

Rodericks Dental Limited

Cookham Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 February 2017 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

Cookham Dental is a dental practice providing NHS and private treatment for both adults and children. The practice is based in a purpose built premises in Cookham, a village close to Maidenhead in Berkshire.

The practice has three dental treatment rooms of which two are based on the ground floor and a separate decontamination area used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs eight dentists, two hygienists, one nurse, five trainee nurses, one receptionist and a practice manager who is managing the practice for part of the week while a new manager is recruited. A number of agency nursing staff also regularly work at the practice.

The practice's opening hours are between 8am and 8pm Monday to Friday and 9am to 1pm 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, via 111.

As a condition of their registration with the CQC, the provider is required to ensure that the regulated activities are managed by an individual who is registered as a manager in respect of those activities at Cookham Dental

Summary of findings

Practice. At the time of the inspection there was no registered manager in place. We were told the previous post holder had left and a new practice manager was being recruited and would become a registered manager when their recruitment was complete.

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 the 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 10 patients on the day of our inspection. These provided a positive view of the services the practice provides. Patients were happy with the quality of care provided by the practice.

Our key findings were:

- We found that the ethos of the dentists and the dental hygienists was to provide patient centred dental care in a relaxed and friendly environment.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The dental treatment rooms appeared clean and well maintained.
- We noted that a wall in the waiting area was suffering from damp.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Infection control procedures were generally effective and the practice followed published guidance. We noted however that the pre-cleaning sterilisation room had several deficiencies. We saw that the working surfaces and the sinks were covered with hard water stains.
- The practice had processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- 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.
- There was not an effective system in place to collate and maintain the training records of staff.
- Staff did not always feel supported by the senior management team of the company.
- Patient feedback during our inspection gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice had clinical governance and risk management structures in place, but we found several shortfalls in systems and processes underpinning the quality of care provided.
- Areas we found that required improvements included policies not being current, staffing numbers, the storage of substances hazardous to health, fire safety and CQC incident notification.

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

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking the regulated activities. For example fire safety management and domestic waste storage.
- Ensure the training, learning and development needs of staff members are collated and reviewed at appropriate intervals.
- Establish a system to ensure that all staff receives practice updates and shared learning.
- Ensure agency staff checks meet the requirements of Schedule 3 of the Health and Social Care Act.
- Ensure that notifiable incidents relevant to the Care Quality Commission are actioned appropriately.
- Ensure the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations is stored securely.
- Ensure that practice infrastructure is maintained to an appropriate standard.

Summary of findings

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

- 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 issued in March 2012.
- Review the storage arrangements of the emergency medicines and lifesaving equipment so that they are stored in a central location in the practice and review the availability of a system for dealing with minor injuries to the eye.
- Review the contents of the practice website, practice leaflet and NHS Choices to bring information up to date.
- Ensure the practice complaints procedure includes the correct named person to deal with complaints.

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

The practice took its responsibilities for patient safety seriously and staff was aware of the importance of identifying, investigating and learning from patient safety incidents.

Records available confirmed that most 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 focused 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 10 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



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.

No action



Summary of findings

The practice had two ground floor treatment rooms and level access into the building for patients with limited mobility and families with prams and pushchairs.

Are services well-led?

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

Although the clinical care provided by the dentists and dental hygienists led to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care.

Areas of concern were policies not being current, permanent staffing numbers, the storage of substances hazardous to health, fire safety and CQC significant event notification.

There were deficiencies to the practice infrastructure. This included a wall in the waiting area that was damp and had peeling paint and the working surfaces and the sinks of the pre-sterilisation cleaning room were covered with hard water stains.

We noted that a burglary at the practice, which involved notifying the police, was not reported to the Care Quality Commission in accordance with the regulations.

Requirements notice 

Cookham Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 7 February 2017. Our inspection was carried out by a lead inspector and a dental specialist adviser.

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.

Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received since April 2016, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of 10 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 10 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 manager demonstrated a good awareness of RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). 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.

Records showed that six accidents occurred during 2015 and were managed in accordance with the practice's accident reporting policy. We noted that a burglary at the practice in 2016, which involved notifying the police, was not reported to the Care Quality Commission in accordance with the regulations.

We discussed with the practice manager the action they would take if a significant incident occurred, they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant, these alerts were shared with all members of staff by the practice manager.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse 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 needle guard when needles were recapped following administration of a local anaesthetic. 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 the staff 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 systems in place should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Although training records showed that some staff had received appropriate safeguarding training for both vulnerable adults and children, records showed that there were gaps in training. Specifically these were with respect to the dentists. 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. Staff had received training in how to use this equipment.

