

Chadwell Heath Dental Practice

Chadwell Heath Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 July 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 not 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

Chadwell Health Dental Practice is based in the London borough of Redbridge in Essex, a suburban area of East London. It provides general dentistry, advanced dentistry including periodontal and orthodontic treatment and a sedation service. The practice treats children and adults. The practice was taken over by the current registered provider, a Partnership of two dentists, in December 2014.

Patients have a choice of NHS and private dental treatment. In terms of turnover, 65% of the treatment provided is NHS. Approximately one third of patients using the sedation service have been referred by other dentists in the local area and 90% of these receive NHS treatment. There is a waiting list of six to seven months for children requiring the sedation service, and two to three months for adults.

The practice is open from 9.00am to 6.00pm Monday to Friday, and from 9.00am to 4.00pm on Saturday. There are seven surgeries. Four of these together, with the recovery area make up the sedation service. There is a separate decontamination room.

Fifteen dentists and three sedationists work at the practice on a part-time basis as associates. Seven dental nurses including a recovery nurse, three trainee dental

Summary of findings

care practitioners, and three hygienists also work part time at the practice. There is a full time practice manager and two full time and two part time reception staff. The principal dentist is one of the two Partners.

The practice manager 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'. 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.

Patients completed CQC comment cards in the two weeks prior to our inspection to tell us what they thought about the practice. We received 23 completed cards all of which were very positive about the service patients had experienced. Patients described treatment and care as being of a very high standard and said staff were caring, helpful, polite and considerate. Patients felt reassured and safe; that they had been listened to and put at ease; and that their treatment had been explained to them well.

We spoke with four patients during our visit. They too had nothing but praise for the service.

Our key findings were:

- Systems were in place so that the practice could learn from incidents, children and vulnerable adults were safeguarded from abuse, and the risk of the spread of infection was minimised.
- The practice was well equipped to carry out the wide range of dentistry on offer and medicines were well managed to ensure they were fit for use and were not misused.
- Employees and associate staff knew how to treat patients in a medical emergency and had the appropriate equipment and drugs available to them.
- Treatment was provided in line with recognised professional guidelines. Clinical staff had the necessary skills and qualifications.
- Patients rated the treatment and care they received very highly.
- The service was responsive to patients' needs, for example through longer appointment times for some

types of treatment, offering a choice of dentist, and providing accessible premises and interpreters where required. There was however a waiting list of several months for the sedation service.

- New governance arrangements introduced by the new provider were not embedded. Lines of accountability were unclear in some areas. Patient feedback was being collected but not acted on.

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

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure risk assessments are completed for all hazardous substances in the practice and that effective precautions are in place to reduce exposure to hazardous substances to a minimum.
- Ensure adequate radiation protection arrangements are in place.
- Maintain records necessary to ensuring good governance and the safety and quality of the service.
- Ensure patient feedback is acted on to improve the service.

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

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

- Put in place a system to provide assurance that employees and associate staff have responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice.
- Review the way information from practice meetings is disseminated to employees and associates not able to attend, to ensure they receive information in a timely way.
- Put in place a system to provide assurance that archived records are stored appropriately.

Summary of findings

- Respond to any staff concerns about the workplace identified in the employee appraisal process before waiting for the implementation of the employee appraisal process to be completed.

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 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 Requirement Notices at the end of this report).

Systems were in place so that the practice could learn from incidents, children and vulnerable adults were safeguarded from abuse, and the risk of the spread of infection was minimised. The practice was well equipped to carry out the wide range of dentistry offered and medicines were well managed to ensure they were fit for use and were not misused. Employees and associate staff knew how to treat patients in a medical emergency and had the equipment to do so.

However pre-employment checks did not include photographic proof of identity to ensure people working for the practice were who they claimed to be. Arrangements were not in place to deal with foreseeable emergencies that might impact on the operation of the service. Not all risk assessments had been completed as required by Control of Substances Hazardous to Health regulations (COSHH) 2002. Local rules were not in place to minimise the risk that people were inadvertently exposed to ionising radiation. There was no system in place to provide assurance that employees and associate staff had responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice.

