Clent Dental Care Limited

Clent Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 and 12 November 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Clent Dental Care has one dentist who works part time, three dental nurses, a dental hygienist and a practice manager. One of the dental nurses is qualified and registered with the General Dental Council (GDC), one is a trainee and the other is completing training and will undertake a 'back to work' course to enable them to register with the GDC. Until registered with the GDC this member of staff is working on the reception.

The practice's opening hours are 9am to 7pm on Mondays and Thursdays and 9am to 5pm on Fridays. The practice is closed on Tuesday and Wednesday. Emergency on call arrangements are in place when the practice is closed. Telephone calls are diverted to a member of staff or the practice manager who pass details on the dentist for advice or to arrange treatment.

Clent Dental Care provides private treatment for both adults and children. The practice is situated in a converted residential property. The practice had two dental treatment rooms; both of which are on the ground floor; one of which is used by the dentist and the other by the dental hygienist. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area and a beautician's room which was not reviewed as part of this inspection.

The practice owner is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 28 patients. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was excellent.

Our key findings were:

- Systems were in place to record accidents and significant events so that staff could learn from these.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff knew how to treat patients in a medical emergency, although the emergency oxygen had expired and was therefore not fit for use. A new emergency oxygen cylinder was purchased during the inspection.
- Staff were following infection control procedures regarding the decontamination of dental equipment and the practice was visibly clean and clutter free, however infection control audits were not undertaken on a six monthly basis.
- Patients told us they were treated with care, respect and dignity. Patients commented they felt involved in their treatment and said that it was fully explained to them.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines and current legislation.
- There were clearly defined leadership roles within the practice and staff told us they felt supported and comfortable to raise concerns or make suggestions.
- Patients were able to make routine and emergency appointments when needed. The appointment system met the needs of patients and waiting times were kept to a minimum.
- New standardised policies had been put in place and the practice manager was in the process of adapting these to meet the needs of the practice. Further work was to be completed to ensure sufficient information was available on these policies to guide staff.
- Staff reported that they enjoyed their work, felt supported and worked well as a team.

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

- Ensure an effective system is establishedto assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. This should include systems to maintain and monitor emergency medicine and equipment, first aid packs, infection prevention and control and fire systems including risk assessments. Where appropriate X-ray signage must be in place.
- Ensure that an accurate, complete and contemporaneous record is maintained in respect of each patient, including a record of the decisions taken in relation to the care and treatment provided.
- Ensure all newly implemented policies and procedures contain a date of implementation and review and that these are audited in practice.

You can see full details of the regulations not being met at the end of this report.

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

- Undertake reviews and audits of consent and provide consent records that contain full details of conversations held.
- Review the training, learning and development needs of individual staff members at appropriate intervals.
- Develop and implement policies to guide staff regarding recruitment of staff.
- Develop systems for obtaining, analysing and acting upon feedback from patients.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to record significant events and accidents and staff were aware of these. Clinical and municipal waste was properly maintained and the segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. There was a sufficient number of staff employed to ensure the smooth running of the practice.

Are services effective?

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

The dental care provided focused on the needs of the patients. The dental care records we looked at did not contain detailed information regarding treatment options discussed, examinations undertaken and oral health promotion advice given. However, patients we spoke with told us that they were given all of the information they needed to be able to make a decision about treatment and all said that they received a good service from this dental practice. Staff registered with the General Dental Council (GDC) completed continuing professional development (CPD) to meet the requirements of their professional registration although some training updates were overdue. The practice manager made arrangements during the inspection to book training updates for staff.

Are services caring?

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

We received feedback from 28 patients; all patients were complimentary about the practice saying that staff were friendly, kind and helpful. Patients who completed the comment cards told us that all the practice team were professional, caring and treated patients with respect and dignity. Patients confirmed the dentists listened to them, explained their treatment options and put them at their ease. We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. We saw that staff had a friendly approach and greeted patients in a welcoming and helpful way when they arrived for their appointments.

Are services responsive to people's needs?

