Broughton Dental Practice Limited

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Inspection Report

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Overall summary

We carried out this announced inspection on 30 September 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Broughton Dental Practice is in Broughton Astley, a large village located in the Harborough district of Leicestershire. It provides private dental treatment to adults and children.

Summary of findings

There is level access for people who use wheelchairs and those with pushchairs through entry at the rear of the premises. There are some limited car parking spaces at the front of the premises and free public car parking is also available on street within close proximity.

The dental team includes two dentists, two dental nurses, one trainee dental nurse, two dental hygienists, one dental hygiene therapist, one clinical dental technician, two receptionists and a practice manager. The practice has three treatment rooms, one is located on the ground floor.

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Broughton Astley Dental Practice is the principal dentist.

On the day of inspection, we collected 27 CQC comment cards filled in by patients.

During the inspection we spoke with one dentist, two dental nurses (including the trainee), the dental hygiene therapist, the clinical dental technician, one receptionist and the practice manager. We looked at practice policies and procedures, patient feedback and other records about how the service is managed.

The practice is open: Monday, Wednesday, Thursday and Friday from 8.30am to 4.30pm and Tuesday from 8.30am to 7pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Appropriate medicines and most life-saving equipment were available with some exceptions. For example, size 0 oropharyngeal airways, a child self-inflating bag with reservoir and the clear face masks for self-inflating bag were not available. Items were purchased after the day of inspection.
- The practice's systems to help them manage risk to patients and staff required review as some were ineffective. Risks were not mitigated in relation to issues such as five-year fixed wiring testing, gas safety testing, lone working and sharps.
- The provider had safeguarding processes, although we were not assured that some members of the team had completed safeguarding training within the previous three years at the time of our visit.
- The provider's staff recruitment procedures required review as they were not compliant with legislative requirements.
- The clinical staff provided patients' care and treatment in line with current guidelines. We found that further detail was required in some aspects of record keeping.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with complaints positively and efficiently.
- Governance arrangements required strengthening.

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

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

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

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

- Take action to ensure the service takes into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.
- Improve and develop staff awareness of Gillick competence and the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities as it relates to their role.

Summary of findings

- Take action to ensure the clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records.

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?	**No action** ✓
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✗

Are services safe?

Our findings

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

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

Staff had some systems to keep patients safe. We also noted areas that required some further review.

Staff we spoke with showed awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We noted that the policies were undated, so it was unclear when the latest versions had been reviewed by management. The lead for safeguarding was the principal dentist.

We were not provided with evidence to show that all staff had received suitable safeguarding training within the previous three years. The documentation was not held for one of the hygienists and the hygiene therapist, one dental nurse and the clinical dental technician. One of the hygienist's certificates did not show that level two training had been completed, as recommended for clinical staff. Following our inspection, the clinical dental technician completed levels one to three safeguarding training and their certificates were sent to us.

Improvements could be made to have regular discussions around safeguarding issues to refresh staff awareness.

The provider had a system to enable them to highlight vulnerable patients and patients who required other support such as with mobility or communication within dental care records.

The provider had a whistleblowing policy. Staff felt confident they could raise concerns without fear of recrimination. We noted that one member of the team was not aware of the existence of the policy.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice. Patients could be seen in another practice owned by the provider in Leicester, if for any reason the premises could not be used.

The provider had a recruitment policy to help them employ suitable staff, although the contents of this did not make reference to legislative requirements.

We looked at six staff recruitment records to check compliance with the requirements. We found that references or other evidence of satisfactory conduct in previous employment were not held for four staff members. We were informed that some of these staff members were known to the provider, for example, having worked in the practice previously to their current employment. We did not see that proof of identity including a photograph was held for four staff members. Whilst staff had disclosure and barring service (DBS) checks, two staff members had checks that had been undertaken by previous employers; a risk assessment had not been undertaken to consider the time lapse and whether a new check was required.

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

Staff ensured that equipment was safe to use, although facilities management required improvement. For example, there was no evidence that electrical five-year fixed wiring testing had been completed. Whilst there was evidence of servicing and maintenance for the gas appliance, a formal annual safety test had not been completed.

Records showed that firefighting equipment was regularly tested and serviced.

The practice had mostly suitable arrangements to ensure the safety of the X-ray equipment. We found that rectangular collimators were not fitted to X-ray equipment in two of the surgeries. This had been a formal recommendation made to the practice previously in 2017. Required information was held in their radiation protection file, but staff had not signed to acknowledge they had read and understood the documents held. The practice had one nominated radiation protection supervisor (RPS); this did not ensure that sufficient cover was in place when they were not in attendance at the practice.

Are services safe?