Are services effective?

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

Treatment was provided in line with recognised professional guidelines. Clinical staff had the necessary skills and qualifications. A wide range of dentistry was on offer and patients could be referred to in house specialists instead of hospital. Treatment and care was provided with the consent of patients.

Are services caring?

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

Patients rated the treatment and care they received very highly. They were treated with compassion and put at ease. They felt listened to and involved in their treatment. Their privacy was respected and reception staff took care to ensure their conversations with patients could not be overheard.

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, offering a choice of dentist, and providing accessible premises and interpreters where required. Time was set aside each day for urgent care appointments and patients were provided with information about emergency dental services available when the practice was closed. The provider responded to complaints appropriately.

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).

The practice was taken over by the current provider in December 2014. Governance arrangements, for example new policies and procedures, were not embedded and lines of accountability were unclear in some areas. Limited progress

Summary of findings

had been made with the implementation of a new appraisal system for employees and a new contract for associate staff. Records relating to the operation of the service were not well managed. Feedback from patients was being collected but was not being acted on to improve the service, for example to reduce the amount of time patients waited to be seen after their appointment.

Chadwell Heath Dental Practice

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 28 July 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information we held about the service and information we received from the provider prior to our inspection.

During our inspection visit we spoke with a range of employed staff and associates, the practice manager, and one of the two Partners who owned the practice. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed staff carrying out disinfection and

decontamination procedures and staff interacting with patients in the waiting area. We reviewed documentation the provider gave us about the operation, management and leadership of the service.

We reviewed Care Quality Commission (CQC) comment cards completed by patients during the two weeks prior to our inspection and spoke with four patients on the day.

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

There was an incident management procedure that provided a framework for reporting and learning from incidents and an incident reporting form. There was a separate reporting system and accident book to record details of injuries from accidents at work that employers must report under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Staff we spoke with was aware of these reporting systems. No incidents had been reported since the new provider took over the practice in December 2014.

Reliable safety systems and processes (including safeguarding)

Dentists we spoke with used a rubber dam for root canal treatments in line with national guidelines. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

Staff had received safeguarding children and vulnerable adults training and demonstrated to us an awareness of the signs of abuse and their duty to report any concerns about abuse. The practice had acted appropriately on a patient telling them they felt suicidal and reported their concerns to the authorities, for example. There was an identified lead for safeguarding in the practice that had been trained to Level 2 in child protection. The safeguarding contact details for the local authority had recently been updated.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All associates and dental nurses had completed mandatory medical emergencies training as part of their continued registration with the General Dental Council (GMC). The practice manager was a qualified trainer in resuscitation and provided in house training to other staff at the practice. Records were not kept that provided assurance that all non-GDC registered staff, including trainee dental care practitioners, had completed resuscitation training within the last 12 months: staff records were disorganised. Nevertheless, staff we spoke knew what action to take in the event of a medical emergency.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. It included an automated external defibrillator (AED) and oxygen. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. There were face masks of different sizes for adults and children. The equipment was regularly tested by staff and a record of the tests was kept. The practice also kept supplies of emergency medicines in accordance with guidance from the British National Formulary (BNF). This too was checked regularly and was kept securely to avoid it being tampered with.

The recovery room had doors that opened to the outside to allow easy access to emergency services.

Staff recruitment

Records showed pre employment checks included full employment history, satisfactory evidence of conduct in previous employment, documentary evidence of qualifications and / or GDC registration, and a Disclosure and Barring Service (DBS) check. It was the provider's policy to DBS check all newly appointed employees and associates and to repeat the check every three years. Proof of identity did not include a recent photograph, however. Records of pre employment checks were not complete, for example the record for one recently appointed staff member who was undertaking exposure prone procedures (EPP) recorded their immunisation status. The record for another member of staff undertaking EPP did not.

Monitoring health & safety and responding to risks

Some risk assessments had been completed and action taken to reduce exposure to known hazardous substances under the Control of Substances Hazardous to Health regulations (COSHH) 2002, including a Legionella risk assessment and infection prevention and control procedures in relation to biological agents such as blood and saliva. However, risk assessments for other hazards for example in relation to anaesthetic agents such as nitrous oxide, strong detergents, and mercury had not been completed. Documentation relating to COSHH had not been updated since the new provider took over the practice in December 2014.

