

Goldman & Sacker Chigwell Smile

Inspection Report

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Overall summary

We carried out this announced inspection on 28 June 2018 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 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

Chigwell Smile is in Chigwell, Essex and provides NHS and private treatment to adults and children.

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

The dental team includes two dentists, three dental nurses, one dental hygienist and a receptionist. The practice has three treatment rooms.

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Chigwell Smile is the principal dentist.

On the day of inspection we collected 35 CQC comment cards filled in by patients and spoke with two other patients.

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

The practice is open: Monday to Thursday from 8am to 1pm and from 2pm to 5.30pm. Friday from 8am to 1pm and from 2pm to 5pm.

Our key findings were:

- We received positive comments from patients about the dental care they received and the staff who delivered it.
- The practice appeared clean and well maintained.
- The practice staff had infection control procedures which reflected published guidance. The practice carried out infection prevention and control audits, but not as regularly as recommended by guidance.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The clinical staff provided 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 practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice staff dealt with complaints positively and efficiently.
- There was no system in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.
- The provider did not have all emergency medicines or equipment in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Risk assessment to identify potential hazards and audit to improve the service were limited.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation/s the provider was/is not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities in relation to this.
- Review the practice's policies and procedures for obtaining patient consent to care and treatment to ensure they are in compliance with legislation, take into account relevant guidance, and staff follow them.
- Introduce protocols regarding the prescribing of antibiotic medicines and review the practice's protocols for completion of dental care records, taking into account the guidance provided by the Faculty of General Dental Practice.

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 impact of our concerns with regards to the use of X-rays and radiation has been reduced due to the registered provider taking urgent action.

The practice had systems and processes to provide safe care and treatment. The assessment of potential hazards was limited, and no risk assessments had been completed for the use of sharps.

Staff received training in safeguarding and knew how to recognise the signs of abuse. There was scope to ensure staff were aware of how to report concerns.

We found that untoward events were not always reported appropriately and learning from them

was not shared across the staff team. We found that not all staff had a clear understanding of the process.

We were told there had been a Legionella risk assessment completed. This was not

available during the inspection or thereafter. We were not assured any recommended actions

which may have been identified had been actioned and completed, or any recommended prevention methods were appropriate and in place.

Staff were qualified for their roles and the practice.

Premises and equipment were clean. The practice followed national guidance for cleaning, sterilising and storing dental instruments. Not all the records for servicing equipment were available at the practice.

Appropriate medicines and life-saving equipment were not all available. We noted the practice was missing some essential medical emergency equipment such as a paediatric ambubag. Other equipment was out of date such as cannulas. The practice did not carry the correct form of medicine to manage epileptic fits, aspirin was not available and the glucagon had not been stored correctly.

No action



Are services effective?

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as friendly, professional and reassuring. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

No action



Summary of findings

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

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

Are services caring?

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

We received feedback about the practice from 37 people. Patients were positive about all aspects of the service the practice provided. They told us staff were exceptional, excellent and professional.

They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

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

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to interpretation services. Multi-lingual staff were available to support patients. The practice had arrangements to help patients with sight or hearing loss.

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

No action



Are services well-led?

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

The staff told us they enjoyed their work and felt supported by the principal dentist and practice manager. However, we found a number of shortfalls indicating that the practice's governance procedures needed to be improved. This included the analyses of untoward events, the availability of medical emergency equipment and medicines, the management of legionella, oversight of the frequency of equipment servicing including decontamination equipment and X-ray servicing and maintenance.

Requirements notice



Are services safe?

Our findings

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

The practice had 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. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect. There was scope to ensure the whole practice team fully understood the reporting pathways for reporting concerns, including notification to the CQC.

There was scope to improve the whole teams understanding of the formal reporting pathways required following serious untoward incidents as detailed in the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) and ensure these were displayed in the practice reception area.