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The provider carried out radiography audits; further action was required to demonstrate outcomes and how audit led to improvement.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography. The associate dentist had not updated their training in respect of the new requirements relating to the Ionising Radiation Regulations 2017 (IRR17) or we were not provided with documentation to demonstrate this.

Risks to patients

The systems to assess, monitor and manage risks to patient safety required improvement; not all risks were effectively addressed.

The provider had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. We noted that the practice had not implemented a safer sharps system, as detailed in EU Directive. Dentists had access to a safeguard and we were informed that only dentists were to handle used needles. We were told that matrix bands used were the fully disposable type and this helped mitigate the risk of sharps injuries to staff. A sharps policy was available to help guide staff but a specific risk assessment had not been completed.

The provider's system to ensure that clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus required some review as not all staff members had this information recorded on their file. For example, the clinical dental technician, two hygienists/therapist and the trainee dental nurse. A risk assessment had not been completed for these staff.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year.

Emergency medicines were available as described in recognised guidance. We found some items were missing in relation to equipment held. This included size 0 oropharyngeal airways, a child self-inflating bag with reservoir and the clear face masks for self-inflating bag. Items missing were purchased after the day of inspection.

We found staff kept records of their checks of medicines, oxygen and the AED to make sure these were available, within their expiry date, and in working order. We did not see evidence to support that logs were held for equipment.

A dental nurse worked with the dentists and the dental hygiene therapist when they treated patients in line with General Dental Council (GDC) Standards for the Dental Team. The two hygienists were not routinely supported by a dental nurse unless requested by them or by a patient. A formal risk assessment had not been completed for when they worked without chairside support.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. There was scope to improve the structure of the file so that relevant information could be obtained quickly, in the event of an accident.

Whilst fire drills were carried out by the team and information was posted in public areas of the practice regarding procedures to take in the event of an evacuation, not all staff had completed fire training. Whilst a fire risk assessment had been completed by a staff member, this was brief and therefore did not include all relevant information. We discussed this with the provider and they told us that they had made a decision to have an assessment completed by a qualified external professional.

The provider had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. The practice may benefit from nominating the infection control lead to complete additional training in this area as the lead.

The provider had mostly suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. When manual cleaning was undertaken, we were not assured that the correct concentration of disinfectant was used, as the amount of water was not checked. We noted that the practice would benefit from undertaking an audit of dental instruments as we found some items still had cement attached or a small number of hand pieces had a part missing.

The records showed most equipment used by staff for cleaning and sterilising instruments was validated,

Are services safe?

maintained and used in line with the manufacturers' guidance. Whilst protein testing was undertaken for one of the ultrasonic baths, records indicated that the second had not been subject to this.

There were suitable numbers of dental instruments available for the clinical staff.

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

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Records of water testing and dental unit water line management were in place. The practice may benefit from nominating a member of the team to complete additional lead training in legionella.

Staff shared cleaning duties for maintaining the general areas within the practice. Whilst cleaning schedules were found, we were not assured that all staff had been shown these, particularly staff more recently recruited. Logs had not been completed to show cleaning undertaken. The practice was visibly clean when we inspected.

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

The provider carried out infection prevention and control audits twice a year. The latest audit in September 2019 showed the practice considered it was meeting the required standards. The audit had not yet been discussed amongst the team.

Information to deliver safe care and treatment

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

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were legible, kept securely and complied with General Data Protection Regulation (GDPR) requirements.

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

Safe and appropriate use of medicines

The provider had reliable systems for appropriate and safe handling of medicines. The practice were no longer dispensing antibiotics but still had some remaining in stock to dispense for emergencies. When staff had prescribed, they were not aware that the practice name and address must be included on the medicine labels.

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

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

Track record on safety, and lessons learned and improvements

There was an accident book held in the practice. We looked at accidents reported within the previous two years and noted one had been recorded in July 2019, which involved a patient trip. The documentation included the details of the accident and a preventative measure put in place to reduce the risk of this reoccurring.

We were not provided with a policy or procedure for reporting significant or untoward incidents. We were informed that there had not been any incidents reported. Staff did not demonstrate a comprehensive understanding of incident identification. We looked at practice meeting minutes and identified untoward incidents that should have been recorded as such. We did note however that the practice took action when issues arose; this was supported by some practice meeting minutes and our discussions held with staff. Further staff training and documentation was required to support that there was a robust approach to incident reporting.

There was an unstructured system for receiving and acting on safety alerts. Whilst these were received by the practice, a lead was not appointed which would ensure that alerts were always effectively managed when required.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We received many very positive comments from patients about treatment received. Patients described the treatment they received as professional, excellent and delivered by outstanding staff. Comment cards made reference to individual staff.

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

A clinical dental technician worked within the practice. Patients were referred appropriately by a dentist prior to completing examinations and assessments. They worked closely with the dentists and provided continuity of care to provide dental services in a timely manner.

