

Dr Bamdad Mohri

Fawdon Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 26 April 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We announced this inspection two days prior in response to information of concern received from a whistle-blower. 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 not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Fawdon dental practice is in Newcastle Upon Tyne and provides NHS and private treatment to patients of all ages.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available near the practice.

Summary of findings

The dental team includes a principal dentist, an associate dentist and three trainee dental nurses (one of whom is also the practice manager). All dental nurses also undertake reception duties. The practice has two treatment rooms.

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.

During the inspection we spoke with the associate dentist, the practice manager, a trainee dental nurse and a qualified locum dental nurse. The principal dentist was abroad on the inspection day and was communicating with us regularly via telephone and email. The practice manager told us the principal dentist works at the practice for a week or more, and then goes abroad for a week. The practice manager told us that this was a regular arrangement.

We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday, Tuesday 8.45am to 5.15pm

Wednesday 8.45am to 6pm

Thursday 9.15am to 6.45pm

and Friday 8.45am to 4.30pm

Our key findings were:

- The practice appeared mostly clean and well maintained. We saw some areas were covered in dust, flooring was cracked in various places and rust had spread to the floor in the decontamination room. We saw a large hole in the wall in one surgery. Two of the wooden panels of the back gate were missing.
- The practice infection control procedures did not reflect published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were not all available as described in national guidance.
- The practice had minimal systems to help them manage risk.

- The practice had minimal safeguarding processes for safeguarding vulnerable adults and children. There was no policy for safeguarding of vulnerable adults.
- The provider did not undertake thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took some care to protect their privacy and personal information.
- The practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- The practice leadership was not effective and a culture of continuous improvement within the practice was not evident.
- Staff felt involved and supported and worked well as a team. The practice manager required more support and time to perform their role efficiently.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.
- The practice had suitable information governance arrangements.

We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

Full details of the regulations 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 systems for monitoring referrals to ensure they are efficient.
- Review the practice's security of patients' record cards to ensure they are kept secure at all times.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

The practice had some systems and processes to provide safe care and treatment. The practice's incident recording procedures could be improved.

The practice had some suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children. There was no adult safeguarding policy in place and not all staff had undergone safeguarding training. The principal dentist could not demonstrate they had undergone training in safeguarding vulnerable adults of an appropriate level and the trainee dental nurses had not had any formal training in safeguarding children or vulnerable adults.

Staff were qualified for their roles.

The provider did not undertake thorough staff recruitment procedures or document any processes carried out.

The practice infection control procedures did not reflect recommended national guidance.

Appropriate medicines and life-saving equipment were not available as described in national guidance.

The practice had minimal systems to help them manage risk.

Enforcement 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. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals. A referral log system was not in place.

The practice supported staff to complete training relevant to their roles. Systems to help them monitor training required improving.

No action



Are services caring?

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

No action



Summary of findings

We viewed feedback about the practice from NHS choices and the practice surveys. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, professional and gave helpful, honest explanations about dental treatment. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff took some care to protect 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?

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

The provider did not assess the needs of all groups of patients. Wheelchair access and a ground floor surgery were available. The toilet was on the ground floor with a narrow entrance. Larger wheelchairs and pushchairs would not be able to get through. The practice manager was not aware of the need to have access to telephone or face to face interpreter services or arrangements to help patients with sight or hearing loss.

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

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).

The practice had some arrangements to ensure the smooth running of the service. There were limited systems for the practice team to discuss the quality and safety of the care and treatment provided.

There was a defined management structure. The practice manager worked as a trainee dental nurse when the principal dentist was working and carried out reception and management activities when he was away. Staff said that they felt appreciated.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely with the exception of one of the filing cabinets where the lock was broken and had not been repaired.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. This required more frequent implementation.

We saw evidence of listening to the views of patients and staff.

Requirements notice



Are services safe?

Our findings

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

The practice had limited systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. There were local safeguarding contact numbers available at reception.

