

Mazdak Eyrumlu and Azad Eyrumlu Manor Dental Care

Inspection Report

7 Manor Buildings
Osler Road
Headington
Oxford
OX3 7RB

Tel: 01865 750056

Website: www.southerndental.co.uk

Date of inspection visit: 01/11/2016

Date of publication: 18/01/2017

Overall summary

We carried out an announced comprehensive inspection on 1 November 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was 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

Manor Dental Care is a dental practice providing NHS and private treatment for both adults and children. The practice is based on the first floor of commercial premises in Oxford.

The practice has four dental treatment rooms and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The practice is situated on the first floor of the building; patients with limited mobility are sign-posted to nearby dental services with ground floor access.

The practice employs two dentists, two locum dentists, one hygienist, two dental nurses of which one is a trainee, one receptionist and a part time practice manager.

The practice's opening hours are 8.30am to 1pm and 2pm to 5.30pm Monday to Friday, 8.30am to 1pm and 2pm to 7pm on Thursday and 8.30am and 2pm on Saturday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

There was no registered manager at the time of our inspection at this location. We were told that the current Practice Manager had resigned and was leaving the practice the day of our visit. A registered manager is a person who is registered with the Care Quality

Summary of findings

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 obtained the views of five patients on the day of our inspection.

Our key findings were:

- The dentists we spoke with had an ethos of providing patient centred dental care in a relaxed and friendly environment.
- Appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The practice appeared clean and properly maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was properly maintained.
- Infection control procedures followed published guidance.
- Staff we spoke with understood the issues around safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting of untoward incidents in the practice. Although the lack of records pertaining to incidents and accidents indicated that there may be under-reporting of such occurrences.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff we spoke with were committed to providing a quality service to their patients.
- The practice manager role was carried out on a 'dual location' basis. Due to the geographical distance between the two practices it was difficult for the practice manager to be fully effective in their role. As a result, staff were not always confident that the practice was effectively managed.
- We found that there were deficiencies in the operation of some clinical governance systems. This included

shortfalls in the systems to mitigate the risk of fire, maintaining certain records and obtaining feedback from patients on the quality of services provided by the practice.

- Information from 13 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Ensure that a system for collating the records of training, learning and development needs of staff members is established.
- Establish an effective system for obtaining patient feedback on the quality of services provided by the practice.

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

- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the availability of hearing loops for patients who are hard of hearing.
- Review staff understanding of the availability of an interpreter service for patients who do not speak English as their first language.
- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.
- Consider the provision of an external name plate providing details of the dentists working at the practice including their General Dental Council (GDC) registration number in accordance with GDC guidance from March 2012.
- Review patient information to ensure that the opening hours are accurately recorded on the practice leaflet and NHS Choices website.
- Review the frequency of staff meetings to ensure that staff have an opportunity to take part in shared learning and provide feedback regularly.
- Review arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports

Summary of findings

issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as Public Health England (PHE).

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 had arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the dental equipment used in the dental practice was maintained.

The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. Although the lack of reported incidents and accidents could indicate that there was an under-reporting of incidents.

We noted shortfalls with respect to managing fire safety risks and the systems that mitigated further risks to patients and the tenants on the first floor of the building in the event of a fire. We have since been provided with evidence to confirm the management of fire safety has been addressed.

We noted that previous alerts from the Medicines and Healthcare Regulatory Agency (MHRA) were retained by the practice but recent alerts that were pertinent to dentistry were not available.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action



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 current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals.

No action



Are services caring?

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

We obtained the views of five patients on the day of our visit. These provided a positive view of the service the practice provided.

All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

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 service was aware of the needs of the local population and took these into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

The practice is situated on the first floor of the building; patients with limited mobility are sign-posted to nearby dental services with ground floor access.

No action



Are services well-led?

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

We noted that although there was effective clinical care provided by the clinicians we spoke with working in the practice, the practice would benefit from an empowered and well trained practice manager. This would ensure that the company's governance policies and procedures are effectively delivered.

Although the practice had clinical governance and risk management structures in place there were shortfalls in the system. This included shortfalls related to managing fire safety risks and the systems that mitigated further risks to patients and the tenants on the first floor of the building in the event of a fire. These included; lack of regular testing of fire alarms and emergency lighting. We have since been provided evidence to confirm the management of fire safety has been addressed.

