

Shayan UK Limited

North Street Dental Care

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 31 March 2016 ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was 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 providing well-led care in accordance with the relevant regulations

Background

North Street Dental Care provides predominately NHS dental services with private treatment options for patients. The practice has three consulting and treatment rooms, has three dentists who are supported by four dental nurses. The practice is managed by a practice manager with a principal dentist supporting the whole team.

One of the dentists is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We spoke with four patients who told us that they were satisfied with the services they had received. All stated their experiences at the practice were good, that staff were kind and caring and appointments were readily available both for emergencies and routine visits. They spoke about how their dignity and privacy was maintained at all times and how they were involved in decisions regarding their care and treatment. We did not receive any comment cards prior to our inspection as this was unannounced.

Our key findings were:

Summary of findings

- Staff had reported incidents and kept records of these and used the information for shared learning.
- Infection control arrangements were not sufficient
- Single use items were used more than once on patients.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff had received some training appropriate to their roles and were supported in their continued professional development (CPD).
- Where risk assessments had been carried out the practice had not implemented the actions required to minimise the risks identified.
- The provider and dentists used an unregistered laboratory for crowns, bridges, inlays, veneers and dentures.
- The practice took into account any comments, concerns or complaints and used these to help them improve the practice.
- Patients were pleased with the care and treatment they received and complimentary about the dentists and all other members of the practice team.

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

- Ensure infection prevention and control policies and procedures are implemented that follow the

Department of Health's Code of practice about infection prevention and control of healthcare

associated infections (Health and Social care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and related guidance) and the Department of Health – Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)

- Ensure that appropriate governance arrangements are implemented for the safe running of the service by establishing systems to identify and minimise any potential or perceived risks.
- Ensure that single use items are disposed of in line with the manufactures instructions and only used on one patient.
- Ensure that training in basic life support and use of the AED is carried out annually
- Ensure that only registered laboratories are used for any dental prosthesis.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were systems in place for identifying, investigating from incidents relating to the safety of patients and staff members. However, we found that no learning was acquired following an event or strategies implemented to reduce the risk of it happening again. The staffing levels were safe for the provision of care and treatment.

The practice did not follow or maintain appropriate infection control procedures which reflected published national guidance and staff could not demonstrate the correct decontamination process. The practice was not operating an effective decontamination pathway, as clean and dirty zones were identified but not adhered to by staff. We also found dental materials that were expired.

Staff had not been recruited safely and staff files did not contain all of the schedule three documents required by law.

Medical emergency training had expired and staff when questioned did not know what the emergency medicines were for.

Requirements notice



Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used national guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive team work within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff who were registered with the General Dental Council (GDC) were supported in their continuing professional development (CPD) and were meeting the requirements of their professional registration

No action



Are services caring?

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

We spoke with four patients and discussed their experiences. All of the information we received from patients provided a positive view of the service the practice provided. Patients told us that the care and treatment they received was caring, patient and thorough. They praised the skills of the clinical staff and the professionalism of the whole practice team.

No action



Summary of findings

Are services responsive to people's needs?

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

The practice provided clear information to patients about the costs of their treatment. Patients could access treatment and urgent care when required. The practice had one ground floor surgery and level access into the building for patients with mobility difficulties and families with prams and pushchairs. The team had access to telephone translation services if they needed and staff spoke a range of other languages.

No action



Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

The practice manager, and principal dentist worked together to co-ordinate the day to day running of the practice. The practice had outdated quality assurance processes which did not help them monitor the quality of the service.

No action



North Street Dental Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 31 March 2016 and was conducted by a CQC inspector and a dental specialist advisor.

We informed NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we spoke with one dentist, two dental nurses and the practice manager. We spoke with four patients who were all complimentary about the services they had received.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system to manage significant events, safety concerns and complaints and staff understood the procedure to follow. There had been one reported significant event within the last year. A risk assessment had been completed, However, mitigating actions had not been implemented to reduce the risk of re-occurrence.

There was also an accident reporting book which we checked. The practice manager showed us that they filed completed accident forms separately to protect the privacy of people involved. They had a system for cross referencing these so they could easily identify and locate them if needed. None of the accidents recorded were serious enough to have been reportable to either RIDDOR or CQC.

The practice manager received national and local safety alerts by email. We saw evidence that they checked these and recorded whether any were relevant to the practice so that staff could be informed and immediate action could be taken.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which had been updated annually. The policies were localised and contained the direct contact details of the local authority safeguarding team and what to do out of hours. This information was displayed prominently and all staff were aware of the procedure to follow.