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

The service was responsive to patients' needs, for example through longer appointment times for some types of treatment and providing accessible premises. The practice had an efficient appointment system in place to respond to patients' needs. Patients commented they could access treatment for emergency care when required. Systems were in place to record and act upon any complaints received at the practice; however details of how to make a complaint were not easily accessible to patients via the practice's website or from information displayed within the practice.

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 at the end of this report).

There was a clearly defined management structure in place and staff all felt supported by management. Regular practice meetings were held and minuted. These provided staff the opportunity to discuss concerns and make any suggestions. Staff said that they felt empowered to make suggestions for change or improvement.

Summary of findings

We identified several aspects of the management and implementation of safety related processes and effectiveness of services which needed to be improved. An infection control audit had been undertaken in 2015 but we did not see evidence that these audits were undertaken on a six monthly basis. Governance arrangements, for example new policies and procedures were not embedded and some had not been adapted to meet the needs of the practice, for example the fire risk assessment included completing checks on fire safety equipment which was not available at the practice. Audits had been undertaken but not on a regular basis and systems for obtaining feedback on the quality of service were limited. Systems for management of emergency medical equipment were not effective as checks on emergency oxygen and some other emergency equipment was recorded but the oxygen was past its expiry date and some of the equipment recorded was not available. The practice manager took immediate action and made changes to some policies and systems in place and was keen to ensure that systems were improved to maintain compliance and patient satisfaction and safety.

Clent Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 11 and 12 November 2015. The inspection took place over two half days and was carried out by a lead inspector, a dental specialist adviser and a Care Quality Commission administrator on 11 November and the lead inspector on 12 November 2015.

During our inspection visit, we reviewed policy documents and staff records. We spoke with four members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient treatment records and patient dental health education programme. We reviewed comment cards completed by patients and spoke to three patients. Patients gave very positive feedback about their experience at the practice.

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We were told there had been no significant events at this practice. We saw that there was a significant events flow chart, corrective action plan and analysis documentation which could be used in the event of an accident or significant event. The practice manager was the lead for significant events and staff would report information to them. We were told that there had been no sharps injuries or other accidents at the practice; an accident log book was available for completion if required.

The dentist told us that they were not registered at this practice to receive national alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding patient safety via email. We were told that these were reviewed at a different practice in which the dentist also worked and information was relayed to practice staff. During the inspection the practice manager showed us evidence that they had registered to receive email MHRA alerts at this practice to enable the information to be disseminated to practice staff. We were told that a file would be set up to store this information and any relevant to the practice would be discussed at team meetings.

Reliable safety systems and processes (including safeguarding)

The practice had a child protection policy and guidance for staff regarding signs and symptoms of abuse in children. The policy recorded that staff should report suspicion of abuse to the social services department. However there were no specific contact details to enable staff to report safeguarding incidents that required further investigation by appropriate authorities. The practice manager confirmed that they had these details and would update the policy. We were told that there had been no safeguarding incidents at this practice. We could not find evidence of a policy regarding the protection of vulnerable adults. The practice manager developed this policy during the inspection visit, contact details for the local authority safeguarding adults department were recorded on the policy. Staff spoken with were aware who to go to within the practice if they had any safeguarding concerns.

Training records did not show that all staff had received safeguarding training for both vulnerable adults and children. We were told that the recently qualified dental nurse would have undertaken this training before qualifying, although there was no documentary evidence to demonstrate this. The practice manager was the safeguarding lead at the practice and had a wealth of knowledge regarding child protection due to a previous job role. During the inspection the practice manager booked a lunchtime training session which they were to provide on 19 November 2015 for all staff regarding child and adult protection and the Mental Capacity Act.

We spoke to the dentist about the prevention of needle stick injuries. We saw that the sharps box was located in the decontamination room which was next to the dentist's treatment room. We saw that information to guide staff regarding the safe use and disposal of sharps was on display in the staff room. The practice manager confirmed that this would also be put on display next to the sharps box. The practice used a system whereby needles were re-sheathed by the dentist following administration of a local anaesthetic to a patient. Dental nurses spoken with confirmed that the responsibility for disposal of sharps instruments rested with the dentist. We were told that there had been no sharps injuries. The practice had a policy for inoculation injury which recorded action to take should a needle stick injury occur including reporting any sharps injury to the local occupational health department. However, contact details were not recorded. We were told that this would be included as soon as possible.