Staff had access to technology such as digital radiography to enhance the delivery of care. One of the dentists had an interest in endodontics, (root canal treatment). The dentist used magnifying loupes to assist with carrying out root canal treatment.

Helping patients to live healthier lives

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

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

The clinicians where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

The practice had a selection of dental products for sale and provided some limited health promotion leaflets to help patients with their oral health.

Staff were aware of national oral health campaigns in supporting patients to live healthier lives. For example, smoking cessation.

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

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

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The principal dentist told us that following an issue that had arisen, they had been focussing this year on making improvements to the process of recording patients' consent to treatments and ensuring that their understanding was also noted.

The dentists told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. We looked at a small sample of patient records. We saw examples where treatment plans were provided. We also found that not all patients had been provided with a treatment plan and information was not always noted regarding the extent of treatment options or choices.

Patients confirmed their dentist listened to them and gave them clear information about their treatment. One patient told us that their dentist explained things well so they understood what was required. Other patients said that their needs were always responded to with the right care and treatment and that there was good 'follow up' when treatment was ongoing.

The practice had a policy about the Mental Capacity Act 2005. The dentist demonstrated awareness about their responsibilities under the Act when treating adults who might not be able to make informed decisions. Whilst we saw that some staff had completed formalised training, we noted that they would benefit from further discussions regarding the application of the Act.

Are services effective?

(for example, treatment is effective)

The consent policy referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. We found that not all staff were aware of the need to consider this when treating young people under 16 years of age. The practice team would benefit from further discussions regarding this issue.

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

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. We looked at a small sample of patient records. We found there was scope to improve the detail recorded in those notes. For example, intra-oral examination soft tissue checks and risk assessment for oral cancer, tooth wear and periodontal condition.

The dentists assessed patients' treatment needs in line with recognised guidance.

We saw the practice audited patients' dental care records to check that the clinicians recorded the necessary information. We found that audit could be strengthened to include further detail and analysis.

Effective staffing

Whilst we noted areas for improvement, staff demonstrated where they had the skills and experience to carry out their roles. For example, the principal dentist had a specialist interest in endodontics, and patients had access to three hygienists/hygiene therapist. The staff provided ongoing support to a trainee dental nurse who was due to start their course, and had previously supported one of the dental nurses to become qualified in their role. The principal dentist paid for staff training, their registration and indemnity, where applicable.

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

Staff discussed their training needs at annual appraisals. There had been an unstructured approach to the completion of staff appraisals, but we were informed that all employed staff who were working in the practice in January 2019 had received an appraisal. The principal dentist told us they had plans for the completion of all staff appraisals that would be undertaken in a blocked period of time allocated in the practice diary. We saw some evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

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

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

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

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

Staff monitored all referrals to make sure they were dealt with.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were welcoming, considerate and helpful.

We saw that staff treated patients respectfully and appropriately and were friendly towards patients at the reception desk.

Patients said staff were compassionate and understanding. Patients could choose whether they saw a male or female dentist when they first attended the practice.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort. One patient told us that staff displayed an attitude that 'nothing is ever a problem or too much trouble'.

A water dispensing machine was available in the waiting area and there was a selection of magazines and children's toys to occupy patients whilst they waited to be seen.

There were two armed chairs for patients with mobility problems and a note was placed on the wall behind them to advise that they were for use by people with reduced mobility.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

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

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

Involving people in decisions about care and treatment

We looked at how staff helped patients be involved in decisions about their care and their compliance with the requirements under the Equality Act.

- Staff were not aware of interpretation services for patients who did not speak or understand English. We were informed that there had not been an identified need for this service. We were informed that some of the team spoke other languages which may assist a patient.
- Staff told us they communicated with patients in a way that they could understand.
- Staff told us they were not aware of where they could obtain information in different formats, if this were to be requested.

Staff told us they gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The dentist described to us the methods they used to help patients understand treatment options discussed. These included written and verbal information and demonstrations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

Staff were clear on the importance of emotional support needed by patients when delivering care. We were provided with specific examples of how staff met the needs of patients with long term conditions and dental phobia. One patient told us that they had a health condition and their dentist spent time talking through treatment and gave them 'confidence in all that they did'. They also made reference to the caring and responsive approach of other staff.

Longer appointment times were allocated for those who would benefit. The receptionist told us they had autonomy to be flexible with appointment time allocations.

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

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. Patients who used wheelchairs had access to a ground floor treatment room.

The practice had made some reasonable adjustments for patients with disabilities. This included for example, step free access and reading glasses which were available. The patient toilet facility had a handrail, but no call bell. The practice information leaflet stated that the toilet was for ambulant access. This was due to building and space restriction. The practice did not have a hearing loop.

A disability access audit had been completed.