The principal dentist was the safeguarding lead. All staff had completed safeguarding training to the appropriate level. Staff were spoke with were confident when describing potential abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the procedure for whistleblowing if they had concerns about another member of staff's performance. Staff told us they would be confident about raising such issues with either the group manager, practice manager or principal dentist.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal)

treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment.

The practice had clear processes to make sure that they did not make avoidable mistakes such as extracting the wrong tooth. The dentists told us they always checked and re-checked the treatment plan and re-examined the patient. They said they took particular care with this where they were extracting a tooth on the recommendation of another dentist (such as when carrying out orthodontic extractions). They told us they had a final read of the letter from the orthodontist and also asked the dental nurse assisting them to check this. The dentists were aware that carrying out incorrect dental treatment of any kind would be reportable to CQC.

Medical emergencies

The practice had arrangements to deal with medical emergencies and one of the dentists was the lead for this. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff had not received regular annual training in how to use this the last training was in March 2015. The practice had the emergency medicines set out as advised in the British National Formulary guidance. Staff when interviewed, did not know which medicine would be required to help specific conditions in an emergency scenario. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines.

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The practice monitored the expiry dates of medicines and equipment so they could replace out of date items promptly.

Staff recruitment

The practice showed us that they had not obtained all of the required information for some members of the team before they had contact with patients.

The practice's written procedures contained clear information about all of the required checks for new staff. This included protocol to follow for prospective employees

Are services safe?

explaining to them what documents they would be expected to provide and what checks the practice would carry out. These included educational certificates, a valid UK Passport or National Identity Card, General Dental Council (GDC) and professional indemnity certificates (if applicable) and Hepatitis B vaccination evidence if available. However we found that one of the dentists did not have current professional indemnity and proof of identification.

The Disclosure and Barring Service (DBS) carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had obtained DBS checks for most staff employed there. However, one DBS certificate was not relevant to the practice and cited a previous employer.

The recruitment protocol informed applicants that the practice would carry out a DBS check and informed them what documentation they would need to provide for this. The information informed applicants that they would be asked to provide a written explanation of any gaps in employment. The protocol also explained that as well as requesting references from applicants' most recent employers the practice would also contact previous employers where the work included contact with children or vulnerable adults. We found that of the nine members of staff employed at the practice, seven had not had any references taken up. Therefore we could not be assured that staff had been recruited safely.

Monitoring health & safety and responding to risks

The practice had a business continuity plan which described situations which might interfere with the day to day running of the practice and treatment of patients. This included extreme situations such as loss of the premises due to fire, flood or utilities. The document contained essential information including contact details for utility companies and practice staff. The practice manager and principal dentist had copies of the plan at home so that essential information was always available.

The practice had a practice wide risk assessment which addressed specific risks associated with dentistry as well as general day to day health and safety topics. This was reviewed annually to ensure that it reflected current guidance.

We saw that there was a fire risk assessment carried out in February 2016. The fire safety records showed that the practice had carried out fire checks and tests every month. We also saw evidence of fire drills over the previous year showing a commitment to fire safety.

We saw a folder containing detailed information about the control of substances hazardous to health (COSHH). The practice manager told us that they had decided to improve how this information was set out to make it more accessible to staff. They showed us that this included clearer information to make it easier for staff to take prompt action in the event of an incident involving substances containing chemicals. However, there was no review date and staff could not remember when the COSHH information had last been updated.

The dental care record system included alerts about information that the team needed to be aware of such as whether patients had allergies or were taking medicines used to thin the blood.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We were not assured that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. One of the dentists held lead responsibility for infection prevention and control (IPC).

We saw that dental treatment rooms, decontamination room and the general environment were generally clean, tidy and clutter free. However, we found that one of the surgeries was dirty. The Staff were responsible for general cleaning at the practice and we saw that cleaning equipment was safely stored in line with guidance about colour coding equipment for use in different areas of the building.

During the inspection we observed that the dental nurses cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the practice had a limited supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves but no aprons. There was also a

Are services safe?

supply of wipes, liquid soap, paper towels and hand gel available. The treatment rooms had designated hand wash basins separate from those used for cleaning instruments. However the decontamination room did not have a designated hand wash basin.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. The practice had a poorly-defined system which did not always separate dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. The practice had a separate decontamination room where the dental nurses cleaned, checked and sterilised instruments. Although the clean and dirty zones had been identified, the autoclave was in the clean zone and a radiograph image receptor was in the dirty zone. All of the nurses at the practice had completed online training so that they understood this process and their role in making sure it was correctly implemented. The dental nurses processed their own instruments in the decontamination room each day and transported instruments in boxes with lids. Different boxes were used for the dirty and clean instruments. However, we noted that the boxes used to transport the clean instruments were quite dirty, this posed a problem as instruments were not being pouched as per current guidance.