We asked about the instruments and equipment which were used during root canal treatment. We were told that root canal treatment was not carried out using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Although the practice was not following the guidance from the British Endodontic Society in relation to the use of the rubber dam, the dentist explained the alternative methods used for isolating the area.

The dentist discussed the measures in place to prevent wrong site surgery, this included a review of dental charts, discussions with the dental nurse and an examination before any treatment was conducted.

Medical emergencies

Some arrangements were in place to deal with medical emergencies at the practice although these were not

Are services safe?

robust. There was an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Different sized adhesive defibrillator pads should also be available for use on children and adults. The practice only had adhesive pads for use on adults. The practice was not monitoring to ensure that the pads available with the AED were within their expiry date. During the inspection we saw an email order for new paediatric and adult pads. The practice had an oxygen cylinder and other related items such as manual breathing aids and portable suction were available. However we noted that the oxygen cylinder was out of date and required replacing; there were only two sizes of oropharyngeal airways available. On 12 November 2015 we saw the practice had purchased a new oxygen cylinder.

The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Other medicines which were not required for emergency situations were also available in the emergency medicines kit. The practice was not monitoring these medicines on a sufficiently frequent basis. We found that systems to monitor emergency medicine and equipment were not robust. However during the inspection the practice manager developed a new monitoring form which also now included checks to ensure defibrillator pads and oxygen were in date. The monitoring of emergency medicines was also to be undertaken on a monthly basis. A fridge monitoring record was also developed. This would help to ensure that any medicine stored in the fridge was being stored in accordance with manufacturer's instructions.

We saw that a first aid kit was available, although this was not being monitored to ensure necessary equipment was available for use and within its expiry date.

The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis. In-house refresher training was also completed during training days held at the practice. Staff spoken with were aware of the location of the emergency equipment and medication.

Staff recruitment

The practice did not have a recruitment policy in place. However, the practice manager described the processes to follow when employing new staff which included obtaining references and conducting appropriate pre-employment checks.

We checked the employment file of the member of staff most recently employed at the practice who was currently working on reception. We also looked at the files of two other dental staff employed. Employment files contained details of the staff member's professional registration and their training certificates. Information was available regarding the immunisation status for each member of staff. We saw that Disclosure and Barring Service checks (DBS) had been completed for dental nursing/hygienist staff. However, these were from the staff member's previous place of employment or from other employees for which the staff member worked. The practice had not undertaken a DBS check for the receptionist and there was no risk assessment in place to demonstrate whether this check was required for this staff member. The receptionist had previously worked at the dental practice as a dental nurse and was undertaking training whilst working on reception to re-qualify as a dental nurse. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. During the course of the inspection the practice manager demonstrated that they had enrolled to undertake DBS checks for staff. We were told that these checks would be undertaken on all staff employed.

Newly employed staff had a period of induction to familiarise themselves with practice procedures before being allowed to work unsupervised. Staff were also required to sign to confirm they had read and understood some of the policies and procedures within the practice such as health and safety, equal opportunities and the grievance policy. We spoke with the staff member who was most recently employed. We were told that the induction process gave them a good insight into how the practice was run but they were still learning and could ask for assistance whenever required.

There were enough staff to support the dentist during patient treatment. The practice manager monitored

Are services safe?

staffing levels and planned for staff absences to ensure the service was uninterrupted. Sufficient numbers of staff were on duty to ensure that the reception area was not left unmanned at any time.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. A number of standardised risk assessments and some Control of Substances Hazardous to Health (COSHH) information were undertaken. We saw that a document entitled 'fire risk assessment' had been completed but this was a standardised document which had not been adapted to meet the needs of the dental practice. For example the document stated that a fire blanket was available and that fire systems were checked. However we were told that there was no fire alarm, smoke alarms, emergency lighting or fire blanket. The practice manager said that an external fire safety company had advised them that these were not required. We did not see documentary evidence to demonstrate this and we could not be sure which risks had been identified and what actions had been taken to mitigate them. The practice manager confirmed that they would contact an external company to undertake a fire risk assessment and complete any actions identified.