Are services safe?

There was no system in place to provide assurance that employees and associates had responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice.

Four of the practice's seven surgeries were equipped to provide inhalation and intravenous sedation. The surgeries were of adequate size and provided a quiet, secluded environment away from the rest of the practice. There was a spacious and well equipped recovery room with direct access to the exterior which provided an easy route for emergency services should they be required. Drugs for sedation, including controlled drugs, were stored securely and managed appropriately. Reversal agents were available for the anaesthetic drugs used.

The equipment was well maintained and there were daily checks to ensure it was fit for use. Safety features built in to the inhalation sedation machine meant that it was incapable of delivering too little oxygen to a patient and there was an emergency nitrous oxide cut off.

Associates and employees providing the sedation service had the necessary qualifications and skills, or were in training. The anaesthetist told us emergency training scenarios were conducted monthly but there were no records to provide assurance that this training was completed by all relevant employees and associate staff.

Sedation was carried out for children and adults in line with current guidelines and regulations. The patient's blood pressure, heart rate and oxygen saturation were monitored continuously throughout the procedure and recorded. The decision to discharge the patient after the procedure was made by the anaesthetist. Equipment and medicines for dealing with medical emergencies were readily available. There was a gas scavenging system in place for the removal of waste nitrous oxide.

The selection of patients suitable for sedation tended to be carried out by the referring dentist with the anaesthetist regarding checking suitability on the day of the procedure. Guidelines suggest that the assessment by the anaesthetist should be completed at a separate visit, giving patients time to assimilate the information they are given and to come to a reasoned judgement, and to change their mind about having the procedure. However, we saw that patients were well prepared for their procedure, having received clear and effective information beforehand.

We observed care provided to patients in the recovery room. They were treated with care, dignity and respect and their carers were briefed to ensure patients took appropriate care of themselves after their procedure.

Infection control

There were systems in place to reduce the risk and spread of infection within the practice. Staff we spoke with demonstrated understanding of infection control and prevention principles and we observed good practice in this area; however it was not possible to locate a single definitive source of policy and guidance. The provider was in the process of identifying an infection control lead for the practice.

An infection control audit had last been carried out in August 2014 which confirmed compliance with the Department of Health (DH) guidance on decontamination in primary dental care practices.

All associates and dental nurses had completed mandatory disinfection and decontamination training as part of their continued registration with the General Dental Council (GDC). Records were not kept that provided assurance that all non-GDC registered staff, including trainee dental care practitioners, had completed infection control training within the last 12 months: staff records were disorganised.

All of the staff were required to produce evidence to show that they had been effectively vaccinated against hepatitis B to prevent the spread of infection between staff and patients, however records were not kept that provided assurance that this requirement was met: staff records were disorganised.

In accordance with DH guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between the surgery and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room with a clear flow from an area for dirty or used instruments to a separate area for clean or decontaminated instruments. We observed one dental nurse working in the room and they demonstrated a good understanding of the correct processes. They wore appropriate protective equipment, such as heavy duty gloves and eye protection. Instruments were washed and

Are services safe?

scrubbed and ultrasonic cleaning was also used for the initial clean. An illuminated magnifier was used to check no debris had been left before placing the instruments in the autoclave (steriliser).

There were daily checks to ensure decontamination equipment was working properly and records we looked at confirmed these checks were completed.

Instruments were placed in pouches after sterilisation and a date was written on each pouch to indicate how long the instrument could be stored for before the sterilisation became ineffective.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and the safe disposal of sharps. Staff demonstrated they understood how to dispose of single-use items appropriately.

Records showed that a Legionella risk assessment had been carried out by an external company in June 2014. This process identified some risks. Action had been taken, or was ongoing, to reduce these risks. The Legionella risk assessment revisit date was 13 June 2015 and the revisit was overdue. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. A dental nurse we spoke with explained the procedure they followed to maintain the dental water lines and prevent the growth and spread of Legionella. Their practice was in line with DH guidelines.