We were told the trainee dental nurses had not undergone any formal safeguarding training at induction; they had learnt this as part of their college course. There were no procedures in the practice to provide staff with information about identifying or dealing with suspected abuse. The practice had a safeguarding policy for children from 2014; this was a template policy, not specific to the practice and had not been reviewed or signed by any existing members of staff. The practice did not have a safeguarding policy for vulnerable adults. The principal dentist was the safeguarding lead for the practice. They could not demonstrate they had training in safeguarding of vulnerable adults to an appropriate level.

There was 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 require other support such as with mobility or communication.

The practice staff were not aware of the need to identify adults that were in other vulnerable situations, for example those who were known to have experienced modern-day slavery or female genital mutilation.

The practice had a whistleblowing policy. Staff told us they 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.

The practice had a business continuity plan describing how the practice would deal with events that could disrupt the normal running of the practice.

The practice did not have a staff recruitment policy to help them employ suitable staff. A template checklist was available to remind them of the checks and procedures required; this was not documented or followed for each employee. They did not have any checks in place for agency and locum staff. We looked at all staff member's recruitment records.

We were told the provider had not carried out a Disclosure and Barring Service (DBS) check for a staff member recruited four months ago. This check ensures staff are suitable to work with vulnerable groups, including children. We found DBS checks for two members of staff were carried out by their previous employer. There was no evidence of risk assessment by the provider to mitigate the risk associated with not carrying out their own DBS checks. The practice frequently used locum agency staff and did not request any documentary evidence from the agency to ensure appropriate DBS checks were carried out.

Photographic identification, such as a passport or driving license, was not sought for a newly recruited trainee dental nurse nor for any locum staff. References were verbally obtained for three members of staff and we were told there was no reference sought for the most recent recruit. References were not obtained for locum staff.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover. We were told the provider did not seek evidence of GDC registration for locum staff.

We were told staff, including locum staff, were provided with verbal inductions at the start of their employment. The practice manager told us verbal inductions cover all policies and procedures within the practice. We discussed a recently recruited locum dentist's induction; the practice manager told us and acknowledged an induction hadn't been carried out.

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

The principal dentist had not undertaken a fire risk assessment of the premises. The practice had smoke

Are services safe?

detectors on both floors and two fire exits on the ground floor which were clearly sign posted. We asked to leave the building via one exit and noted the key was kept in the reception; this would delay leaving the building in an emergency. We saw records to confirm their fire extinguishers were regularly tested. The practice had no emergency lighting and did not undertake routine testing of the smoke alarms. None of the practice staff had fire marshalling training and we were told fire drills were only discussed and not acted out.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The provider had not registered with the Health and Safety Executive in accordance with the Ionising Radiation Regulations 2017 (IRR). They had maintained 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; the most recent audit was 2016. These audits were not carried out annually following current guidance and legislation.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were limited systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies were template policies which had not been amended to be practice specific. The provider had not carried out a practice health and safety risk assessment to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The practice staff did not follow relevant safety regulations when using needles and other sharp dental items. A signed statement was present to confirm staff had read the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013; these stipulate the need to undertake a sharps risk assessment and the use of safety measures if using traditional needle and syringes. We found the practice had not carried out a sharps risk assessment and were using traditional syringes without a safety guard. Several "safer" disposable syringes were available and we saw these had all passed their expiry date.

The provider did not have evidence 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. The practice manager told us the provider checked the immunity status of all staff members prior to employment. We asked to see records of these and were shown these for only one member of staff. We were told the other documents were with previous employers. The provider did not check the immunity status for locum staff and told us responsibility lay with the agencies who assigned them.

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

Emergency equipment and medicines were available; this was not completely as described in recognised guidance. We found a child's self-inflating bag and non-rebreather mask were not part of the emergency kit and also saw the Glucagon (used for diabetic emergencies) had expired. The practice manager took immediate action to order these items and we received email confirmation of this the following day.

Staff kept records of their checks to make sure these were available, within their expiry date, and in working order.

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

The provider had some suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. We found the practice's Control of Substances Hazardous to Health (COSHH) file contained risk assessments and safety data for only eight materials held within the practice. These were dated 2014 and had not been reviewed. We spoke to the practice manager about the need to assess all hazardous substances on-site and to regularly review these for updates. They assured us this would be rectified.