We found shortfalls in relation to staff recruitment files, specifically the failure to obtain satisfactory written references, although this is being addressed by the company.

The practice did not collate records of staff training and thus could not be assured that staff were meeting the needs of their professional registration. We also noted that staff meetings, an effective way of facilitating shared learning within the practice, were not routinely rostered. We found that when they were undertaken, the record of the meetings was unsatisfactory with little or no detail of the agenda items discussed and any outcomes/actions following staff discussions.

The staff had an open approach to their work and shared a commitment to continually improving the service they provided.

We saw evidence of appraisal being carried out and evidence of clinical audit.

Requirements notice



Manor Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 1 November 2016. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of four members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of five patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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 an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

We noted that apart from one incident in 2016, records showed that there were no other incidents or accidents reported over several years. This suggested that there may be under-reporting of incidents and accidents in the practice. The practice had a policy in place for RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations).

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Agency (MHRA). The practice did keep a record of such alerts, although the records did not show several recent alerts that were pertinent to dentistry that had been issued by MHRA. These included those relating to Automated External Defibrillators, emergency medicines used in dentistry and electrical socket covering devices. We also noted that there did not appear to be an effective system in place for sharing alerts with staff by practice managers such as using regular practice meetings.

Reliable safety systems and processes (including safeguarding)

We spoke to a staff about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked both dentists on duty how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use

only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

The practice had a policy and protocol in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. The policy had been reviewed in January 2016. We obtained information on the day of our inspection that showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had 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. We noted that staff were due to undergo training in the use of this device and how to deal with other medical emergencies soon. We saw evidence that a course for this training had been booked.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

Staff recruitment

All of the dentists, dental hygienist and dental nurse had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a

Are services safe?

recruitment policy that detailed the checks required to be undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We saw that all staff had received appropriate checks from the Disclosure and Barring Service (DBS). These are 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.

We looked at four staff recruitment files and records confirmed they were not recruited in accordance with the practice's recruitment policy. None of the four staff had evidence of references available for inspection. We were told that whilst references had been applied for these had not been received and were not chased. We were advised that company policy had recently been changed and were assured that under no circumstances would a person be employed without having a reference in place first.

Staff recruitment records were stored securely.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We noted shortfalls with respect to managing fire safety risks and the systems that mitigated further risks to patients and the tenants on the first floor of the building in the event of a fire. These included; a fire risk assessment that was not fit for purpose, lack of regular testing of fire alarms and maintaining emergency lighting and fire doors. The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention

and control in dental practices) Essential Quality Requirements for infection control was being exceeded. It was observed that audit of infection control processes carried out in March and October 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the two of the three dental treatment rooms in use, waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of both treatment rooms in use were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in July 2015. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging of processed instruments. The dental nurse we spoke with demonstrated the process from taking the dirty

Are services safe?

instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of an ultra-sonic cleaning bath and automated washer disinfectant for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath and washer disinfectant were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in three separate yellow bins adjacent to the practice prior to collection by the waste contractor. We noted that one of the yellow bins had a broken lock. We pointed this out to the Head of Compliance who assured us that this would be attended to as soon as practically possible. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

We found the practice did not produce an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in March 2016 and the washer disinfectant used in the decontamination processes had been serviced in March 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in October 2015.

Portable appliance testing (PAT) had been carried out in January 2016 and was due to be carried out again in January 2017.

We noted that batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We saw records that showed that auditing of the quality of X-rays taken by dentists working at the practice had been carried out. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. Both dentists we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown to us by the dentists demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care.

Both dentists explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

Dental care records we observed demonstrated that the dentists had given appropriate oral health advice to patients.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council. We noted that the external name plate which detailed names of the dentists working at the practice did not include their General Dental Council (GDC) registration number in accordance with GDC guidance from March 2012.

The majority of the patients and staff asked told us they felt there was enough staff working at the practice. Staff told us they felt a full time practice manager, a second nurse and receptionist would help deliver a better service.

Staff we spoke with told us they felt supported by the dentists. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed two dentists, two locum dentists, one hygienist, two dental nurses of which one was a trainee, one receptionist and a part time practice manager. There was a structured induction programme in place for new members of staff.