There were good supplies of protective equipment for patients and the staff including gloves, masks, eye protection and aprons. There were dedicated hand washing facilities in the surgeries, the decontamination room and toilet. Patient areas were visibly clean and tidy.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. Service and maintenance contracts were in place and a label on each piece of equipment gave the date its next service was due. Portable appliance testing (PAT) was completed annually and equipment was labelled appropriately in the respect too. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were stored securely and a system was in place to track their use and prevent them being misused.

All medicines were stored securely to prevent unauthorised access and there were checks in place to ensure none were past their expiry date.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X-ray equipment. It had been assessed by an independent expert within the recommended timescales as required. It was found not to be meeting Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The practice manager was in the process of bringing the file up to standard, however the support they were being given to do this effectively, and training to take over the role of RPS was unclear.

This radiation protection file contained the name of the Radiation Protection Advisor and gave the name of the principal dentist as the Radiation Protection Supervisor (RPS) for the practice. The principal dentist did not regularly attend the practice and it was unclear how they carried out the RPS role.

The necessary documentation pertaining to the maintenance of the X-ray equipment was present as was the X-ray set inventory and recent notification to the Health and Safety Executive as required by Ionising Radiation Regulations 1999. Training records showed staff kept up to date with their knowledge and use of the X-ray equipment.

However, local rules were not present in the radiation protection file. The practice manager told us they had been taken down from the walls of the surgeries due to recent decoration. There was a document in the full mouth X-ray (Orthopantomogram, OPT) room but it did not carry the detail recommended by the RPA. Examination of care records where X-rays had been taken showed that dental X-rays were justified and reported on, but not quality assured every time. There was no evidence of practice audit in relation to the diagnostic quality of radiographs in accordance with IRMER 2000 and Faculty and General Dental Practice guidelines.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised professional guidelines. The patient journey began with the patient completing a medical history questionnaire disclosing any health conditions, medication, and allergies. We saw evidence that the medical history was updated at subsequent visits. The medical history was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and any signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since their last appointment. Following this clinical assessment, a diagnosis was made and discussed with the patient and treatment options explained. The patient dental care record was updated with the agreed course of treatment and a treatment plan was then given to the patient that confirmed the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

During the course of our inspection we checked dental care records to confirm the findings. They showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums which had been assessed using the basic periodontal examination (BPE) scores and of the soft tissues lining the mouth. These checks were carried out at each dental health assessment. The records we saw showed that dental X-rays were justified and reported on in keeping with accepted frequency guidelines.

The records we saw showed each patient had a clearly stated diagnosis and risk assessments for recall interval were recorded. In all cases it was recorded that options had been discussed. In one case there was a very detailed recording of discussions with patients and clear justification for the clinical decisions. In other cases, options discussed and discounted could have been recorded in more detail. Details of the treatment the patient received were well documented and included local anaesthetic details including type, the site of administration, and batch number and expiry date.

Health promotion & prevention

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products.

Staffing

Dental nurses involved with sedation were appropriately trained or undergoing appropriate training. Most of the dental nurses were qualified to expose radiographs. Associate staff were expected to manage their own training and their continued registration with the General Dental Council (GDC) was taken as proof by the provider that they had completed mandatory training in medical emergencies, disinfection and decontamination, and radiography and radiation protections. Many of the associate staff had achieved significant postgraduate qualifications.

An induction programme was in place for newly appointed employees.

A new appraisal system had been introduced for employed staff. These staff had completed the first part of the appraisal, setting out their recent activities and achievements, rating their performance, identifying training and development needs, and stating how they would like their role to develop over the next 12 months. There had been no further progress on the implementation of the appraisal system because the provider's operations manager had only recently returned from an unplanned extended leave of absence. No system was yet in place for the routine review of performance with associate staff.

Working with other services

The practice was able to refer patients to in house specialists, for oral surgery, orthodontics or advanced conservation for example. The provider was keen that the practice be developed to take as much dental care out of the hospital setting as possible to provide patients with better access to services and better continuity of care.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the dental care records. They demonstrated awareness of what to do when a patient lacked capacity to make a decision

Are services effective?