The dental nurse showed us the full process of decontamination including how staff rinsed the instruments, checked them for debris and used the autoclaves (equipment used to sterilise dental instruments) to clean and then sterilise them. The practice used a manual scrubbing method followed by checking under an illuminated magnification device and then autoclaved. We found that this process was not effective. Instruments were being scrubbed in plain water under a running tap, guidance clearly states that manual scrubbing must take place whilst immersed in an enzymatic detergent to facilitate sufficient decontamination. Staff did not wear full PPE whilst carrying out decontamination duties. Clean instruments were not packaged and date stamped according to current HTM01-05 guidelines, with the exception of extraction forceps. General instruments were processed and stored unwrapped in drawers and were not re-processed at the end of the clinical session.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. They

showed us the paperwork they used to record and monitor these checks. These were fully completed and up to date. We saw maintenance information showing that the practice maintained the decontamination equipment to the standards set out in current guidelines.

The practice used single use dental instruments whenever possible which were re-used we found rose head burs and matrix bands that were visibly contaminated with debris and ready for re-use on patients. However, we noted that the special files used for root canal treatments were used for one treatment.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. We found that some of the actions identified had not been carried out, such as monitoring the temperature of the hot and cold water at the practice to ensure that it remained within a safe parameter. Legionella is a bacterium which can contaminate water systems. We saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of Legionella. The practice used a continuous dosing method to prevent a build-up of legionella biofilm in the dental waterlines. Regular flushing of the water lines was carried out in accordance with the manufacturer's instructions and current guidelines.

The practice carried out audits of infection control using the format provided by the Infection Prevention Society (IPS). However, the last IPS audit carried out in February 2016 had attained a score of 99%. This did not reflect our findings on the day of inspection and is not an achievable result without a washer disinfectant. We brought this to the attention of the practice manager who stated that the audit would be conducted following changes made, following our inspection.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. However, some staff had not undergone a serum conversion to determine their level of coverage or if they were covered sufficiently. There were clear instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument including the contact details for the local occupational health department.

Are services safe?

The practice manager told us that all sharps injuries were recorded as accidents and we saw evidence that this was done.

The practice stored their clinical and dental waste in line with current guidelines from the Department of Health. Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. The practice had an appropriate policy and used a safe system for handling syringes and needles to reduce the risk of sharps injuries.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary required waste consignment notices.

Equipment and medicines

We looked at the practice's maintenance information. This showed that they ensured that each item of equipment was maintained in accordance with the manufacturer's instructions. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies. All electrical equipment had been PAT tested by an appropriate person. PAT is the abbreviation for 'portable appliance testing'.

We found thirteen dental materials that had expired in the surgeries. We brought this to the attention of the practice manager who assured us they would be disposed of immediately and a system would be created to monitor stock expiry dates.

Prescription pads held by the practice were securely stored. We saw that the practice had written records of prescription pads to ensure that the use of these was monitored and controlled.

The batch numbers and expiry dates for local anaesthetics were always recorded in the clinical notes.

Temperature sensitive medicines were stored in a fridge and the staff kept a record of the fridge temperatures.

Radiography (X-rays)

The practice was working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). They had a named Radiation Protection Adviser and Supervisor and a well maintained radiation protection file. This contained the required information including the local rules and inventory of equipment, critical examination packs for each X-ray machine and the expected three yearly maintenance logs.

We saw evidence of recorded reasons why each image (X-ray) was taken and that X-rays were always checked to ensure their quality and accuracy. The dentists graded each image taken to quality assured this process. Staff showed us their ongoing clinical audit records for the quality of the X-rays they took; this showed they were using this process to monitor their own performance in this aspect of dentistry.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found that the practice planned and delivered patients' treatment with attention to their individual dental needs and views about the outcomes they wanted to achieve. The dental care records we saw were clear and contained detailed information about patients' dental treatment.

The dentists were using a structured oral health assessment screening tool. This was to help them monitor patients' oral health and communicate areas of concern to patients in a more effective way. The tool used a traffic light style red, amber, green system which the dentists said they and their patients found helpful in understanding their risks of developing dental problems.

The records contained details of the condition of the gums using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed and offer tailored advice to help patients improve their dental health). We saw that the dentists also checked and recorded the soft tissue lining the mouth and external checks of patients face and necks which can help to detect early signs of cancer.