There was a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination. Staff said that they worked well as a team and were encouraged to speak out if they had concerns.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. We were told that a Rubber dam kit was used most of the time during root canal instruments. In those instances where rubber dam was not used, the practice used cotton wool rolls and high volume suction to prevent inhalation or ingestion on root canal treatment. We were told the practice used hypochlorite as the irrigant during root canal treatment without the use of rubber dam. Using cotton wool roles and high volume suction does not

provide adequate protection from inhalation or ingestion of hypochlorite. We discussed the use of this with the principal dentist and we were told the practice protocol would be reviewed immediately.

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

The practice had a staff recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at seven staff recruitment records. We did not look in detail at staff recruitment records as all staff had been employed at the practice prior to registration.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities such as gas and electrical appliances were safe. We found that not all servicing documents were available during our inspection to confirm that equipment was maintained according to manufacturers' instructions and recommendations.

Records showed that firefighting equipment, such as fire extinguishers, were regularly serviced.

During our inspection the principal dentist told us that the three-yearly servicing and safety checks of the X-ray equipment had lapsed and was six months overdue, no electrical or mechanical annual testing had been undertaken. There was no radiation protection file available at the practice so we were unable to confirm what information was in the file. We held discussions with the principal dentist regarding the necessity to hold adequate records and ensure equipment was regularly serviced if the service was to continue being provided. The practice took immediate action and agreed to stop all X-ray services until the practice equipment had been surveyed and the correct documentation was available and provided on site. Following the inspection, the practice provided evidence to CQC that servicing of all X-ray equipment had been undertaken on 5 July 2018.

We noted that rectangular collimation was not used on X-ray units to reduce the dosage to patients. We discussed this with the principal dentist during the inspection.

Are services safe?

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation.

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

Risks to patients

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

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. We looked at a health and safety self risk assessment that had been undertaken in January 2016, reviewed in January 2017 and again in January 2018. We noted that where areas of work were identified in 2016 there was no confirmation that these had been undertaken or completed. One item with regard to radiation signage was recorded as needing attention on the original risk assessment which had been completed in 2016. There was no evidence of this being revisited, or of any action being taken or completed at the following two reviews.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. Not all staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had not been undertaken; we were told that it was only the dentists who handled sharps. We noted two incidents in the practice accident book which detailed sharps injuries to dental nurses, one incident in March 2018, another in 2017 for which there were no details of referral for medical advice or blood tests.

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, and that the effectiveness of the vaccination was checked.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. Staff did not regularly rehearse emergency medical simulations so that they had a chance to practise their skills. We noted the practice was missing some essential medical emergency equipment such as a paediatric ambubag, there was only one airway which was out of date and no clear face masks were available for the

ambubag. We noted that the cannulas were also out of date. The practice did not carry the correct form of medicine to manage epileptic fits, there was no 300mg aspirin available and the glucagon had not been stored correctly. We found the practice carried a range of other medicines in the emergency kit that were not suggested in the Resuscitation Council Guidelines, such as Chlorphenamine, Atropine and Hydrocortisone. Staff kept records of their checks. We found these were undertaken monthly. This is not at the frequency suggested in the Resuscitation Council Guidelines.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team. We were told that although the hygienist worked alone, staff were available should chairside support be required.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. We noted there was an absence of signage and appropriate hand washing agents available for handwashing in the decontamination room.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05.

There were no records available during the inspection to evidence that equipment used by staff for cleaning and sterilising instruments had been serviced in line with the manufacturers' guidance. For example, there were no records to confirm the servicing of the autoclave.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

We were told there had been a Legionella risk assessment completed but the principal dentist could not confirm when this was undertaken. This was not available during the inspection or thereafter. We were not assured any recommended actions which may have been identified had

Are services safe?

been actioned and completed, or any recommended prevention methods were appropriate and in place. We saw that sentinel temperature checks were undertaken monthly and logged but we noted these rarely reached the recommended 55 degrees. There was no evidence that the air conditioning units in the practice had been serviced recently. We were told the previous provider for this service had retired and the practice were in the process of sourcing another engineer.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual. Staff had their hair tied back and their arms were bare below the elbows to reduce the risk of cross contamination. We noted they changed out of their uniform to eat their lunch. We were told staff were provided a minimum amount of uniforms which did not allow for frequent laundering for those staff who worked a full week.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted the yellow clinical waste bin was locked but was not secured to the building or stored in a safe area. We discussed this with the principal dentist who confirmed this would be immediately secured.