The practice occasionally used locum and agency staff. We noted that a recently employed member of locum staff did not receive an induction to ensure that they were familiar with the practice's procedures.

The practice had an infection prevention and control policy; this was not read and signed by all staff.

Are services safe?

Staff did not follow the guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

We found several cracks in flooring – for example in the entrance way (this was sealed with brown tape), in the surgeries and toilet.

The decontamination area was sited in a room which was also used for staff changing and as a kitchen. We saw there was a table in the room with rusty legs. Staff kept their outdoor clothes and shoes under the table. The rust from the table had spread to the floor in the room. We were told the principal dentist had not mentioned any plans to correct this.

The practice had suitable protocols for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05 however staff did not follow these. We observed a trainee dental nurse and the qualified locum dental nurse in their decontamination procedures. We saw staff did not follow appropriate hand-washing prior to or after decontamination, did not wear appropriate personal protective equipment such as aprons and face masks, instruments that had been used on patients were carried in a container without a lid and with bare hands, measurements were not used for the detergents, temperature checks were not being followed to manufacturers guidance and instruments were left overnight without being kept moist.

We also noted the designated hand washing sink was being used to wash cups and other crockery.

The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. We saw the practice had a spare autoclave in case the cycle failed on their main. This was serviced annually and we spoke to the practice staff about the need to carry out the daily and weekly tests in addition to the annual service.

We found the surgeries and toilets had rubbish bins which were hand operated and the foot pedal for the clinical waste bin in the decontamination room was broken. The hand paper towels in the downstairs surgery were left on the side work surface rather than being in a wall mounted container. We also found several hand-pieces and mouth mirrors were scratched and rusty in the upstairs surgery.

The practice had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. A Legionella risk assessment had been carried out by the provider in 2016. This did not contain schematic drawings nor did it assess the risk of Legionella at all outlets. The control measures listed in the risk assessment were not detailed sufficiently and we found there was no evidence of any control measures being implemented since the assessment. We requested evidence to show the provider had the appropriate training to carry out the risk assessment; none was available.

We saw cleaning schedules for the premises. The practice was mostly clean when we inspected with the exception of some areas which were dusty such as window sills with dead flies and other corner surfaces. Cleaning equipment was colour coded and we observed a red bucket had been labelled for use in the "bathroom" but we were told this was being used in clinical areas. The practice manager told us the labelling was incorrect and the grey equipment was used in bathroom. We saw mops appeared dirty and their handles were rusty. We also noted both red and grey mops were kept together inside the red bucket.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. Clinical waste was stored in the back yard. The clinical waste bin was always kept locked and we saw this on the inspection day. The back yard was accessed through a wooden gate. Two of five wooden panels had been broken and the yard could be accessible to public. We discussed the importance of ensuring the security of the clinical waste bin with respect to this.

Staff completed infection prevention and control training and received updates as required. The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards. We spoke with the practice about the results of the audit and the need to ensure they are consistent with the findings on-site.

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

Are services safe?

findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were accurate, complete, and legible and were kept securely and complied with data protection requirements.

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

We were told there was no system in place to ensure referrals were logged and followed through. The practice manager assured us this would be acted upon.

Safe and appropriate use of medicines

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

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

We saw the practice had posters of the antibiotic guardianship in both waiting rooms.

Track record on safety

There were no comprehensive risk assessments in relation to safety issues. The practice did not monitor and review all safety incidents. For example, the incident of the gate being vandalised nor the wall being damaged by the dental unit light were not recorded nor documented to be acted upon. We were told of other incidents where patients were verbally aggressive to staff; these were not recorded as significant events.

The practice staff were unclear of what constituted an accident and what an incident. A needlestick injury had been documented appropriately as an accident; a medical emergency and hospitalisation had also been documented as an accident rather than an incident.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

There was a system for receiving safety alerts. The practice manager received safety alerts and told us these were not shared amongst the practice staff for learning.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

A care home was situated opposite the practice. The dentists occasionally went to the care home to provide treatment to patients there. The provider took into account guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence.

