G T Bennett

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Inspection Report

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Overall summary

We carried out this announced inspection on 1 May 2019 in response to receiving information of concern, and under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

These questions form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services effective?

We found that this practice was not 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

G T Bennett is a dental surgery in Middleton, Manchester and provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs. On-street parking is available near the practice.

The dental team includes the principal dentist and an associate dentist, two dental nurses (one of whom is a trainee), and a dental hygienist who also manages the practice. The practice has three treatment rooms.

Summary of findings

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we collected 11 CQC comment cards filled in by patients.

During the inspection we spoke with the principal dentist, the dental nurses and the dental hygienist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday, Wednesday and Friday 9:30am to 5pm

Tuesday 9:30am to 7pm

Thursday 8am to 1pm

Our key findings were:

- The premises were not clean or well maintained.
- The infection control procedures did not reflect published guidance.
- Appropriate medicines and life-saving equipment were not available to enable staff to respond to medical emergencies.
- The practice did not have systems to help them identify and manage risk to patients and staff.
- The provider had suitable safeguarding processes. However not all staff received training or knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures.
- The clinical staff did not provide patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider did not have effective leadership or a culture of continuous improvement.
- Staff felt supported and worked well as a team.
- The provider had suitable information governance arrangements.

We identified regulations the provider was not complying with. They must:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences
- Ensure care and treatment is provided in a safe way to patients
- Ensure all premises and equipment used by the service provider is fit for use and maintain appropriate standards of hygiene for premises and equipment
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

Full details of the regulations the provider was not meeting are at the end of this report.

We took urgent action to ensure people could not be exposed to a risk of harm and suspended the provider's CQC registration for a period of three months to allow the provider to act on the risks.

This notice of urgent suspension was issued because we believe that a person will or may be exposed to the risk of harm if we do not take this action.

The provider sent a written confirmation on 3 May 2019 that they were taking immediate retirement and confirmed that no further regulated activities will be carried out at the location.

This was confirmed by NHS England who were making arrangements to ensure patients could continue to receive care elsewhere.

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?

Enforcement action 

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

The practice did not have systems and processes to provide safe care and treatment.

Not all staff received training in safeguarding people. Staff, apart from the principal dentist knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles and the practice completed essential recruitment checks. There was no evidence of professional indemnity insurance for the associate dentist.

Premises and equipment were not clean or properly maintained. Electrical safety was not assured.

The practice did not follow national guidance for cleaning, sterilising and storing dental instruments. There was evidence that single use items were reprocessed, and equipment was not validated appropriately. Not all instruments were stored appropriately.

The practice did not have suitable arrangements for dealing with medical and other emergencies.

Fire risks were not adequately assessed. Fire detection means and arrangements for safe evacuation were ineffective. There was large quantities of clutter throughout the practice.

Legionella risks had not been assessed and water quality management was not in place. Dental unit water bottles were visibly dirty.

Hazardous substances, including mercury and dental amalgam waste, were not risk assessed or stored and disposed of appropriately.

Are services effective?

Enforcement action 

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

Patients said they were made to feel comfortable when receiving treatment. The principal dentist told us they discussed treatment with patients so they could give informed consent.

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

Summary of findings

Care was not carried out in compliance with current legislation, or relevant nationally recognised evidence-based standards and guidance. For example, the selection criteria and frequency of radiographs and periodontal assessments and care were not in line with recognised guidance.

Dental care records were not appropriately maintained. The care documented did not include diagnosis, evidence of or discussions with patients of treatment planning, options, risks and benefits.

Are services caring?

No action

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

We received feedback about the practice from 11 people. Patients were positive about the service the practice provided. Comments included that staff were friendly, polite and helpful.

They said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

Are services responsive to people's needs?

No action

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

The practice's appointment system took account of patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for patients with a disability and families with children. The practice did not have access to an interpreter services but staff told us this had never been required.

Are services well-led?