An external agency provided fire extinguisher servicing and these were all up to date. Staff had not received fire training but we were shown an email to confirm that fire training had been booked for 20 November 2015. One fire procedure notice displayed did not record details of the safe meeting point in the event of a fire. Staff spoken with were aware of the 'muster' points where they should meet in the event of a fire.

We saw that a health and safety legislation poster was on display in the staff kitchen. We saw evidence to demonstrate that staff had been given a copy of the health and safety guidance available at the practice.

A standardised business continuity plan was in place to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. However, this had not been adapted to meet the needs of the practice. The practice manager made changes to this document to include contact details for external contacts such as plumber, electrician and computer system engineers. This document records information regarding NHS responsibilities and therefore requires further review as the practice did not offer NHS treatment.

Infection control

The practice had followed the majority of the national guidance on the essential requirements for infection control as set out in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05; National guidance from the Department of Health for infection prevention control in dental practices). The dentist was the lead responsible for infection control procedures and staff we spoke with were aware of who held this lead role. We saw that an infection control procedure was available for staff to review. We were told that an in-house infection control audit had been completed on an annual basis and we saw a copy of the audit dated July 2015. We were not provided with any evidence that infection prevention and control monitoring had been undertaken by any external companies nor that six monthly infection prevention and control audits had been undertaken by staff at the practice. We could not find evidence that all staff had undertaken recent training regarding infection control.

Feedback from patients confirmed that the practice was always clean. We observed that the two dental treatment rooms, waiting area, reception and toilets were visibly clean, tidy and clutter free. Hand washing facilities were available including wall mounted liquid soap and gels and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. Environmental cleaning was carried out in accordance with the national colour coding scheme and cleaning schedules which were developed by the practice manager during the inspection were available for use.

Personal protective equipment (PPE) such as gloves, aprons and masks were available. However these were not stored in wall mounted containers in accordance with good practice guidance.

The practice utilised a small separate decontamination room for instrument processing. This room was clean, tidy

and clutter free. The practice did not display protocols on the wall to remind staff of the processes to be followed at each stage of the decontamination process. However the dental nurse who demonstrated the decontamination process to us; from taking the dirty instruments through to clean and ready for use again, was knowledgeable about the processes to follow. We noted that there was only one sink in this room and no separate hand washing facilities. We noted that due to the size and layout of the room, it was difficult to follow a well-defined system of zoning from dirty through to clean. Notices were in place reminding staff of the clean and dirty areas. The practice manager and dentist discussed further methods which were to be put in place after this inspection to more clearly define the clean and dirty zones.

The dentist described the end to end process of infection control procedures at the practice. They explained the daily decontamination of the general treatment room environment following the treatment of a patient. This included the treatment of the dental water lines. Dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). We were told about the methods used which were in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in March 2011 and was overdue for review. The practice manager showed an email which confirmed that a further legionella risk assessment had been booked to take place on 25 November 2015.

The practice used an automated washer disinfector for the initial cleaning process, following inspection they were placed in an autoclave (a machine used to sterilise instruments). The practice used a non-vacuum autoclave. When instruments had been sterilized they were pouched and stored appropriately until required. We looked at a random sample of pouched instruments and saw that some were not dated with an expiry date in accordance with current guidelines. The practice manager developed a documented system for bagged instruments including logging the date for disposal on pouches.

The dental nurse demonstrated that systems were in place to ensure that the autoclaves and automated washer disinfectors used in the decontamination process were working effectively.