The practice carried out infection prevention and control annually, but not as regularly as recommended by guidance which states completion on a six-monthly basis. The latest audit showed the practice was meeting the required standards.

Information to deliver safe care and treatment

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

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that not all individual records were written and managed in a way that kept patients safe. Some dental care records we saw were not accurate or complete. We noted records were kept securely and complied with General Data Protection Regulation (GDPR) protection requirements.

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

Safe and appropriate use of medicines

Medicines were stored securely in a locked safe and a log was kept of all prescriptions issued to patients. We did find however that there was potential for over supplying medicines to patients because the practice dispensed full boxes of antibiotics to patients irrespective of the particular clinical situation. We signposted the practice to appropriate guidance which included that from the British Dental Association on prescribing and medicines management which gives guidance on splitting bulk medicine packs. In addition, we found medicine labels did not contain the name and address of the practice and the dentists did not routinely audit their antibiotic prescribing as recommended.

Track record on safety

There were limited risk assessments in relation to safety issues.

We noted the significant event log for the previous year recorded that no significant events had occurred.

There was no evidence to confirm that where incidents had occurred in the practice these were investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

Lessons learned and improvements

Staff we spoke with were not aware of any policies in relation to the reporting of significant events, or of other guidance on how to manage different types of incidents. We found staff had a limited understanding of what might constitute an untoward event and they were not recording all incidents to support future learning. For example, we noted two incidents of sharps injuries in the practice accident book, one dated March 2018. There was no evidence to demonstrate that these had been investigated and discussed to prevent their reoccurrence.

We were not assured the practice used incidents and learning from internal or external sources to understand risks and ensure a clear, accurate and current picture that led to safety improvements.

There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dental records we reviewed for the dentist partner demonstrated that patients' dental assessments and treatments were carried out in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines.

Our discussion with the dentist and review of other dental care records demonstrated that improvement was needed in the continuity of recording in some patients' dental records. For example, in one patients dental records we found there were no details of some of the patients visits to the practice. There were no records that evidenced that the proposed treatment options had been discussed. We found no evidence of the procedures used during preparation of the teeth for treatment, the local anaesthetic used or the dental cement used to cement subsequent crowns. Other notes we reviewed followed a drop-down format with little detail which resulted in dental records being identical and not specific to the patient. We discussed this with the principal dentist who confirmed they had struggled to familiarise themselves with the computer system and found it difficult to navigate.

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

The dentists told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided a limited selection of health promotion leaflets to help patients with their oral health.

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

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

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves. The staff were not aware of the need to consider this when treating young people under 16 years of age. Staff were not fully aware of the need to establish and confirm parental responsibility when seeking consent for children and young people.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The dentists audited their own dental care records. There was no audit of the hygienist's dental care records and no peer review system or oversight between the dentists to ensure that dental records across the practice team met national standards.

Effective staffing

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

The practice had an induction protocol and we were told staff new to the practice had a period of induction based on a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

The dental nurses had annual appraisals. We saw evidence of appraisals in staff records.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

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

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

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

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

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 exceptional, courteous and professional. We saw that staff treated patients with dignity and respect and were helpful and friendly towards patients at the reception desk and over the telephone.

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

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

All consultations were carried out in the privacy of treatment rooms and we noted that doors were closed during procedures to protect patients' privacy. Blinds in treatment room windows prevented passers-by from looking in. The reception area was not particularly private but patient information was not overlooked. Patients' notes were secured in a lockable cupboard.

Staff password protected patients' electronic care records and backed these up to secure storage.