Enforcement action 

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

The practice did not have arrangements to ensure the smooth running of the service. Leadership was ineffective and governance systems were inadequate.

The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

Dental care records we saw were incomplete and not consistently stored appropriately.

The provider did not monitor clinical and non-clinical areas of their work to help them improve and learn. Opportunities were missed to highlight the concerns found during the inspection.

The provider did not ensure staff were up to date with training. There was no evidence of professional indemnity insurance for the associate dentist.

Are services safe?

Our findings

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

The practice did not have clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. The practice was unable to provide evidence that staff received safeguarding training. With the exception of the principal dentist, staff demonstrated they knew about the signs and symptoms of abuse and neglect and how to report concerns. We were unable to confirm whether the principal dentist would recognise and act on safeguarding concerns.

The practice had a whistleblowing policy but this did not include how to raise concerns externally. Staff only knew to raise any concerns with the manager.

The principal dentist did not use dental dams or other methods to protect the airway in line with guidance from the British Endodontic Society when providing root canal treatment.

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

The practice had a recruitment procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at staff recruitment records. These showed the practice followed their recruitment procedure.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover, with the exception of the associate dentist for whom evidence of professional indemnity cover was not provided.

The practice did not ensure that facilities and equipment were safe, or make sure equipment was maintained according to manufacturers' instructions.

The premises appeared to be in a poor state of repair, with evidence of active damp. Carpets appeared dirty and the flooring in the decontamination room unsealed.

A fire risk assessment had been carried out in February 2017 by a member of staff. We found they were not competent to do this. This document showed that smoke alarms had been considered but not installed. The practice had powder fire extinguishers. We were unable to identify the age of these and the provider confirmed these had not been serviced or maintained to ensure they were in working order. The provider did not demonstrate that they had ensured that this type of extinguisher was appropriate for the premises and equipment. The premises had one smoke detector, which when tested during the inspection did not work and there had been no consideration of installing additional fire detection, emergency lighting, or the provision of a rear fire exit. We observed significant quantities of clutter including combustible materials in two rooms and in the cupboard under the stairs. A referral was made to the Greater Manchester Fire Service to assess the risks.

The provider confirmed that to their knowledge, the fixed wiring systems in the premises had never been tested, and they were unsure whether this was requirement of their public liability insurance. The principal dentist carried out testing and visible checks on portable appliances.

The practice had some arrangements to ensure the safety of the X-ray equipment. Three-yearly routine tests of the equipment were carried out but a recommendation in the last report from October 2016 to ensure that power to the equipment could be cut without entering the controlled area had not been actioned. The report had also recommended the use of rectangular collimation. We saw that a rectangular collimator was available but this did not fit correctly and would be difficult to use. The dentists did not use beam aiming devices appropriately and as a result, the X-rays we reviewed were of reduced diagnostic quality due to 'coning'. Coning is an error in taking a radiograph where the film is incorrectly aligned with the x-ray beam.

The provider did not have a radiation protection file and could not show that they had access to the services of a radiation protection adviser (RPA).

The dentists did not justify, grade or report on the clinical findings of the radiographs they took. Radiography audits were not carried out following current guidance and legislation.

Are services safe?

The provider could not show evidence that the dentists completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

Systems were not in place to assess, monitor and manage risks to patient safety.

The practice's health and safety arrangements were ineffective. Procedures and risk assessments were not reviewed effectively to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken but this related to dental needles and did not include the risk from other sharp items. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury and staff were aware of the importance of reporting inoculation injuries. Staff confirmed that only the dentists were permitted to assemble, re-sheath and dispose of needles where necessary to minimise the risk of inoculation injuries to staff.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. There was no evidence of the effectiveness of this, or a risk assessment in place for two clinical members of staff.

Staff completed training in emergency resuscitation and basic life support (BLS) every year.