We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and the segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. An appropriate contractor was used to remove dental waste from the practice and this was stored in a separate locked location within the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

The practice maintained a file of information regarding equipment in use, for example service records and maintenance contracts. We saw that the autoclave, washer disinfector and the practices' X-ray machines had been serviced and calibrated as required. We found that the equipment used at the practice was regularly serviced and well maintained. Portable appliance testing (PAT) had been undertaken by an external professional and stickers were in place on portable electrical equipment to demonstrate this.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients. The practice dispensed prescription only medicines (antibiotics) but at the time of inspection there were no records regarding this and no method of checking stock of antibiotics held at the practice. During the inspection the practice manager developed an antibiotic stock check form which was to be signed by staff when antibiotics were given to patients.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. Information was recorded in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The local rules were also on display in the room which housed the X-ray machinery.

Are services safe?

There was no signage on the door of the treatment room to show that X-ray machinery was located in the room. The practices' decontamination room was adjacent to the dentist's treatment room. There was no documented system to remind staff that they should not be in the decontamination room when X-rays were being taken due to the lack of screening.

Radiographs were taken in accordance with the Faculty of General Dental Practice (FGDP) guidance and Ionising Radiation Medical Exposure Regulations (IRMER) 2000 and Ionising Radiation Regulation (IRR) 1999 in relation to X-rays. Radiographs were taken at appropriate intervals and were justified and reported.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist described to us how they carried out their assessment. Patients were asked to use an electronic device to complete a medical history questionnaire. The information recorded was linked direct to the patient records. The medical history questionnaire asked patients to disclose any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. Patients we spoke with on the day of inspection confirmed that they were always asked about their medical history. We were told that they were also asked about their smoking status and alcohol intake.

An examination covering the condition of a patient's teeth, gums and soft tissues and any signs of mouth cancer was undertaken. Dental care records seen showed that the findings of the assessment were not always recorded appropriately. We saw that although the dentist reviewed the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth, the scores were not always recorded. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need).

Dental care records seen demonstrated that record keeping could be improved. For example, records did not always show that treatment options had been discussed. We were told that the dentist had been printing off the treatment options discussed with patients but not recording this information on their records. A dental hygienist worked at the practice and we were told that both the dentist and hygienist provided information to patients to assist them to maintain healthy teeth. However records seen did not demonstrate this. The patient feedback we received demonstrated that patients were aware of their treatment options and were given sufficient information to enable them to make a decision. Patients confirmed that the dentist was also very good at giving advice.

Health promotion & prevention

The waiting room at the practice contained literature in leaflet form regarding gum disease, tooth sensitivity and plaque; these were also available as a laminated poster. We were told that practice staff had visited two local schools and a local village fete to discuss dentistry and give advice regarding oral health. Staff told us, and patients that we spoke with confirmed, that dietary, smoking and alcohol advice was given to patients as well as general advice regarding oral hygiene. However, the dental care records we observed did not demonstrate that dentists had given oral health advice to patients.

The practice manager confirmed that the practice participated in "National Smile Month" and promoted this through their practice Facebook page.

Staffing

Staff received an induction when they started working at the practice. Induction covered orientation to the practice, key policies and procedures and roles and responsibilities. We were told that staff were responsible for ensuring that their continuous professional development (CPD) training was up to date and this was not monitored by the practice manager. CPD is a compulsory requirement of registration as a dental professional. The practice manager told us that informal discussions were held with staff and support was offered. The practice provided journals and lunch and learn sessions were held to provide non-verifiable CPD for staff. Currently the dental hygienist was undertaking CPD. The practice manager discussed systems that were to be implemented to monitor staff and provide support if required.

The practice did not have a method of quickly identifying training undertaken by staff. From a review of staff recruitment files we saw that key staff training including fire safety, safeguarding of vulnerable adults and children and basic life support had not been provided within the last 12 months. During the inspection, the practice manager made arrangements for update training to be provided regarding these topics for all staff.

The systems in place for supervision and appraisal of staff were not robust. We were told that all dental nurses received an annual appraisal in which training requirements were discussed. The three staff files that we reviewed contained a blank copy of a personal development plan ready for completion in 2016. We saw one partially completed CPD log for a member of staff which the practice manager said was discussed during an appraisal meeting. The dental hygienist did not receive an

Are services effective?