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.

Are services safe?

The emergency medicines and oxygen we saw were all in date, we noted that the emergency kit was stored in a remote area of the practice. It would be more appropriate if this kit was stored in a central location that was more readily accessible to staff in an emergency.

Staff recruitment

All of the dentists, dental hygienists and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work. For example, proof of identity, employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We looked at five staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy.

The practice manager told us they made use of agency staff regularly. We asked for records to confirm these staff met the fit and proper requirements of the health and social care act. We have yet to receive this information.

The systems and processes we saw were in line with the information required by regulations. Staff recruitment records were stored securely to protect the confidentiality of staff personal information.

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.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. These included risk assessments with respect to radiation, general health and safety and those pertaining to all the equipment used in the practice. An asbestos audit on the practice was carried out in October 2010.

We noted that there were shortfalls with respect to fire safety. This included the fire risk assessment recommendations not being carried out and the lack of effective weekly and monthly fire safety checks. A fire

escape route passed through a neighbouring property. We were told checks of this were not undertaken to ensure this route was free of obstructions as the property was now owned by the provider.

A wall in the waiting area that was damp and had paint peeling. There was a metal spiral staircase available for patients to access the lower ground treatment room. The steps were painted black with no contrast colour to define the edge of each step.

The practice had in place a well-maintained 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. We noted that some substances hazardous to health were not stored in accordance with COSHH guidelines. Cleaning agents and chemicals used in the decontamination process were stored in rooms that were accessible to the public.

Infection control

There were generally 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 met.

It was observed that an audit of infection control processes carried out in June 2016 and January 2017 confirmed compliance with HTM 01 05 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.

We saw that the three dental treatment rooms, 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.

Are services safe?

The drawers of two treatment rooms were inspected and these were generally 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.

A 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 February 2016. 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 separate decontamination rooms for instrument cleaning, sterilisation and the packaging of processed instruments. However, we saw that the working surfaces and the sinks of the pre-sterilisation cleaning room were covered with hard water stains.

The dental nurse we spoke with demonstrated the process from taking the dirty 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 manual scrubbing and an 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 autoclaves used in the decontamination process were

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 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 and clinical waste bags were properly maintained in accordance with current guidelines. We did note that the storage of municipal waste was unsatisfactory as this presented a fire hazard at the rear of the premises.

The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. 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. The practice had equipment that was stored in accordance with current national guidelines, although cleaning chemicals were not stored in accordance with COSHH regulations.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in October 2016 and other equipment used in the decontamination processes had been serviced in September 2015. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in December 2016 and were due to be tested again in December 2019.

Portable appliance testing (PAT) had been carried out in May 2016, and the fire extinguishers and emergency lighting in August 2016.

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

The practice had in place a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions.

Are services safe?

We observed that the practice had equipment to deal with minor first aid problems and body fluid and mercury spillage. We did note that there was no system for dealing with minor injuries to the eye.

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 were shown that a radiological audit for each dentist had been carried out in 2016. 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 was protected from unnecessary exposure to radiation. We saw training 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. One dentist 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 two dental hygienists to work alongside of the dentists in delivering preventative dental care.

A dentist 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).

We spoke to one of the dental hygienists who described the advice that they gave which included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that the dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council. We did note that there was only one qualified nurse working at the practice.

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.

All of the patients we asked told us they felt there was enough staff working at the practice. Staff told us there was not enough permanent staff but adequate cover from agency staff made up the shortfall. Staff we spoke with told us they felt supported by the dentists and practice manager.

Are services effective?

(for example, treatment is effective)

The practice employed eight dentists, two hygienists, one nurse, five trainee nurses, one receptionist and a practice manager who is managing the practice for part of the week while a new manager is recruited. A number of agency nursing staff also regularly worked at the practice.

There was a structured induction programme in place for new members of staff. The dental hygienists always worked with chairside support.

Working with other services

A dentist explained how the dentists worked 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 as well as specialists who worked within the company.

Consent to care and treatment

A dentist 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 had an understanding of their treatment options.

The dentist 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 mainly electronically. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; We did note that some paper records were stored in an area of the practice that was accessible to unauthorised members of the general public. We were told these were being moved to another practice for archiving and were assured they would be secured until this happened.

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 10 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 and on the practice website that detailed the costs of both NHS and private treatment.