The emergency equipment and medicines available were not as described in recognised guidance which the General Dental Council requires dental practices to follow. For example:

- The medical emergency oxygen cylinder was past its use by date of November 2010. The provider was not aware that there was a sticker stating this on the cylinder, or that periodic checking and maintenance were required.
- There was no Glucagon injection available to treat low blood sugar.
- There was no child sized self-inflating bag and mask.
- Midazolam oromucosal solution for the treatment of epileptic seizures was not available. Diazepam injection was present but this had expired in June 2018 and the provider did not have sufficient training to administer this.
- A member of staff told us that the pads for the automated external defibrillator had expired two months before the inspection. We found that these actually expired in January 2018. We saw evidence that replacement adult and child pads had been ordered.
- Expired medicines such as adrenaline, salbutamol inhalers and oral glucose solution.were stored alongside medicines that were within their expiry date.

Staff did not carry out regular checks of the emergency equipment and the provider was not aware of the need to inspect the kit on a weekly basis to make sure appropriate medicines and equipment were available, within their expiry date, and in working order. We observed the emergency kit had been separated into six large containers which were stored in the ground floor office. We discussed how this may delay access to these items, particularly if staff were required to respond to an emergency in the first-floor surgeries.

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

The provider did not have suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. For example, bottled mercury was available for use and this was not risk assessed. We also found significant quantities of dental amalgam waste in a cupboard in the decontamination room. These were stored in glass coffee jars and not rigid white receptacles with a mercury suppressant as described in The Health Technical Memorandum 07-01: safe management of healthcare waste. The provider was not aware that all dental mercury must now be in encapsulated form only.

The practice did not have an up to date infection prevention and control policy or procedures. They did not follow the guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care.

Staff completed infection prevention and control training and received updates as required.

Are services safe?

The practice did not have suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. We saw evidence that single use items including impression trays and a dental matrix band were reprocessed. The records showed equipment used by staff for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance. We observed that the printer which provides evidence that the steriliser was operating effectively was broken. The lead dental nurse was aware to check the colour of sterilisation indicators on the instrument pouches. Daily checks were carried out using Time / Steam / Temperature (TST) indicator strips. Staff were unaware that the vacuum autoclave required a different type of test to ensure that steam penetrates into pouched instruments.

Sterilised instruments were not consistently pouched and the reprocessing date was not marked on some pouches.

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

The practice did not have procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. The lack of a risk assessment was raised at the previous CQC inspection in 2012. This had not been actioned. The provider carried out monthly water temperature testing. A toilet on the ground floor was identified as a lesser-used outlet. This was not flushed weekly as staff could not access the room due to significant quantities of clutter. There were no control measures in place for the dental unit water lines. The provider told us that only purified water was used. We saw the inside of bottles used to store purified water and the bottles attached to the dental units all contained visible biofilm and this was shown to the provider. Biofilm is a microbial community composed of cells irreversibly bound to a surface which support bacterial growth.

Staff told us that purifying tablets were previously used in the bottled systems but these had run out. Since then they occasionally used a bleach solution to flush the bottled system in the first-floor surgery. A water maintenance solution was used in the ground floor surgery waterlines approximately once a month for the continuous maintenance of water quality in procedural water lines. This was not in line with the manufacturer's instructions, which states the dental unit must be free from biofilm and contamination before introducing this solution.

We highlighted that the first-floor dental hygienist surgery unit was not isolated from the mains water by using an independent bottled water system on the unit.

The practice employed a cleaner. Effective cleaning was inhibited by significant quantities of clutter and the poor state of repair of the premises. Cabinetry in the treatment rooms and the decontamination room was in a poor state of repair with rusted handles, collapsed cupboards and wooden inserts which inhibited effective cleaning. There were torn dental chairs and operator stools, and floors were not sealed. Drawers in the treatment rooms were cluttered and did not appear to be cleaned effectively.

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

We were told that annual infection prevention and control audits were carried out but evidence of these could not be found.

Information to deliver safe care and treatment

Staff had the information they needed to deliver care and treatment to patients.