(for example, treatment is effective)

appraisal as the practice manager felt that it was not appropriate for her to complete this. The practice manager told us that the dentist would conduct this appraisal in the future.

Staff told us that they had access to practice policies and procedures and felt that they could speak with a member of the management team if they had any issues or concerns. Records showed professional registration with the GDC was up to date for all staff.

Working with other services

The practice manager explained that specialist dental services were provided in-house and staff had the relevant expertise to manage most conditions. However, where required the practice would refer patients externally for the necessary support and treatment, for example regarding suspected oral cancer. We saw that a text referral that had been sent, this did not maintain patient confidentiality. Patient records demonstrated that internal referral was also made to the dental hygienist within the practice.

Consent to care and treatment

We spoke with the dentist regarding consent. The dentist explained that individual treatment options, risks, benefits and costs were discussed with each patient and that verbal consent was always obtained. The dental care records reviewed did not demonstrate this. We were told that there was no consent policy in place; however the practice manager had started to develop a policy which required adapting to meet the needs of the practice. Patients we spoke with told us that the dentist always fully explained information about any treatment options, risks and costs involved in a way that they could understand. One patient who told us that they were anxious about visiting the dentist said that the dentist always asked if the patient was alright to carry on with the treatment.

We could not see any evidence to demonstrate that staff had undertaken any training regarding the Mental Capacity Act (MCA) and its relevance to dental practice. We were told that this training would be undertaken at the same time as the adult and child protection training on 19 November 2015. Staff spoken with were not aware of the MCA or the requirement to ensure a patient has the ability to fully understand the implications of their treatment in order that they may make an informed decision. The practice manager said that if there was any doubt about a patient's ability to understand or consent to the treatment, then treatment would be postponed.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed the 25 CQC comment cards patients had completed prior to the inspection; we spoke with three patients and observed how staff interacted with patients. We observed staff were welcoming and professional when patients arrived for their appointment. Staff treated patients with dignity and respect.

We discussed confidentiality with the practice manager and receptionist. We were told that if patients wished to speak to a member of staff in private this could be accommodated in the practice manager's office or in any of the rooms not being used at the time. We saw that patients' clinical records were stored electronically and all computers were password protected to prevent unauthorised access. Practice computer screens at reception were not overlooked which ensured patients' confidential information could not be viewed by patients.

The waiting area was situated near to the reception desk. Staff said that they were aware that conversations held at the reception desk could possibly be overheard by patients waiting to be seen. Staff said that they spoke quietly to patients and always tried to ensure confidentiality was maintained. Treatment room doors were closed at all times when patients were with the dentist. Conversations between patients and the dentist could not be heard from outside the rooms which protected patient's privacy.

The comment cards we received and the patients we spoke with all commented positively on staff's professional and friendly attitude. We were told that privacy and confidentiality was always maintained. Patients told us that staff were helpful and kind and commented on the friendly and relaxed atmosphere at the practice. Patients who were anxious about dental treatment told us that the dentist always put them at their ease, took their time and explained treatment procedures fully to them.

Involvement in decisions about care and treatment

The practice did not display information in the reception area which gave details of dental treatments available and fees. The dentist told us that all fees and treatment options were discussed with patients before treatment was agreed. We were told that patients were given time to consider the implications of any treatment to be received. Patients spoken with confirmed this and said that all information was fully explained to them in a way they could understand. Patients said that they always knew how much things were going to cost. The patient records we saw did not all record information regarding patient involvement in decisions. We were told that the dentist printed off a copy of the treatment plan and gave this to patients but did not keep a copy at the practice. The practice manager confirmed that in future all treatment plans would be scanned onto patient records or kept separately to demonstrate the options discussed. This new system commenced during our inspection.

We were told about the use of the screens in each treatment room to show patients information regarding, for example treatments and dental hygiene. We were told that patients could be given a printed copy of any information from the internet.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in their practice leaflet and on their website. The services provided included preventative advice and treatment, routine and restorative dental care and cosmetic dental treatments. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. We found the practice had an efficient appointment system in place to respond to patients' needs.

