Albert Vincent Group Limited

Bridge House Dental Practice

Inspection Report

Bridge Foot
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Overall summary

We carried out this announced inspection on 25 October 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

Bridge House Dental Practice is in Market Deeping, a market town in the South Kesteven district of Lincolnshire. It provides NHS and private dental treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs through an alternative entrance at the side of the practice. Car parking spaces are available at the rear of the premises in their own car park.

The dental team includes two dentists, one dental hygienist, three dental nurses; one of the dental nurses also undertakes the role of practice manager.

Summary of findings

The practice has three treatment rooms; two are on ground floor level.

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 Bridge House Dental Practice is the principal dentist.

We sent 50 comment cards in advance of our visit to the practice for patients to complete. On the day of inspection, we collected six CQC comment cards that had been filled in by patients. This represented a 12% response rate.

During the inspection we spoke with one dentist, two dental nurses (including 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 and Thursday from 8.15am to 5.15pm, Tuesday 8.15am to 6pm, Friday 8am to 4pm. The practice also opened on two Saturdays a month by appointment only.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which mostly reflected published guidance. We noted there was scope for improvement when manual cleaning was undertaken.
- Staff knew how to deal with emergencies. Most appropriate medicines and life-saving equipment were available with exception of glucagon. This is used to treat severe low blood sugar in the event of a dental emergency. This was ordered promptly after our inspection.
- The provider had insufficient systems to help them manage all risks to patients and staff.
- The provider had safeguarding processes, although some of this required review. Staff were trained to know their responsibilities for safeguarding vulnerable adults and children.
- The provider did not have adequate staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system took account of patients' needs.
- The provider did not demonstrate effective leadership and culture of continuous improvement.
- The provider had not asked staff and patients for any detailed feedback about the services they provided.
- The provider had systems to deal with complaints positively and efficiently.
- It was not clear that learning always took place when things went wrong.

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:

- Improve the security of NHS prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the necessity of a second oxygen cylinder where appropriate for the practice's circumstances.
- Improve and develop staff awareness of Gillick competency and consent and ensure all staff are aware of their responsibilities in relation to this.
- Implement processes and systems for seeking and learning from staff feedback with a view to monitoring and improving the quality of the service.

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)

The practice systems and processes to provide safe care and treatment were not always operating effectively.

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 safeguarding policy required review as it did not include the most up to date contact details for reporting concerns to external agencies. The practice manager told us they were aware of recent changes and were planning to update the documentation. Following our visit, we were sent documentation to show it had been updated.

Contact details held for reporting concerns were contained in a file and not posted elsewhere within the practice; this may assist staff in the event of a concern.

We saw evidence that staff received safeguarding training, although we were unable to confirm that the hygienist had completed this training to the level expected for clinical staff.

We were made aware of a safeguarding issue that had previously been reported by staff to an external agency. Staff had not kept details of this, so we were unable to view how the information had been recorded or whether it had been discussed amongst the team. Staff were not aware that safeguarding referrals also require notification to the CQC.

We were informed that a pop-up note could be created on patients' records if they were identified as vulnerable or required other support such as mobility.

The provider had a whistleblowing policy. This included details for external organisations that could be contacted if a concern arose. Staff we spoke with felt confident they could raise concerns without fear of recrimination, although they were not aware of the organisations listed within the policy. They told us they may approach their indemnity provider for advice.

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 referred to a buddy practice in the event of the premises becoming unusable.

The provider had a recruitment policy and procedure to help them employ suitable staff and had checks in place for agency or locum staff. We looked at compliance with legislative requirements when we viewed three staff recruitment records. We did not find references or other evidence of satisfactory conduct in previous employment in the three staff files. We were told that one staff member had worked with the practice manager in previous employment and another had started as a trainee nurse through an apprenticeship.

One staff member did not have a photograph held on their file. The staff member who had started work as a trainee nurse did not have a disclosure barring service check (DBS) held and other staff had DBS checks that had been undertaken by previous employers. Risk assessments had not been undertaken to ascertain if new DBS checks were required on their appointment. Following our inspection, we were sent evidence regarding new DBS checks being undertaken.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC). Whilst we noted that the dentists had professional indemnity cover in their files, we were unable to confirm from the documentation held, if dental nurses were included in the principal dentist's cover.

Staff ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection and firefighting equipment were regularly serviced.

Are services safe?

The practice had suitable arrangements to ensure the safety of the X-ray equipment and we saw the required information was in their radiation protection file. We found that rectangular collimators were not fitted to some X-ray equipment. We saw that a rectangular collimator was available in the surgery room on the first floor; this was stored in a box adjacent to the equipment. We were told that the hygienist did not use the X-ray machine in their surgery room where there was no collimator.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. We looked at a sample of X-rays on patients' records and found that grading given was not always accurately reflected. We noted that some X-ray images were not of suitable quality; this may impact upon the clinician's ability to diagnose patients' dental care needs.