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 associate dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients based on an assessment of the risk of tooth decay.

The associate dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a 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 available in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

We spoke with the associate dentist who described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice, taking plaque and gum bleeding scores and detailed charts of the patient's gum condition

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

Consent to care and treatment

The practice staff 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 told us they 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 the legal precedent (formerly called the Gillick competence) by which a child under the age of 16 years of age can 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.

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 audited patients' dental care records to check that the dentists recorded the necessary information.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a verbal induction; a structured induction programme was not documented. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at annual appraisals.

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

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

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

The associate dentist 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 had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems and processes 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 did not maintain a log or monitor of 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, patient and respectful. We saw that staff treated patients respectfully, appropriately and were friendly towards patients at the reception desk and over the telephone.

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

Information folders, patient survey results and thank you cards were available for patients to read.

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 waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would 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 in lockable filing cabinets. We saw the lock for one of the cabinets was broken and discussed the importance of record card security with the practice manager. They told us this had been broken for several years and assured us this would be rectified.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care. We spoke to staff about the Accessible Information Standards and the requirements under the Equality Act

(a requirement to make sure that patients and their carers can access and understand the information they are given):

- The principal dentist and other members of staff spoke a range of languages. Staff were not aware of the need to also have interpretation services information available for patients who did not have English as a first language.
- Staff were not fully prepared to communicate with patients in a way that they could understand, for example, using communication aids. Staff were not aware of the need to have easy read materials available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

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

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

The associate dentist described to us the methods they used to help patients understand treatment options discussed. These included the use of models and X-ray images.

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.

For example, the practice met the needs of more vulnerable members of society such as patients with dental phobia by arranging appointment times to the patient's convenience and scheduling an extended treatment slot. Staff were also aware of the support required by vulnerable groups as they frequently treated patients from the care home situated opposite the practice.

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

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made minimal reasonable adjustments for patients with disabilities. The practice had not assessed the needs of all groups of patients in accordance with the Equality Act 2010. For example, a disability access audit or review had not been completed. There was no plan formulated in order to continually improve access for patients where reasonably practicable.

The premises had step free access, a ground floor surgery and ground floor toilet. The ground floor surgery was accessible to large wheelchairs and pushchairs. The ground floor toilet was accessible to small wheelchairs; the doorway appeared narrow for entry of larger wheelchairs or pushchairs. The toilet had a small hand rail for support. There was no security alarm or call bell in the toilet and two doors separated the reception area and toilet; this may cause delay if a disabled patient required help in the toilet. A magnifying glass was available for patients who requested it.

An induction (hearing) loop was not available. The practice manager told us they were not aware of the requirement for assessing the needs of all patient groups.

Timely access to services

Patients were able to 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 on their website.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day or within 24 hours. Patients told us they 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 waiting.

They took part in an emergency on-call arrangement with other local practices and the 111 out of hour's service.

The practice website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely 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 complaints 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 these. Staff told us they would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

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

We looked at comments and compliments the practice received within the last 12 months. The practice had received no complaints in that period. We observed the practice responded to any comments appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist carried the overall leadership for the practice. We were told they worked on-site every other week and spent an equal amount of time abroad.

The principal dentist had the experience and skills to deliver the practice strategy.

On the day of the inspection, the principal dentist was abroad yet very approachable and promptly answered any queries made by the practice manager via telephone.

They were not knowledgeable about all issues and priorities relating to the quality and future of services.

The principal dentist and practice manager were approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

The practice did not have effective processes to develop leadership capacity and skills. The practice manager was always on-site yet was not given specific time to carry out their management duties. They carried out reception work alternative weeks and when the principal dentist was on-site they were carrying out dental nursing assistance whilst also completing their dental nursing training.

Vision and strategy

There was a clear vision and set of values. The practice had a realistic strategy. We saw no future plans to carry out refurbishment to the back gate, hole in the surgery wall, rusty, torn flooring and no supporting business plans to achieve priorities.