The dentists we spoke with were aware of various best practice guidelines including National Institute for Health and Care Excellence (NICE) guidelines and the Faculty of General Dental Practice Guidelines.

Health promotion & prevention

The practice was aware of the Public Health England 'Delivering Better Oral Health' guidelines and were proactive in providing preventative dental care as well as carrying out restorative treatments. Staff told us that they discussed oral health with their patients. For example, effective tooth brushing, oral hygiene, prevention of gum disease, and dietary / lifestyle advice. We looked at dental care records for eight patients and saw that oral health advice given was not routinely recorded. Patients we spoke with said that they had all been given oral health and dietary advice.

We observed that the practice provided targeted health promotion materials, by issuing and discussing advice sheets and leaflets to patients during consultations.

The water supply in East Sussex does not contain fluoride and the practice offered fluoride varnish applications as a preventive measure for adults and for children.

Staffing

Staff who were under training were supported by more experienced senior members. New staff underwent induction to ensure they understood how the practice operated and that they were competent in their role. Staff had received an appraisal. We looked at four staff files and found that their appraisals were very brief and in some cases had covered performance, training and development needs which had been addressed.

Staff told us they felt supported and confirmed that training was available for them to undertake via an online training provision. Support staff said that the dentists at the practice were supportive and always available for advice and guidance.

We saw evidence that members of the clinical team had completed most of their appropriate training to maintain the continued professional development required for their registration with the General Dental Council. This included, infection control, child and adult safeguarding, dental radiography (X-rays), oral cancer and other specific dental topics. However, training for medical emergencies had lapsed for all staff. The staff files contained details of confirmation of current General Dental Council (GDC) registration, current professional indemnity cover and immunisation status. The practice manager had a system for monitoring this information. However, we found that one of the dentists indemnity had expired and some staff had not had serum conversions to determine their level of immunity to Hepatitis B.

Working with other services

We saw evidence that the practice liaised with other dental professionals and made appropriate referrals to other services when this was needed. For example, they referred children who needed orthodontic treatment to specialists in this aspect of dentistry. The practice had arrangements with the local out of hours dental provision for emergency treatment when the practice was closed and details on how to access this service was displayed inside and outside the practice, on the practice website and in the patient information leaflet. The practice also provided a 24 hour emergency service on a private basis only.

Are services effective?

(for example, treatment is effective)

The practice was using the services of an unregistered dental laboratory. We found laboratory slips (prescriptions) for three patients who had received crowns made at the unregistered laboratory. Staff told us that they used the laboratory in question for crowns and bridges frequently. It is a criminal offence to procure dental prostheses from a lab that is not registered with the Medicines and Healthcare Regulatory Agency (MHRA).

Consent to care and treatment

The practice had a consent policy which was up to date and based on guidance from the General Dental Council (GDC). The dentists described the methods they used to

make sure patients had the information they needed to be able to make an informed decision about treatment. They told us that they often used diagrams and models as well as X-rays to illustrate information for patients.

The Mental Capacity Act 2005 provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff at the practice had not completed specific training about the MCA and consent, although this had been covered during safeguarding training. Members of the team told us that at present they had few patients where they would need to consider the MCA when providing treatment but were aware of the relevance of the legislation in dentistry.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients we spoke with were complimentary about the care and treatment they received at the practice. Some highlighted that they had been patients for many years or had remained patients even after moving away from Forest Row. Patients commented on the kindness and gentleness of their dentist as well as the positive attitudes approach of the whole team. All the staff we met spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity. This view was reflected in information patients had written in compliments made directly to the service.

We observed that the staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking with patients on the telephone.

Patients indicated that they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke

with told us that they had no concerns with regard to confidentiality; we noted that there had been no complaints or incidents related to confidentiality and that dental care records were stored securely.

Involvement in decisions about care and treatment

We looked at dental care records and saw that the dentists recorded information about the explanations they had provided to patients about the care and treatment they needed. This included details of alternative options which had been described. One dentist explained and showed us how they described root canal treatments to patients using leaflets about the subject and models of teeth. We saw another example where a patient had been to the practice for an emergency appointment. The dental care records showed that the dentist gave them information about the risks and benefits of the possible treatment options. They provided temporary treatment so that a full treatment plan could be discussed in a longer appointment and the patient had time to come to a decision.

Patients told us that they felt involved in their care and had been given adequate information about their treatment, options and fees. Staff told us and we saw they took time to explain the treatment options available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS dental treatment and private dental treatment. The practice statement of purpose and website provided information about the types of treatments that the practice offered.

