in June 2018 under previous ownership. They used verbal comments to obtain patients' views about the service and told us they had an open door approach for staff to provide feedback.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Are services well-led?

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

The systems and processes for learning and continuous improvement were in development at the practice at the time of our inspection. We were informed that a structured audit programme would be implemented in October 2019, a year after the current provider had joined the practice.

We noted that an infection prevention and control audit had been undertaken in November 2018.

We saw evidence that staff completed some of the 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. We did not view documentation to show that all staff had completed training in radiography and infection prevention and control as their files were not made available to us on the day.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>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.</p> <p>In particular:</p> <ul style="list-style-type: none">• An effective policy and procedure framework was not in operation to enable staff to learn from incidents that had occurred.• Ineffective monitoring for staff training requirements, for example GDC recommended training.• Not all dentists new to the practice had received a formal induction. <p>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:</p> <ul style="list-style-type: none">• The risks presented by legionella had not been mitigated.• The registered person did not mitigate risk in relation to the hygienist working alone.• Not all fire risks had been mitigated, for example, fire drills and records of staff checks on equipment.• X-ray equipment was overdue routine testing.• The registered person had not implemented a robust system for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority. (MHRA)• The registered person had not ensured that all staff new to employment had been subject to appropriate checks as specified in Schedule 3, at the point of

This section is primarily information for the provider

Requirement notices

recruitment. In particular, Disclosure and Barring Service (DBS) checks, references or other evidence of previous satisfactory conduct and a recent photograph.