Involving people in decisions about care and treatment

The practice had access to interpretation services. We were told multi-lingual staff were available to support patients, languages spoken included Italian, Portuguese, Hebrew and Afrikaans. The dentist described how they often relied on family members to interpret for other languages. The practice could not ensure what was being communicated was in the best interests of the patient. We discussed this with the principal dentist who agreed to urgently review this practice.

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

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

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Staff were clear on the importance of emotional support needed by patients when delivering care.

Staff described the support they would provide for adults and children with a learning difficulty, the homeless, those with drug and alcohol dependence and those living with dementia, diabetes, autism and other long-term conditions. The practice had arrangements to help patients with sight or hearing loss.

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

The practice had made reasonable adjustments for patients with disabilities. These included step free access and a ground floor patient toilet. We noted access to the toilet was narrow with a low door frame, there was no sign or visual aid in place to alert people of the risks of hitting their head on the door frame. We discussed this with the principal dentist who confirmed they would review this.

Staff told us that they telephoned some older patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

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

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who

requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

They took part in an emergency on-call arrangement with a local practice and through the NHS 111 out of hour's service.

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

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The principal dentist was responsible for dealing with these. Staff told us they would tell the principal dentist or the dentist partner about any formal or informal comments or concerns straight away so patients received a quick response.

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

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist had overall responsibility for the management and clinical leadership of the practice. Staff told us both the principal dentist and partner dentist were approachable and listened to them.

Vision and strategy

The practice did not have a specific vision or strategy in place, other than to keep operating as usual and managing its NHS contract.

Culture

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

The practice focused on the needs of patients.

Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

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

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

Governance and management

We identified a number of shortfalls in the practice's governance arrangements including the analysis of untoward events, the management of known risks and the availability of emergency medical equipment and emergency medicines. Assessments of potential risk from sharps had not been undertaken. The registered provider had failed to ensure staff had an understanding of what constituted an untoward event and how this should be reported and shared. There were no systems in place or oversight to ensure that servicing of decontamination equipment or surveying and annual testing of X-ray equipment was undertaken when required. We were not assured any recommended actions which may have been identified in the Legionella risk assessment had been actioned and completed, or any recommended prevention methods were appropriate and in place. Emergency medicines and medical emergency equipment were not all available or in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.

Audits for dental care records, infection control and radiography were not undertaken in line with national guidance. There was no system in place to ensure good governance and effective leadership in the practice

Appropriate and accurate information

Some quality and operational information was used to ensure and improve performance.

Performance information was combined with the views of patients.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice used patient comments, patient surveys, emails and testimonials available on the practice website to obtain patients' views about the service. We looked at one patient survey that was not dated. The principal dentist told us as a result of patient feedback the practice were exploring access to local parking for patients.

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 NHS Choices website recorded that 91% of patients who responded would recommend this practice (11 responses).

The practice team held meetings and informal discussions to gain feedback and offer suggestions for improvements to the service. Staff said these were listened to and acted on. We were given examples of when staff suggestions had made improvements at the practice. For example, with regard to staff rotas.

Continuous improvement and innovation

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

The dental nurses had annual appraisals. We saw evidence of staff appraisals.

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

Are services well-led?

The General Dental Council also requires clinical staff to complete continuing professional development. Staff told us the practice provided support and encouragement for them to do so.

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>Regulation 17 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p> <p>How the regulation was not being met;</p> <p>There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:</p> <ul style="list-style-type: none">· The registered provider had failed to ensure staff had an understanding of what constituted an untoward event and how this should be reported and shared.· Emergency medicines and medical emergency equipment were not all available or in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.<ul style="list-style-type: none">· There was no system in place to ensure that electrical and mechanical testing of decontamination and X-ray equipment was undertaken.· We were not assured any recommended actions which may have been identified in the Legionella risk assessment had been actioned and completed, or any recommended prevention methods were appropriate and in place.· Assessments of potential risk from sharps had not been undertaken.

This section is primarily information for the provider

Requirement notices

- Audits for dental care records, infection control and radiography were not undertaken in line with national guidance.
- There was no system in place to ensure good governance and effective leadership in the practice.

Regulation 17 (1)