We discussed this with the dentist who was working on the day of our inspection. They told us that the intra-oral radiography plates used in the process required replacement as they had signs of wear. This had been raised by staff to the provider around two months prior to our visit. This had not yet been replaced. The day after our inspection, we were informed that new plates had been purchased and were sent order confirmation details.

We looked at a radiography audit that had been undertaken in August 2018. The audit did not have clear aims or objectives or a clear action plan included as a result of information collated.

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

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. We were informed that only dentists handled used needles. The dentist we spoke with did not use a safeguard when touching used needles, however. Precautionary measures were not in place when staff dismantled matrix bands. A sharps policy was held, and this stated that a risk assessment was in place. We noted that a risk assessment had not been undertaken to mitigate the risk of sharps injuries to staff.

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 review as not all staff members also had their immunity levels recorded. For example, the three dental nurses. The practice manager told us that they, as well as the principal dentist, were aware that this information was not held. We were told that efforts had not been made to obtain this due to cost implication. A risk assessment had not been completed in the interim to ensure that these staff were suitably protected. Following our visit, we were sent evidence to show that a risk assessment had been completed.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support every year. Immediate Life Support training with airway management for sedation was also completed for those staff involved in this.

Emergency equipment and most medicines were available as described in recognised guidance. We noted an exception in relation to glucagon (a hormone used to increase blood sugar levels in patients with low blood sugar when they are unconscious), as this was not held. The practice manager was aware of the need to hold this but told us they had encountered problems when attempting to order it. We were told that glucagel (a tube of gel that raises blood glucose levels quickly when a patient is conscious) had been sent to the practice instead. Following our inspection, we were sent confirmation to show that a new order had been placed for glucagon and had been received.

The practice had not considered whether a spare emergency oxygen cylinder should be obtained.

We found staff kept monthly records of their checks of medicines and equipment held to ensure these were available, within their expiry date, and in working order. Weekly checks are recommended in guidelines.

A dental nurse worked with the dentists when they treated patients in line with General Dental Council (GDC)

Are services safe?

Standards for the Dental Team. The dental hygienist was not supported however, and a risk assessment had not been undertaken. We were informed that a risk assessment was completed after the inspection.

The provider had 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.

Regular fire drills were carried out by the team. Whilst a basic fire risk assessment had been completed by a staff member, they had not received suitable training to undertake this task. Following our visit, we were informed that a risk assessment had been booked for completion together with training for staff.

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. 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. We observed staff undertake the decontamination process. When manual cleaning was undertaken, the water temperature was not tested to ensure that it did not exceed 45 degrees maximum. Whilst a magnifier was available and working in the decontamination room, we did not see that it was used to check the instruments cleaned. We were informed that this was an oversight on the day and assured that instruments were usually checked.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. There were suitable numbers of dental instruments available for the clinical staff.

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 undertaken in 2012. We did not see that all recommendations had been actioned, as the nominated individual had not received training in the area of legionella management. Following our visit, we were informed that further measures were being taken to mitigate the risk presented by legionella.

Records of water testing and dental unit water line management were in place.

Staff shared cleaning duties amongst themselves. 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.

Staff carried out infection prevention and control audits twice a year. The latest audit in October 2019 showed the practice was meeting the required standards. The audit did not include a score or details of when any action required would be undertaken.

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 complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

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

Safe and appropriate use of medicines

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

There was a mostly suitable stock control system of medicines which were held on site. We found a local anaesthetic needle that had expired in the surgery used by

the hygienist and this was disposed of when we identified it to the practice manager. They told us that the hygienist did not use local anaesthetic. The system used by the practice ensured that enough medicines were available if required.

We saw staff kept NHS prescriptions securely as described in current guidance. Monitoring systems were not in place for NHS prescription numbers; this would identify if an individual prescription was taken inappropriately.

The dentist was 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. This contained details of some historic accidents that required removal from the book, as they included personal details of individuals. There had not been any accidents reported within the previous two years.

We were provided with a policy and procedure for reporting significant or untoward incidents. Staff demonstrated some awareness of the type of incident they would report. We looked at four incident records dated from November 2018. Three of the incidents did not identify or require any staff learning, and one event involved a misunderstanding between a staff member and patient. The incident record did not include details of any staff discussion held for learning purposes to prevent a future recurrence. We looked at practice meeting minutes which were brief and did not refer to the incident or to the safeguarding issue that had also occurred previously. It was not clear that processes were robust to ensure that staff learned when things went wrong.

The practice did not have a written protocol to prevent a wrong tooth extraction.