(for example, treatment is effective)

and how to make a decision for them that was in their best interests. The practice manager told us staff had completed dementia awareness training, however we were unable to find confirmation of this in the staff records which were disorganised.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all gave positive feedback about caring and helpful attitude of the staff. They described staff as attentive, understanding and polite, and said they were treated respect. We observed staff were welcoming and courteous when patients arrived for their appointment. The waiting area was cramped and reception staff took care that conversations with patients were not overheard by other people in the waiting area.

Doors were always closed when patients were in the treatment rooms. Special observation windows in the

doors allowed patients to be observed appropriately, for example during X rays, but they could not be seen by people who were casually passing by, ensuring patients' privacy and dignity were respected.

Patient records were stored electronically and kept securely to protect confidential information.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS and private dental charges or fees. The practice website also displayed this information.

Staff told us that they took time to explain the treatment options available and that they made use of visual aids. Feedback from patients we received indicated patients felt listened to and kept informed at every stage of their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The facilities and premises were appropriate to the wide range of dentistry the practice offered. Appointment times were scheduled so that there was enough time to assess and meet patients' needs and longer appointments were scheduled for some types of treatment or reviews. We received feedback from patients that their dentist took their time and did not hurry, and that patients were able to see the dentist of their choice.

The practice largely treated children on Fridays to ensure the entire range of child dentistry was on offer. Because children came to the surgery accompanied by at least one parent or guardian, the waiting area was very crowded on Fridays.

The practice manager told us they had completed autism awareness training, however records were not available to corroborate this.

Tackling inequity and promoting equality

The premises and facilities were accessible to people who use wheelchairs. We observed staff treating people equally and welcoming patients from a range of different backgrounds. Records we looked at showed for example that an interpreter had been employed with a patient who was deaf to ensure they were able to access the service.

Access to the service

The practice displayed its opening hours on their premises and on the practice website. Unless patients were waiting for treatment under sedation, they told us they had not had to wait long for their appointment to be seen.

Time was set aside each day for urgent dental care patients and information was available about the local emergency dental service that was available when the practice was closed.

Concerns & complaints

Full information about how to make a complaint was available on the practice website, including contact details for the Independent Complaints Advocacy Service (ICAS) which supports patients and carers wishing to make a complaint regarding their healthcare. A complaints log was maintained and we saw that complaints were responded to appropriately. We saw evidence of the provider taking action to put things right. There had been three complaints since the new provider took over the practice in December 2014.

There was a suggestions box available in the waiting area, although few comments had been received since the new provider took over the practice in December 2014.

Are services well-led?

Our findings

Governance arrangements

Governance arrangements were not developed and lines of accountability were unclear. The principal dentist was identified as one of the two Partners owning the practice, however they did not regularly attend the practice and dentists we spoke with were unclear who the clinical lead was. The principal dentist was also the named Radiation Protection Supervisor but how this role was carried out was unclear. There was no identified infection control lead. The Health and Safety at Work poster in the staff room had not been completed with the name of the practice's designated Health and Safety representative.

We saw that the new provider had begun to implement new ways of working, for example a two-drawer filing cabinet of what the practice manager referred to as CQC Policies had been delivered to the practice, staff appraisal had been introduced, and a new contract with associate staff was under discussion. However, these initiatives were not being progressed because the provider's operations manager had taken an unplanned extended leave of absence we were told. Materials in the CQC Policies filing cabinet were organised according to an out of date inspection framework.

The new policies and procedures were not embedded and it was not possible for staff to locate definitive guidance and instruction readily. As part of the inspection we were directed to several places in the premises for policies and procedures. In none of these places did we find a complete, up to date set of relevant policies and procedures. We were told that perhaps the dental nurses had taken them home with them.

The practice manager told us no documents or records had been disposed of since the practice first came into operation some 20 years ago. The practice was running out of space to archive paper records and much of the small staff room was taken up with bundles for payment forms for archiving. The provider could not provide assurance that archived records were being stored in line with the Data Protection Act or health records legislation.