The dental hygienist did not work with chair side support. We pointed this out to the practice manager and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team', specifically standard 6.2.2 working with other members of the dental team.

Are services effective?

(for example, treatment is effective)

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

Both dentists we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options.

The dentists went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists.

Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored on paper and on computer. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; with paper records stored in an area of the practice not accessible to unauthorised members of the general public.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 13 patients prior to the day of our visit and five patients on the day of our visit. These provided a positive view of the service the practice

provided. All of the patients commented that the dentists were good at treating them with care and concern. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area.

Both dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable and estimates and treatment plans for private patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint.

The practice website was generic and did not provide opening hours and out of hour's information. The practice was listed on NHS Choices. Information from these sources was not up to date. For example opening hours on the patient leaflet, NHS Choices and the practice front door did not match. We spoke with the practice manager about this who assured us this would be addressed as soon as practically possible.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist.

The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services. Although the practice was situated on the first floor of the building, patients who found stairs a barrier were sign-posted to nearby dental services with ground floor access.

The provider used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment. This was not shared with the receptionist who when asked was unaware of this facility.

The practice did not provide a hearing loop for patients who used hearing aid but undertook to purchase one.

Access to the service

The practice's opening hours were 8.30am to 1pm and 2pm to 5.30pm Monday to Friday, 8.30am to 1pm and 2pm to 7pm on Thursday and 8.30am and 2pm on Saturday. Opening hours on the patient leaflet, NHS Choices and the practice front door did not match. We spoke with the practice manager about this who assured us this would be addressed as soon as practically possible.

All the patients we asked told us they were satisfied with the hours the surgery was open.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information booklet kept in the waiting area, NHS Choices website and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within three working days and a full response would be given in 14 working days.

We were told a trained person at head office managed complaints. The complaint log content was described to us by telephone which listed three complaints received since April 2016. We were satisfied these were being managed correctly and in accordance with the practice complaint procedure.

Are services well-led?

Our findings

Governance arrangements

Although the company had in place a system of policies, procedures and risk assessments pertaining to clinical governance in dental practice. There were shortfalls in the operation of some of the governance systems in the practice.

We noted that policies and procedures were held on the company intranet called the 'nerve centre,' this enabled all staff to access these policies as required. We saw for example that these policies and procedures in relation to COSHH and Legionella were maintained and up to date by the Head of Compliance on a regular basis.

The governance arrangements for this location consisted of a practice manager who was responsible for the day to day running of the practice. This individual managed two practice locations which were a considerable distance apart. Therefore, it was difficult for the practice manager to effectively manage this location which resulted in shortfalls in several areas including managing fire risk effectively, rostering and conducting effective staff meetings and maintaining records.

Leadership, openness and transparency

The individual dentist's ethos focused on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach.

Due to the dual nature of the practice manager role staff were not always confident that the practice was effectively managed. Despite this problem staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of an appraisal system and several clinical audits.

With respect to clinical audit, we saw results of audits in relation to clinical record keeping and the quality of X-rays which demonstrated that good standards were being maintained. For example, we saw evidence of record keeping audits which contained an analysis of the findings by the Clinical Support Manager. They would then provide useful hints and tips as to how the dentists could improve their standards. Each dentist was also given a red, amber or green rating of their records. The system in place ensured that any dentist rated red would be invited to discuss the findings with the company Clinical Director who would then arrange for further training or support.

We noted there was not an established system in place for collating the records of completed training and development needs of staff members. The Compliance Manager confirmed the shortfall and assured us training would be addressed as soon as practically possible. We have since been provided with evidence to confirm training in Fire Safety has been undertaken by relevant staff.

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

The practice was provided with patient feedback templates in order to carry out patient satisfaction surveys. We asked the practice manager for the most recent survey results and report and was told they had not undertaken any surveys.

We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

The practice was listed on NHS Choices website and patient feedback was responded to however some information was not up to date

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. As a result of staff feedback the practice extended opening hours one evening a week. Staff told us that they had meetings but these were infrequent

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>We found the provider did not have effective systems in place to:</p> <ul style="list-style-type: none">• Maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.• Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. <p>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <ul style="list-style-type: none">• Training, learning and development needs of staff members were not maintained and the provider was unable to demonstrate that relevant training had been undertaken by all relevant staff.• Patient satisfaction monitoring was not carried out. |