There was an appointment reminder service for patients to remind them to attend.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs. We noted that there were routine appointments available within a short timeframe if a patient made contact with the practice.

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

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Patients had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept unduly waiting.

The staff took part in an emergency on-call arrangement with some other local practices.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment when the practice was closed. Patients confirmed they could make routine and emergency appointments easily.

Listening and learning from concerns and complaints

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

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

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

The practice manager aimed to settle complaints in-house and invited patients to speak with them in person to discuss these, if appropriate. Information was available about organisations patients could contact if not satisfied with the way the practice manager had dealt with their concerns.

We looked at comments, compliments and complaints the practice received within the previous 12 months.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service. There was scope to improve the documenting of learning outcomes in practice meeting minutes we reviewed.

Are services well-led?

Our findings

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 section at the end of this report).

Leadership capacity and capability

The clinical team had the capacity and skills to deliver high-quality, sustainable care. We found that improvements were also required in the service.

The principal dentist was knowledgeable about issues and priorities relating to the quality and future of services. There was a plan to update parts of the premises which was ongoing at the time of our visit.

Leaders at all levels were visible and approachable. Staff told us they worked closely with them and others.

Vision and strategy

There was a vision and set of values. The provider's statement of purpose included the provision of dental care and treatment of consistently good quality for all patients, and to make care and treatment as comfortable and convenient as possible.

Staff planned the services to meet the needs of the practice population. This included patient access to the clinical dental technician to provide them with advice and support with dentures. Practice opening hours included late opening one day a week to provide treatment to those who were unavailable during usual working hours.

Culture

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

The staff focused on the needs of patients. We received extremely positive feedback from patients about the effective, caring and responsive service provided.

Openness, honesty and transparency were demonstrated when responding to complaints. We saw that one complaint had resulted in improvements being made within patient record keeping. We also noted issues that required further documentation by the provider to show how they had been effectively managed. For example, a patient verbal complaint regarding a staff member.

The provider was aware of the requirements of the Duty of Candour. Whilst some evidence supported how this was applied, the systems for the reporting and investigating of significant and untoward incidents required strengthening.

Staff could raise concerns and were encouraged to do so, and they had confidence that these would be addressed.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. Staff knew the management arrangements. Staff may benefit from having formally assigned lead roles in areas such as legionella management. Greater oversight was required regarding areas such as the checking of emergency equipment and maintaining adequate logs for this and the checking of dental instruments to ensure they were suitable for use.

The provider's system of clinical governance in place which included policies, protocols and procedures required strengthening. We found that not all policies and risk assessments required in a dental setting were held. For example, incident reporting and risk assessments such as lone working and sharps.

It was not clear when current policies and assessments were subject to review as they were not dated. We found there was scope to improve governance arrangements, for example, discussions regarding safeguarding and the Mental Capacity Act to ensure staff knowledge and awareness were kept up to date.

Appropriate and accurate information

The practice did not hold all appropriate information needed. For example, evidence of all staff immunity to Hepatitis B. Where this information was not held, a risk assessment had not been completed.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

Staff were aware of the importance of confidentiality in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

Are services well-led?

Staff involved patients, staff and external partners to support high-quality sustainable services.

The provider used patient surveys, comment cards and verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from staff the practice had acted on. For example, changes made to diary management.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on, if appropriate.

Continuous improvement and innovation

The systems for learning and continuous improvement required review.

The provider had some quality assurance processes to encourage learning and continuous improvement. This included audits of infection prevention and control, record keeping and radiography. We found that some audit outcomes were limited and not driving improvement.

Staff directly employed had annual appraisals, although a structured approach was required moving forwards. We saw some evidence of completed appraisals in the staff folders.

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 Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • There was ineffective monitoring for staff training requirements, for example safeguarding, fire training, IRR training for the associate dentist. • Effective procedures were not in place for significant event and untoward incident reporting. • There were limited systems for monitoring and improving quality. For example, radiography audit. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • The provider had not identified that electrical fixed wiring testing or gas safety testing was required to be completed. • Risk assessments had not been implemented in relation to safety issues including: • Sharps • Not holding staff immunity status for Hepatitis B.

This section is primarily information for the provider

Requirement notices

- DBS checks that had been accepted from staff previous employers.
- Lone working for the hygienists.
- The registered person had not ensured that information was held for each staff member as specified in Schedule 3. In particular: satisfactory evidence of conduct in previous employment.
- The registered person had not ensured that all emergency equipment was held that may be required. Logs were not maintained regarding all equipment.
- Recommendations for rectangular collimation to be fitted on X-ray equipment had not been addressed by the registered person.
- There was not a structured approach to ensure that patient safety alerts were appropriately actioned.
- Not all tests required had taken place for one of the ultrasonic baths in use.

Regulation 17 (1) (2)