Monthly practice meetings formed part of the practice's governance structure. They were not taking place at this frequency however. There had been two meetings in the first six months of 2015, one in April and one in June. The

minutes for the meeting on 23 June had not been written up more than one month after the meeting. The practice manager told us they would do this once they had spoken with each employee and associate that had not attended the meeting. This was all but four members of the staff.

Leadership, openness and transparency

The employees and associates we spoke with felt the practice was a good place to work. They told us they would have no reservations about reporting problems or concerns to the practice manager. It was not clear that staff knew who to turn to when the practice manager was not there however, for example when the practice manager was providing resuscitation training at one of the owners' other practices, although there was a deputy practice manager.

Policies and procedures were not in place to support a culture of openness and transparency in respect of the new statutory duty of candour which was introduced for dentists registered with CQC from 1 April 2015. The staff handbook did not include policies and procedures about bullying and harassment to support openness and transparency more generally.

Learning and improvement

Processes were in place for identifying where quality and / or safety was being compromised in relation to clinical notes, infection prevention and control including Legionnaires' disease, and autoclave checks. There were surgery spot checks which followed a checklist that included for example cleanliness, equipment and supplies. Record card audits were carried out which enabled associates to reflect on their practice and identify areas for improvement.

There was little audit activity to provide assurance that sedation guidelines were being adhered to at all times and that outcomes for patient were being continuously monitored and improved. The anaesthetist told us they had conducted an audit recently to check that patients had been appropriately selected for sedation. We were not provided with any other sedation related audits. The anaesthetist also told us the use of a reversal agent usage was very rare, however there were no audits available to support this and we were unable to confirm that the use of reversal agent had been reported. Midazolam over-sedation is defined as a never event by the

Are services well-led?

Department of Health in England, which must be reported centrally in England and Wales to the National Reporting and Learning System and, if applicable, to the body commissioning the care.

There was no evidence of practice audit in relation to the diagnostic quality of radiographs.

Employees were supported to access training and to maintain their registration with the General Dental Council (GDC), where relevant. Associates were responsible for organising their own continuing professional development and maintaining their GDC registration.

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

The practice gathered feedback from patients using a practice questionnaire. It was unclear what the practice did with this feedback, however. Amongst the completed questionnaires we looked at there was a lot of positive feedback about the caring and supportive nature of the

practice. However, several respondents had commented on waiting a long time to be seen after their appointment time. While the practice manager indicated that they knew the reason why some patients were kept waiting a long time to be seen, they could not demonstrate that action had been taken to improve the service. The positive feedback received had not been disseminated to staff.

The practice had started to collect information through the NHS friends and family test from 01 April 2015.

A system of staff appraisal for employees had been introduced. We saw that staff had completed the first part of the appraisal form, giving their own assessment of their performance and development needs and identifying any areas of the practice they felt would be improved. The appraisal process was on hold however, pending further input from the provider's operations manager. Concerns staff had raised as part of their appraisal about the workplace had not been addressed.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider had not assessed the risk to the health and safety of patients receiving care and treatment. Risk assessments had not been completed for all hazardous substances in the practice for example in relation to anaesthetic agents such as nitrous oxide, strong detergents, and mercury had not been completed. Regulation 12.-(2)(a)</p> <p>The provider was not doing all that is reasonably practicable to mitigate risks. Radiation protection arrangements were inadequate. Regulation 12.-(2)(b)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Systems were not in place that enabled the provider to maintain records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. It was not possible for inspectors to locate or for the practice manager to direct them to records, for example immunisation and infection status records for recently appointed staff undertaking exposure prone procedures (working with sharp instruments or tissues), training records, and operational policies and procedures. Regulation 17.-(2)(d)</p> <p>Systems were not in place that enabled the provider to act on feedback from patients for the purposes of continually evaluating and improving the service. The provider was collecting feedback using a practice questionnaire, however it was not taking action to improve the amount of time patients waited to be seen after their appointment. Regulation 17.-(2)(e)</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Photographic proof of identity was not available in relation to each person employed by the provider or working for them as an associate. Regulation 19.-(3)(a)