We looked at a sample of dental care records and noted that dental care records we saw were incomplete and not consistently stored appropriately. We found two dental care records in the complaints file. The provider was not aware they had been placed there. Another dental care record had been left in the domiciliary kit from a home visit carried out on 11 April 2019.

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

Safe and appropriate use of medicines

The provider did not have reliable systems for appropriate and safe handling of medicines.

Expired local anaesthetic cartridges were found in the first-floor surgery and expired dental materials were evident throughout the practice.

Are services safe?

The practice did not store NHS prescriptions as described in current guidance. Prescriptions in the first-floor surgery were pre-stamped. The practice did not have a system to log prescriptions or identify if any were missing.

The principal dentist was aware of current guidance with regards to prescribing medicines.

Track record on safety and Lessons learned and improvements

The practice did not have risk assessments in relation to safety issues. The practice had an accident book for staff to report any accidents. Staff could not recall any incidents that had occurred in the last few years.

There was a system for receiving and acting on safety alerts from the Medicines and Healthcare Products Regulatory Agency. We saw they were acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice did not have systems to keep dental practitioners up to date with current evidence-based practice. We discussed how the dentists used radiographs as part of the assessment process. The provider was not aware of accepted guidance from the Faculty of General Dental Practice (UK) for the frequency of radiographs. They told us they rarely took X-rays. Where X-rays were taken, they did not document a justification, grade the quality of, or report on the clinical findings of radiographs.

Dental care records were not maintained in line with the Faculty of General Dental Practice recommendations, or guidance to similar effect, regarding clinical examinations and record keeping. For example, the dental care records lacked documented diagnosis and treatment planning.

Basic Periodontal Examinations (BPE) were carried out by the dental hygienist only. The BPE is a screening tool that is used to indicate gum health, the level of examination needed and to provide basic guidance on treatment need. The principal dentist confirmed they did not carry out six-point pocket charting as indicated in national guidance.

The provider told us they did not carry out domiciliary care, but we found evidence that a domiciliary visit had taken place on 11 April 2019. There was no evidence that the provider took into account guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children and adults based on an assessment of the risk of tooth decay.

The dentists discussed and encouraged patients to reduce or stop smoking and reduce alcohol consumption. and diet with patients during appointments. The practice had an interactive smoking cessation display and provided health promotion leaflets to help patients with their oral health.

The dentists referred patients to the dental hygienist for treatment and preventative advice. No diagnosis, prescriptions or instructions were provided to the dental hygienist to enable them to provide appropriate care.

Consent to care and treatment

The systems to record consent to care and treatment were ineffective.

The practice team understood the importance of obtaining and recording patients' consent to treatment. There was no documented evidence that the dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions in line with the General Dental Council standards for the dental team. Patients comments confirmed the dentist listened to them and gave them clear information about their treatment.

The team understood their responsibilities under the Mental Capacity Act 2005 when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

Monitoring care and treatment

The dental care records containing information about the patients' current dental needs, past treatment and medical histories. Evidence could not be provided that care was assessed, planned, carried out and documented in line with nationally accepted clinical standards.

There was no system to audit the quality of dental care records or review them against nationally agreed guidance from the Faculty of General Dental Practice.

Effective staffing

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

Staff new to the practice had a period of induction based on a structured programme. We asked to see evidence that

Are services effective?

(for example, treatment is effective)

clinical staff completed the continuing professional development required for their registration with the General Dental Council. There was no evidence that the dentists had received up to date training in safeguarding or radiography.

Co-ordinating care and treatment

The principal dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice did not have systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections. The principal dentist did not demonstrate an understanding of sepsis recognition and processes to identify if a patient could have life-threatening infection in relation to dentistry.

The practice had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were friendly, polite and helpful. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff listened to them and were compassionate and understanding.