The practice had a system to schedule enough time to assess and meet patient's needs. Each dentist had their own time frames for different treatments and procedures. Staff told us that although they were busy they had enough time to carry out treatments without rushing. The practice were able to book longer appointments for those who requested or needed them, such as those with a learning disability.

We found that the practice was flexible and able to adapt to the needs of the patients, and to accommodate emergency appointments. Patients we spoke with confirmed this and told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day.

Tackling inequity and promoting equality

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

The practice was accessible to wheelchairs and patients with pushchairs by a small flight of stairs at the entrance and one ground floor treatment room. The ground floor waiting area could accommodate a wheel chair or pushchair. Staff told us that this had not been a problem as the appointments would usually be extended.

Access to the service

Appointment times and availability met the needs of the patients. The practice surgery hours were Monday to Friday

9am to 5pm. Information about opening times was displayed at the entrance to the practice in both waiting rooms, on the practice website and patient information leaflet.

Patients needing an appointment could book by phone, in person or on the practice website. Patients with emergencies were seen on the same day even if there were no appointments available, staff would work later to accommodate them. The practice offered patients with pain the option to sit and wait and the dentist would see them. Patients we spoke with confirmed this.

If patients required emergency treatment when the practice was closed, the answer phone message would direct them to the local NHS dental out of hours service. This was also displayed in the waiting room, on the entrance door and on both the website and patient information leaflet. The practice also ran a private 24 hour access service and information about this was displayed in the same manner.

Concerns & complaints

The practice had a complaints process which was available on the practice website as well as in print at the practice. We looked at information available about comments, compliments and complaints dating back two years. The information showed that there was a longstanding commitment to listening to concerns raised. The practice had only received one complaint in the last year and we saw it had been handled in accordance with the practice complaints policy and resolved to the patient's satisfaction.

We also looked at the practices summary of more formal complaints and the records of these. These showed that the practice had listened to patients views and concerns, looked into these and offered explanations and where necessary an apology.

Are services well-led?

Our findings

Governance arrangements

There was a full range of operational policies, procedures and protocols to govern activity. All of these policies, procedures and protocols were subject to review. Some of the policies contained out of date information but had been reviewed recently, we brought this to the attention of the practice manager who stated that all of the policies would be reviewed again to ensure they contained up to date information for staff to refer to. Staff we spoke with were aware of the policies, procedures and protocols, their content and how to access them when required.

The practice undertook a series of practice wide audits to monitor and assess the quality of the services they provided. These audits had been repeated to evidence that improvements had been made where gaps had been identified. Records we looked at related to audits for infection control, the quality of X-rays taken and record keeping. There was clear evidence that these were taking place regularly. However, the findings of the audits had not documented an analysis of results, or some areas identified for improvement. We noted that actions identified in the legionella risk assessment had not been implemented, such as maintenance of the practice air conditioning system and the monitoring and recording of water temperatures. Therefore it was not clear that these audits were driving improvement and maintaining standards.

Leadership, openness and transparency

The practice had an enthusiastic practice manager who was being given effective support by the principal dentist. There was some understanding of the requirements of the regulations under the Health and Social Care Act 2008 and how these applied to dental practices. However, there were areas that required improvement, such as infection control.

We saw that relationships between members of the practice team were professional, respectful and supportive. Staff in all roles described the practice as a happy place to work where they were supported by the partners and other team members.

Learning and improvement

The practice had carried out some learning and development to develop their knowledge and skills. We found that the clinical dental team had undertaken the majority of the necessary learning to maintain their continued professional development which is a requirement of their registration with the General Dental Council (GDC).

The practice had team meetings which were used to share information. These provided opportunities for shared learning within the team. The meetings were for the whole team and had been rearranged following a period of eight months where none had taken place.

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

The practice gathered feedback from patients via the monthly NHS friends and family test. Results from the most recent months were very positive scoring between 98 and 100% of patients happy to recommend the practice to others. Other feedback was collected through testimonials from both patients and staff and results were available on the practice website. All of the feedback in the testimonials was positive especially where patients had been extremely anxious and in some cases phobic but could now attend without the stress and anxiety previously experienced.

Staff told us that the practice manager and dentists were approachable and that they could discuss anything they needed to whenever they needed to.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients were at risk of unsafe care and treatment because the provider did not have suitable systems in place to assess, manage and mitigate the risks associated with healthcare infection, prevention and control and the safe recruitment of staff. 12 (1) (2) (a), (b), (h)