The dentist we spoke with paid 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 also contained useful information to patients such as how to provide feedback to the practice, details of out of hour's arrangements and the costs of treatment under NHS and private care. 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.

To improve access for patients who found steps a barrier two treatment rooms were based on the ground floor. A wheelchair accessible toilet was available and the practice provided a hearing loop for patients who used hearing aid.

Access to the service

The practice's opening hours were between 8am and 8pm Monday to Friday and 9am to 1pm on Saturday.

We asked 10 patients if they were satisfied with the hours the surgery was open; all but one patient said yes. This patient said they did not have an opinion.

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 noted the person responsible for handling complaints was the previous practice manager and details required updating. We asked 10 patients if they knew how to make a complaint if they had an issue and eight said yes, one said no and one was not sure.

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 10 days. We were told the practice had not received any complaints since April 2016.

Are services well-led?

Our findings

Governance arrangements

Although the clinical care provided by the dentists and the dental hygienists led to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care. Areas of concern were policies not current, staffing numbers with respect to the ratio of qualified nurses to trainee nurses, the storage of substances hazardous to health, fire safety and CQC significant event notification.

The governance arrangements of the practice were developed through a process of continual learning and improvement. The governance arrangements for this location consisted of the practice manager who was responsible for the day to day running of the practice.

The practice maintained a system of policies and procedures contained in files in the practice manager's office. All of the staff we spoke with were aware of the policies and how to access them. We noted that some management policies and procedures were not kept under review on a regular basis. For example, the complaints policy was last reviewed in 2009; we also noted that the safeguarding policy for children was last reviewed in 2013 and the adult safeguarding policy in 2011.

The practice used the Information Governance Tool Kit. This tool kit is a contractual requirement for providers of NHS services.

Leadership, openness and transparency

We found that on the day of our inspection the covering practice manager endeavoured to provide leadership in the practice. The previous practice manager had left several weeks prior to our visit. We found that staff were not adequately supported by senior managers within the company. Staff reported that they made senior managers aware of practice issues but these were either not responded to or not dealt with in a timely manner.

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

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed

that all staff received an annual appraisal. There was a system of peer review in place to facilitate the learning and development needs of the dentists and dental nurses which took place on a quarterly basis but records seen confirmed the last meeting was held in July 2016.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development.

The provider encouraged staff to carry out professional development wherever possible but we found that evidence of completed training did not always come back to the practice.

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

All the patients we asked told us they would recommend the practice to a family member or friend.

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area. The last practice survey was due in 2016 but not completed. We were told this was due to there not being a permanent manager in place since October 2016.

The practice was listed on NHS Choices website and information was generally up to date and patient feedback was responded to.

Results of the most recent NHS Friends and Family survey carried out indicated that 92% of patients, who responded, said they would recommend the practice to a family member or friend.

As a result of patient feedback the practice appointed a second receptionist to answer the telephone at busy times

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. Staff told us that team meetings had not taken place since October 2016 but felt this was due to the lack of a permanent manager at the practice.

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	<p data-bbox="815 658 1385 725">Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p data-bbox="815 748 1513 927">The registered person did not have effective systems in place to ensure that the regulated activities at Cookham Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p data-bbox="815 1010 1294 1043">How the regulation was not being met:</p> <ul data-bbox="823 1122 1517 2085" style="list-style-type: none"><li data-bbox="823 1122 1517 1379">• The fire risk assessment carried was not fit for purpose and actions arising from it were not carried out. A fire escape route was via a neighbouring property. Checks of this were not undertaken to ensure this route was clear. The ‘responsible person’ for fire safety at the practice had not received appropriate training to fulfil this role.<li data-bbox="823 1402 1517 1503">• Written policies and procedures were not reviewed regularly and updated to reflect changes in legislation and guidelines.<li data-bbox="823 1525 1517 1637">• A wall in the waiting area was visibly damp. The sinks and work surface of the pre-sterilisation cleaning room were covered with hard water stains.<li data-bbox="823 1659 1517 1771">• Training records of staff members were not maintained to demonstrate relevant training had been undertaken by all relevant staff.<li data-bbox="823 1794 1517 1861">• Domestic waste storage arrangements were not effective<li data-bbox="823 1883 1517 1995">• The system to ensure that all staff received practice updates and shared learning had not taken place since October 2016.<li data-bbox="823 2018 1517 2085">• Notifiable events relevant to the Care Quality Commission were not reported appropriately.

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Requirement notices

- Products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations were not stored securely.