Practice information was available for patients to read in the waiting rooms.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and ground floor waiting area provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff would take them into another room. Staff did not leave patients' personal information where other patients might see it.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the principles of the Accessible Information Standards and the requirements under the Equality Act.

The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given.

The practice did not have access to interpretation services for patients who did not understand or speak English but staff told us these had never been needed. Staff communicated with patients in a way that they could understand and communication aids and easy read materials were available.

Patients confirmed that staff listened to them, did not rush and discussed options for treatment with them.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

A disability access audit had been completed. The layout of the premises prevented the practice from making reasonable adjustments for patients with disabilities. There was a treatment room on the ground floor but this was not in use on the day of the inspection. The toilet was on the first floor, the space was too narrow to install any hand rails.

Timely access to services

Patients commented that they could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their information leaflet and on the NHS Choices website.

Patients who requested urgent advice or care were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Patients could choose to receive appointment cards for forthcoming appointments. Staff told us they did not send out recall appointments when patients were due for a check-up because they did not have time.

The practice's information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice had a procedure for handling complaints. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

The manager was responsible for dealing with these. Staff would tell them about any formal or informal comments or concerns straight away so patients received a quick response.

The manager aimed to settle complaints in-house and invited patients to speak with them in person to discuss these.

The practice had not received any recent complaints. Information relating to previously handled complaints could not be found.

Are services well-led?

Our findings

Leadership capacity and capability

The leadership of the practice was ineffective.

The principal dentist lacked knowledge about issues and priorities relating to the quality and future of services. When these omissions were brought to their attention, they could not demonstrate that they understood the challenges, or would take the appropriate action to address them.

After the inspection, the provider told us they were closing the practice with immediate effect. They were working with NHS England to ensure that patients could continue to receive care from another provider.

Culture

Staff stated they felt valued and worked well together.

There were systems to deal with poor performance, but not all staff were familiar with these.

The provider had systems to ensure compliance with the requirements of the Duty of Candour.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The dental hygienist was responsible for the day to day running of the service. Staff knew the management arrangements and their roles.

The clinical governance systems in place were ineffective. The manager struggled to locate policies and procedures due to the large quantities of retained documents which had amassed over many years. Many of these documents were from other organisations. There was no evidence that practice protocols and procedures were reviewed on a regular basis.

Systems were not in place to identify and manage risks, issues and performance. Particularly in relation for premises, electrical and fire safety, Legionella and the arrangements to respond to medical emergencies. The provider could not provide assurance that staff carrying out key roles, did so appropriately. For example, infection prevention and control procedures and the validation of sterilisation equipment did not follow HTM01-05 guidance.

Appropriate and accurate information

Quality and operational information was not used to ensure and improve performance.

Staff were aware of the importance of protecting patients' personal information. We could not be assured that information governance arrangements were in place. Patient information was not consistently held securely. For example, we found dental care records in the complaints file and the domiciliary box.

Engagement with patients, the public, staff and external partners

On the day of the inspection, the provider did not engage effectively with the inspection process. They were not open to discussion and would not fully participate in clinical discussions, stating that other staff members were responsible for areas relating to safeguarding, infection prevention and control and responsibilities under the Mental Capacity Act.

The practice used verbal comments to obtain patients' views about the service.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used.

The practice held occasional meetings, and informal discussions with staff.

Continuous improvement and innovation

The principal dentist did not show a commitment to learning and improvement.

There were no quality assurance processes to encourage learning and continuous improvement. The provider did not carry out audits of dental care records or radiographs. We were told that annual infection prevention and control audits had been carried out but saw no evidence of these. The provider had missed opportunities to identify and act upon concerns raised during the inspection.

The practice manager told us that they discussed learning needs and general wellbeing informally with staff, but these discussions were not documented.

The practice could not demonstrate that staff completed 'highly recommended' training as per General Dental

Are services well-led?

Council professional standards. We saw evidence that medical emergencies and basic life support training was undertaken annually. There was no evidence that staff received radiation protection or safeguarding training.