

MA Surgeries Limited

MA Surgeries Ltd also known as Wilton Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 13 November 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 and an additional CQC inspector.

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Wilton Dental Practice is in Wilton on the outskirts of Salisbury and provides NHS and private treatment to adults and children.

Summary of findings

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 (one of whom is the principal dentist), two trainee dental nurses, one receptionist and a practice manager. The practice has three treatment rooms, one of which we were assured by the provider was not currently used to treat patients.

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 37 CQC comment cards filled in by patients and spoke with two other patients.

During the inspection we spoke with both dentists, two trainee dental nurses, one receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

- Monday to Thursday 08.45am – 1.00pm and 2.00pm – 5.00pm
- Friday 08.45am – 1.00pm
- Closed at weekends.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance, although there was scope to improve the application of the procedures.
- Staff knew how to deal with emergencies and had the appropriate medicines available. Not all the appropriate life-saving equipment was available.
- The practice had some systems to help them manage risk to patients and staff but they were not robust. For example, the the health and safety risk assessment of the practice and the sharps equipment.
- The provider had suitable safeguarding processes. and staff knew their responsibilities for safeguarding vulnerable adults and children. Staff had received training and mostly knew their responsibilities for safeguarding vulnerable adults and children.

- The provider had suitable staff recruitment procedures.
- 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.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider had limited leadership and a culture of continuous improvement but more work was required to ensure good governance of the practice.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints adequately.
- The provider had suitable information governance arrangements.

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

- Ensure care and treatment is provided in a safe way to patients. For example:
 - Ensure the practice sharps procedures are compliant with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
 - Ensure all staff are fully conversant with, and are able to apply, the practice infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practice.
 - Ensure the high risk recommended actions from the Legionella and fire risk assessments are addressed to minimise risk to patients.
 - Ensure the availability of equipment in the practice to manage medical emergencies taking into account the guidelines issued by the Resuscitation Council (UK) and the General Dental Council.
 - Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care especially with

Summary of findings

regard to significant event reporting, recording and management with a view to preventing further occurrences and ensuring that improvements are made as a result.

- Ensure systems for assessing, monitoring and mitigating the various risks arising from the undertaking of the regulated activities are completed by competent persons to ensure all risk are identified and actions taken to mitigate the risks. E.g. health and safety risk assessment of the practice.

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

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

- Review the practice policy for the control and storage of substances hazardous to health identified by the Control of Substances Hazardous to Health Regulations 2002, to ensure risk assessments are undertaken and the products are stored securely.
- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010 taking account of people living with hearing and sight loss.

Summary of findings

Are services safe?

We found 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 Requirements Notice section at the end of this report).

The safety elements which require attention in the practice are not directly related to the clinical delivery of dental care.

The practice did not have robust systems and processes to provide safe care and treatment. They had not used learning from incidents to help them improve with regard to the management of sharps. They had not addressed the identified high-risk areas in the legionella risk assessment or all the areas identified in the fire risk assessment.

Staff received training in safeguarding people and mostly 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.

Premises and equipment were clean and properly maintained. The practice mostly followed national guidance for cleaning, sterilising and storing dental instruments. The practice was not following national guidance with regard to the management of sharp instruments.

The practice had suitable arrangements for dealing with medical and other emergencies but did not have all the required equipment available.

Requirements notice



Are services effective?

We found 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 very good, friendly and efficient.

The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

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

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

No action



Are services caring?

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

We received feedback about the practice from 39 people. Patients were positive about all aspects of the service the practice provided.

No action



Summary of findings

They told us staff were friendly, caring and helpful. Patients said they were given honest explanations about dental treatment; costs were fully explained and they always received the care they needed. They said their dentist listened to them.

Patients commented staff made them feel at ease, especially when they were anxious about visiting the dentist.

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

Are services responsive to people's needs?

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

The practice 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 had access to telephone interpreter services but did not have arrangements to help patients living 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 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 Requirements Notice section at the end of this report).

The practice had arrangements to ensure the smooth running of the service but these were not always operated effectively. These included systems for the practice team to discuss the quality and safety of the care and treatment provided. For example, the system for reporting, recording and managing significant events and the system for ensuring appropriate risk assessments were ineffective.

There was a clearly defined management structure and staff felt supported and appreciated.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.

The provider monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff.

Requirements notice



Are services safe?

Our findings

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

The practice had systems to keep patients safe but they were not always operated effectively.

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 and these were in an easily accessible format e.g. a flow chart. We saw evidence staff had received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The practice had 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 felt confident they could raise concerns without fear of reprimand.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record and a risk assessment completed.