The feedback we received from patient comment cards and patients we spoke with confirmed that they found it easy to get a routine appointment. Patients said that they were generally seen within a few minutes of their appointment time. We were also told that patients were seen for emergency treatment on the same day that they telephoned the practice. Patient comment cards recorded that the dentist was professional, staff were friendly, helpful and caring and offered flexibility for appointments to meet people's needs

Tackling inequity and promoting equality

The practice is located in a converted residential bungalow which had a car park for patient use. Ramped access was available to gain entrance to the property. The reception desk has been lowered at the front for ease of use by wheelchair users. Two patient toilets were provided one of which had been adapted for use by disabled patients. The dentist and dental hygienist treatment rooms were easily accessible to wheelchair patients.

We were told that there were no patients registered at the practice who could not speak English. The practice manager was aware that Dudley hospital provided a translation service which would be used if required. The practice did not have a hearing loop; however the practice manager told us that there were no patients at the practice who would require this equipment.

Staff had signed to confirm that they had read the practice's equality and diversity policy and this was available to staff in the policy file. However staff had not received training regarding this.

Access to the service

The practice is open Monday 9am to 7pm, Thursday 9am to 7pm and Friday 9am to 5pm. Emergency only appointments were provided each day when the practice was closed. On call arrangements were in place. Information was passed to the dentist who would assess whether emergency treatment was required. The routine opening hours were available on the practice website. The practice leaflet required updating as it recorded incorrect information.

Patients were able to book their appointment up to six months in advance. We were told that a text message reminder service was in place. Patients were reminded one month and then again two days before their appointment. This helped to reduce the amount of patients who did not attend (DNA) their appointment. Patients told us that they could get an appointment at a time to suit them and none raised any concerns about accessing the service. Patients said that they did not have difficulty getting through to the practice on the telephone. One person confirmed that they had received an emergency appointment on the day that they had telephoned the practice and all said that staff were helpful and accommodating.

Concerns & complaints

There was no information for patients on display in the practice about how to complain. Neither the practice leaflet nor the website gave details of who to speak to if patients wished to make a complaint. We were told that the practice had not received any formal written complaints. We saw that a complaint log was available but no complaints had been recorded. Staff spoken with were aware that there was a complaint log available. Staff said that if patients were unhappy they would try to resolve the issue immediately. A meeting would be offered with the practice manager.

A new complaint policy had recently been introduced; this had not been dated to show the date of implementation. The practice manager was the designated lead for investigating and responding to patient complaints and staff were aware who held this role.

Are services well-led?

Our findings

Governance arrangements

The practice did not have robust governance arrangements in place. Risk assessments completed were generic and the practice had only developed two further practice specific risk assessments. We could therefore not be sure which risks had been identified or what actions had been taken to mitigate them. The legionella risk assessment undertaken was overdue as the last risk assessment was undertaken in 2011; a further risk assessment had been booked for 25 November 2015. The practice's fire risk assessment recorded an assessment of fire safety equipment that was not available at the practice. The practice manager said that they had completed a standardised risk assessment which had not been amended to meet the requirements of the practice. We were told that a risk assessment would be undertaken by an external fire company as soon as possible.

Standardised policies had been purchased and the practice manager had implemented some of these. However, not all had been personalised to meet the needs of the practice, for example there were no external agency contact details recorded regarding child protection and the business continuity plan required updating. Some policies did not contain a date of implementation or review. We also identified that there was no recruitment policy. The practice manager was aware of this and had made changes to some of these policies during the inspection. Staff were aware of the location of policies and procedures and confirmed that they were always able to ask for assistance when required.

We also noted that systems in place to monitor emergency medicines and equipment were not effective. Staff had been completing records regarding checks made on emergency oxygen but the oxygen was out of date. There were no checks made on defibrillator pads with only adult sizes being available. Only two sizes of oropharyngeal airways were available. Checks were not made on the first aid kit to ensure all equipment was available for use. Staff were not monitoring fridge temperatures to ensure that any medicines stored in the fridge were stored in accordance with manufacturer's instructions.