Culture

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

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

Governance and management

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.

There were not clearly defined responsibilities for the practice manager nor other members of staff. The principal dentist had not assigned roles and systems of accountability to support good governance and management.

Staff knew the management arrangements.

The principal dentist had a brief system of clinical governance in place which included some policies, protocols and procedures.

Policies were not reviewed on a regular basis for updates and changes. We found the practice did not have a recruitment policy, safeguarding vulnerable adults policy and had template policies for safeguarding children and health and safety. These and other policies were not practice specific and we were told some policies had not been read by all members of staff.

The processes for managing risks, issues and performance could be improved. For example, the principal dentist did not have an effective recruitment procedure to eliminate the risks to staff and patients, they were not aware of the new requirement of the IRR 17 to register with the HSE nor for the need of a competent person assessing the risk of Legionella. They did not understand the importance of having a risk assessment for all hazardous materials on-site nor for a fire risk assessment.

We were told the practice had regular staff meetings. They took place every 2 -3 months and we were told these were documented. We asked to see evidence of these documents and were provided with some evidence to support this. We were told all minutes were recorded but not all could be found on the day of inspection.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

Are services well-led?

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, the public, staff and external partners to support high-quality sustainable services.

The practice used patient surveys and verbal comments to obtain staff and patients' views about the service.

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.

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

Continuous improvement and innovation

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

The practice had limited quality assurance processes to encourage learning and continuous improvement. We saw audits of dental care records, radiographs and infection prevention and control. We noted the infection prevention

and control audits had not identified several of the issues that we saw on the inspection day. We also saw the most recent X-ray audit was completed in September 2016; this should be completed annually.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

The practice employed trainee dental nurses. We were told they had had annual appraisals however did not have any personal development plans or logs in place to supervise and facilitate their learning, as recommended by the GDC. We saw evidence of completed appraisals in the staff folders.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

The General Dental Council also requires clinical staff to complete continuing professional development.

We found the principal dentist did not actively monitor the training requirements of all staff. For example, we found the trainee dental nurses did not have safeguarding children and vulnerable adults training at the practice; they had learnt this as part of their college course. We were also told the principal dentist was not aware of whether the locum dental nurse or associate dentist had appropriate medical emergency training.

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 The registered person did not have effective systems in place to ensure that the regulated activities at Fawdon dental practice were compliant with the requirements of Regulations 4 to 20A of 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: • Management and governance systems were not effective. Adequate time was not assigned for management duties. • Policies were not complete nor practice specific. Not all policies were read, and followed by, all staff including locum staff. • Practice procedures and policies were not regularly reviewed by the practice staff. • Assessments of the needs of all population groups was not apparent. For example, a disability access assessment had not been completed. • Practice meetings were not regular, nor documented. Safety alerts, significant events and accidents were not recorded appropriately and shared with the whole team for learning. • Training requirements for all staff was not effectively monitored, for example, using a training matrix.
Regulated activity	Regulation

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The registered person did not have effective systems in place to ensure that the regulated activities at Fawdon dental practice were compliant with the requirements of Regulations 4 to 20A of 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:

- Recruitment procedures were not completed adequately.
- Procedures were not documented in line with legislation for DBS checks, immunisation status, references, induction and employment history.

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have effective systems in place to ensure that the regulated activities at Fawdon dental practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • The practice infection control procedures did not reflect published guidance Health Technical Memorandum HTM 01-05: Decontamination in primary care dental practices. • Areas required repairing including the rusty floor in the decontamination room, the rusty base of the dental chair, the broken wooden back gate and the hole in the wall in the downstairs surgery. • Medicines and life-saving equipment were not available as described in national guidance. • The practice had minimal systems to help them manage risk. There was no fire risk assessment, nor did the practice undertake regular fire drills or carry out regular checks of the smoke alarms. The Legionella risk assessment was not completed by a competent person and control measures were not documented. COSHH risk assessments were not available for all hazardous materials. • The practice had minimal suitable safeguarding processes for safeguarding vulnerable adults and children.