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 policy and procedure to help them employ suitable staff and had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at eight staff recruitment records. These showed the practice followed their recruitment procedure.

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

The practice ensured facilities and equipment were safe and that some but not all equipment was maintained according to manufacturers' instructions. The principal dentist had not taken any action to minimise the fire risks from electrical appliances as identified in the fire risk assessment completed in 2016.

For example, they did not have a certificate of safety for electrical hard wiring of the practice. We were shown documentary evidence they had arranged for an electrician to complete this a few days before the inspection. Due to unforeseen circumstances this had been rescheduled by the electrician to be completed in December 2018.

The principal dentist told us they could not find the previous certificate. The principal dentist had not replaced extension cables and block adaptors with surge protected fixtures as stated in the fire risk assessment.

The documentary evidence demonstrating checks of the fire detection equipment such as emergency lighting and smoke detectors was completed to evidence regular testing. We saw documentary evidence the firefighting equipment, such as fire extinguishers, were regularly serviced.

The principal dentist had not acted to mitigate the high risks identified in the fire risk assessment completed in 2016 with regard to the installation of a fire door to the decontamination room at the bottom of the stairs. They had not arranged for staff to undertake fire awareness training. They had appointed two fire marshals but these had not completed any fire awareness or fire marshal specific training.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. During the inspection the principal dentist demonstrated to us they could not see the patient when taking x rays. As they could not see the patient they would not be aware if the patient moved prior to taking the x ray and may need to have a further exposure to achieve a satisfactory image for diagnosis.

Are services safe?

We saw evidence the dentists justified, graded and reported upon 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. On the day of the inspection we observed for one x ray machine the outer casing of the lead from the control panel to exposure button was frayed and had loose wires. The inner wires had the plastic casing intact. The principal dentist took immediate action and sent us evidence the next day showing a new lead had been installed.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety but they were not always robust in identifying or mitigating all potential hazards.

The practice health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice arrangements for safe dental care and treatment. The staff did not follow the relevant safety regulation when using needles and other sharp dental items. We observed the sharps risk assessment was contradictory and staff spoken with corroborated this. The risk assessment stated a needle safe system was in use and referred to staff re-sheathing needles. Thus, no clear action to mitigate the risk was identified. Staff and dentists spoken with told us they all re-sheathed needles.

The provider had a system in place 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.

Emergency medicines were available as described in recognised guidance. However not all the equipment as described in recognised guidance was available. Staff kept records of their checks of these to make sure they were available, within their expiry date, and in working order. The checklist required amendment to include all medical emergency equipment and medicines required in line with recognised guidance.

A dental nurse worked with the dentists 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. They had not retained the product safety data sheet alongside the risk assessment in case the additional information was needed.

The practice occasionally used locum or agency staff. We noted these staff received an induction to ensure they were familiar with the practice procedures.

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 (HTM 01-05) published by the Department of Health and Social Care. Staff had completed infection prevention and control training the previous day.

When the decontamination process was described to us during the inspection it did not include all the key steps as identified in the national guidance HTM 01-05. For example, they did not have a thermometer to test the water temperature for manual cleaning of instruments.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. On the day of the inspection the autoclave used for sterilising instruments had broken and the additional autoclave in the decontamination room had not been maintained in line with the manufacture's guidance.

The practice therefore had no way of decontaminating instruments. The principal dentist took immediate action and the following day sent us documentary evidence the broken autoclave had been repaired by the manufacturer.

The practice had a separate decontamination room which was accessible to the public and a potential fire hazard due to the lack of fire door. The door was directly beside the bottom of the stairs.

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

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems. An appropriately qualified person had undertaken a risk assessment of the premises. Records of water testing

Are services safe?

and dental unit water line management were in place but a high-risk action from the assessment had not been completed. Staff had not undertaken any legionella awareness training.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

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

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

Information to deliver safe care and treatment

Staff mostly had the information they needed to deliver safe care and treatment to patients. We observed the practice had trainee nurses only working with the dentists. The principal dentist told us they had a qualified dental nurse commencing the following week.

We discussed with the dentists 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 individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance. They did not have a robust system to follow up referrals to ensure timely action for patients. The practice manager took immediate action and implemented a tracking system during the inspection.

Safe and appropriate use of medicines

The provider had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured medicines did not pass their expiry date and enough medicines were available if required.

The practice kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regard to prescribing medicines.

An antimicrobial prescribing audit had not yet been completed as recommended by national guidance.

Track record on safety and Lessons learned and improvements

There were risk assessments in relation to safety issues but they were not always comprehensive. The practice monitored and reviewed incidents. This helped it to understand risks and gave a clear, accurate and current picture but did not always lead to safety improvements.