Systems were not in place to monitor stocks of prescription only antibiotics held at the practice. However during the inspection the practice manager put recording keeping and stock take systems in place regarding this.

The practice undertook a limited amount of clinical and non-clinical audits. We were told that clinical audits were undertaken on alternate years with patient audits. We saw evidence of an oral care audit in 2013 and an infection control audit in 2015.We did not see evidence of any other audits which would form part of a system of improvement and of learning

Leadership, openness and transparency

There was a management structure in place to ensure that responsibilities of staff were clear. The practice manager was in charge of the day to day running of the service and the dentist took responsibility for clinical issues. Staff were clear about their roles and responsibilities

and who within the practice held any delegated lead roles, such as complaints, infection control and safeguarding.

We found staff to be caring towards the patients and committed to the work they did. The staff we spoke with all told us they enjoyed their work and they said that team working was important and worked well. We were told that there was an open and honest culture within the practice. Staff told us they felt well supported, there was strong leadership in the practice and they said they were confident to raise issues which they felt would be dealt with immediately. Staff said they felt they were listened to and responded to appropriately.

Learning and improvement

Dentists and dental nurses completed some training to support their continuous professional development (CPD). We saw copies of training certificates as evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC). CPD logs were available and we saw one partially completed CPD log for a member of staff, we did not see CPD logs for other staff members. Training information we saw showed that update and other training was required by staff, for example regarding safeguarding, basic life support, fire safety and mental capacity. Staff spoken with were not aware of the mental capacity act or its implications for provision of treatment for patients who

Are services well-led?

may lack capacity. The systems in place for monitoring to ensure staff completed appropriate training within required timescales were not effective. During this inspection the practice manager arranged outstanding training for staff.

The dentist, dental hygienist and one dental nurse were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. One trainee dental nurse was currently undertaking a training course and the receptionist; whose registration had lapsed as a dental nurse with the GDC, was attending a back to work course before obtaining re-registration with the GDC.

The systems in place for supervision and appraisal of staff were not robust. We were told that all dental nurses received an annual appraisal in which training requirements were discussed. The dental hygienist did not receive an appraisal as the practice manager felt that it was not appropriate for her to complete this. The practice manager told us that the dentist would conduct this appraisal in the future.

We were told that as this was a small practice, formal documented staff meetings were held every two to three months. We saw minutes of meetings to confirm this. The practice manager said that informal meetings were held as required and management staff always made themselves available to speak with staff when required. Staff confirmed that lunch and learn sessions were also provided by equipment suppliers and the practice manager provided occasional lunchtime refresher training sessions. We were told that staff were able to discuss issues or concerns as and when they arose and staff said that management were approachable and helpful.

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

A staff survey had been undertaken in 2013 but none had been completed since. Staff said that they did not feel that there was a need for a questionnaire as they would speak out and share any thoughts or raise issues at any time. Staff said that they felt listened to and confirmed that the dentist and practice manager were very approachable.

We were told that the practice had undertaken patient satisfaction surveys in the past, but none had been recently carried out. We saw that the results of a previous questionnaire had identified the need for more chairs in the waiting room. We were told that chairs were provided as a result of this feedback. The practice manager said that satisfaction questionnaires were completed by patients who had left the practice's dental membership scheme. Feedback was apparently given to the practice; however there were no records available to confirm this. The practice manager also said that if a patient left the practice they were contacted to obtain feedback. There were no records available to confirm this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The practice did not have effective systems in place to; • Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. This should include systems to monitor: the availability, correct storage and recording of emergency medicines and equipment; the provision of fit for use first aid packs which are regularly checked for expiry date; regular audits of infection prevention and control ; the undertaking of a fire risk assessment with information relating to the practice with checks made of fire systems; systems for regular appraisal of staff and monitoring to ensure staff receive regular training at appropriate intervals to enable them to carry out the duties they are employed to perform; the appropriate signage on doors of rooms in which X-rays are located; maintain a record of staff training to identify when update training is due. Maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the decisions taken in relation to the care and treatment provided. Regulation 17 (1)(2)(a)(b)(c)(d)(f)