In the previous 12 months there had been one safety incident. This had not been fully investigated or documented.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and acted to improve safety in the practice.

There was a system for receiving and acting upon safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice had access to three intraoral x ray machines to enhance the delivery of care. One of these machines was in the third surgery which was not being used and had not been maintained in accordance with the manufacturers guidance.

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 and clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentists described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventive advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

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

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists 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 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 may give consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

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 practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw the practice audited patients' dental care records to check all clinicians recorded the necessary information.

Effective staffing

Some staff but not all had the skills, knowledge and experience to carry out their roles. The practice had two trainee dental nurses who had been in training for six months or less.

Staff new to the practice had a period of induction based on a structured programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs at an annual appraisal. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

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

Are services effective?

(for example, treatment is effective)

The 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 to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

The practice also 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 system to monitor all referrals to make sure they were dealt with promptly was not robust. The practice manager addressed this immediately and implemented a suitable system.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Patients commented positively that staff were courteous, professional and efficient. We saw staff treated patients respectfully, kindly and individually and were 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.

Information folders and patient survey results were available for patients to read.

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 waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

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

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care but were not aware of the

Accessible Information Standards and the requirements under the Equality Act.

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

- Interpretation services were available for patients who did not use English as a first language.
- Staff communicated with patients in a way they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed 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 information leaflet and NHS Choices provided patients with information about the range of treatments available at the practice.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example models 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 about the importance of emotional support needed by patients when delivering care.

Patients described satisfaction with the responsive service provided by the practice.

A disability access audit had been completed and disability access arrangements had been considered.

Staff had an appointment reminder system to ensure appointments were fully utilised.

Timely access to services

Patients 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.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients 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.

The practice information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. 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 policy providing guidance to staff about 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 would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The principal dentist 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.

We looked at comments and complaints the practice had received in the last 12 months.

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

Are services well-led?

Our findings

Leadership capacity and capability

We found the principal dentist had the capacity and skills to deliver sustainable care. The principal dentist demonstrated they had some experience and a willingness to learn and develop the necessary skills to deliver the practice strategy and address risks to it.

They had limited knowledge about issues and priorities relating to the quality and future of services. They did not always understand the challenges to address them.

Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

The practice had processes to develop leadership capacity and skills but they were not always operated effectively. The practice manager had a grasp of the practice areas for development and was planning for the future leadership of the practice.

Vision and strategy

There was a clear vision and set of values.

The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture of sustainable care.

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

The practice focused on the needs of patients.

We were told how the provider would take effective action to deal with poor performance. The principal dentist told us this was an issue that had not arisen in the practice.

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 could raise concerns and were encouraged to do so. They had confidence these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability but these were not always effectively operated to support good governance and management.

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

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed regularly.

However, these systems and processes were not always effectively managed to ensure regulatory compliance. This included the following;

- Management of risks and significant events.
- Management of sharp instruments.
- Management of out of date equipment and products a number of which were found in both the decontamination room and the treatment room that the provider assured us was not currently used to treat patients.

Appropriate and accurate information

The practice acted upon appropriate and accurate information.

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 involved patients, the public, staff and external partners to support sustainable services.

The practice used patient surveys, comment cards and verbal comments to obtain staff and patients' views about the service.

Are services well-led?

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 gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted upon.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

The practice had two trainee dental nurses. We looked at their training and support records and discussed the supervision and support arrangements with the principal dentist. We identified they were well supported by the course staff but not always by staff in the practice.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. They had clear records of the results of these audits but did not always have a resulting action plan for improvements and a re-audit date.

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

The whole staff team had an annual appraisal. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. The provider supported and encouraged staff to complete CPD.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensure all identified risks are mitigated by appropriate action. How the regulation was not being met: • Risks to the health and safety of people using the practice were not always identified. High risk areas that had been identified in relation to fire and the spread of legionella had not been acted upon to minimise the risk. • Not all equipment relating to the prevention, detection and control of the spread of infection had been passed as safe to use. For example the second autoclave in the decontamination room had not been serviced for a significant period of time.
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. How the regulation was not being met: • The systems in place were not operated effectively to ensure compliance with assessing, monitoring and mitigating risks. For example, fire including the decontamination room and legionella. • Trainee dental nurses were not being appropriately monitored and supervised to ensure learning and appropriate application in practice for the safety and protection of patients.

This section is primarily information for the provider

Requirement notices

- Sharp instruments were not being handled in line with legislation requirements.