We were not assured that there was a system for receiving and acting on safety alerts. The practice manager and other nurse that we spoke with did not know about how alerts were received and managed within the practice. Following our visit, we were informed that safety alert documentation was now being stored in a folder.

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

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.

The practice offered dental implants. These were placed by the principal dentist who had undergone appropriate post-graduate training in the provision of dental implants which was in accordance with national guidance.

The practice had a small contract with NHS England to provide orthodontic treatments to children. Orthodontics is a specialist dental service concerned with the alignment of the teeth and jaws to improve the appearance of the face, the teeth and their function. Orthodontic treatment is provided under NHS referral for children except when the problem falls below the accepted eligibility criteria for NHS 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 dentist we spoke with 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 health promotion leaflets to help patients with their oral health.

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

The dentist 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 told us they understood the importance of obtaining and recording patients' consent to treatment. We found that some staff knowledge required updating regarding whom was able to provide valid consent, for example, if a child presented with a foster parent or other family member, and the documentation required in these instances.

The dentist we spoke with gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions and we saw this documented in patient records. One patient commented in a CQC comment card that explanations given by their dentist were understandable.

The practice's consent policy included information about the Mental Capacity Act 2005. The staff we spoke with understood their responsibilities under the Act when treating adults who might not be able to make informed decisions.

The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. Whilst the dentist we spoke with was aware of the need to consider this when treating young people under 16 years of age, other staff we spoke with did not know of this principle.

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

Are services effective?

(for example, treatment is effective)

The dentist's notes we looked at showed they kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist assessed patients' treatment needs in line with recognised guidance.

We saw that the practice had undertaken a recent patient dental care record audit dated 21 October 2019 for one of the dentists. This was to check if they had recorded the necessary information. It had identified some areas for improvement moving forward.

The practice occasionally carried out conscious sedation for patients who were nervous. This included people who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

Effective staffing

We saw examples where staff had the skills, knowledge and experience to carry out their roles. The principal dentist had obtained qualifications in implants, sedation and had a specialist interest in orthodontics. Dental nurses involved in sedation and implants had completed courses in these areas. One of the dental nurses had started work as a trainee and had qualified during their employment at the practice. They had received support from the other dental nurses to undertake their role.

One of the dental nurses also worked as the practice manager. They undertook their management role with limited time allocated to this. This impacted upon their ability to fulfil all required tasks effectively.

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.

We were not provided with documented evidence to show how staff discussed their training needs. Whilst we were informed that appraisals had previously taken place, these were informal and not recorded.

Co-ordinating care and treatment

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

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

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 referrals to make sure they were dealt with promptly. Patients were not offered a copy of a referral letter.

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.

We received feedback from a small number of patients in CQC comment cards. Those said that they had received a 'fantastic service' and 'were very happy' with treatment received.

We looked at feedback left on the NHS Choices website. The practice had received mostly positive feedback based on four patient experiences. The reviews included comments regarding dental care received including the after care, and the kindness and helpfulness of staff. One comment was negative regarding treatment and care received. The practice had not responded to comments left.

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

An information folder was available in the waiting area for patients to read. There was also a small selection of magazines to read.

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 did not provide privacy when reception staff were dealing with patients.

If a patient asked for more privacy, staff told us they could take them into another room. The reception computer screen was 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 requirements of the Accessible Information Standard and the Equality Act. (The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given).

We saw that interpreter services were available for patients who did not speak or understand English. We were told that because of the geographical location of the practice, this service had not been required to date.

Staff told us they communicated with patients in a way that they could understand. Staff were not clear however, where they could access information in different formats for example, large print, easy read or braille should the need arise. They told us that they would seek to contact 'Language Line' to enquire about this.

Staff gave patients information to help them make informed choices about their treatment.

The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website provided patients with information about the range of treatments available at the practice. This included information for patients who were nervous.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, study models, pictures, X-ray images and other written and verbal information.

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. The associate dentist was due to leave working for the practice and the provider had been seeking to recruit a new dentist. This process was ongoing at the time of our inspection.

Staff were clear on the importance of emotional support needed by patients when delivering care. We were provided with examples of how the practice met the needs of patients who were nervous about attending the practice. We were informed that patients with a mental health condition or dementia were seen in the downstairs surgery. Information provided to them about their dental care needs was given using appropriate language to help them understand. Longer appointment times could be allocated if required. Staff told us they knew their patients and their needs well.

Patients who had responded in CQC comment cards stated they were satisfied with the service provided by the practice.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made most reasonable adjustments for patients with disabilities. This included step free access, a magnifying glass and accessible toilet with a hand rail but not a call bell. The practice did not have a hearing loop installed.

We were not provided with a disability access audit.

Staff contacted patients in advance of their appointment to remind them to attend based on individual patient preference.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs. We were informed that the current waiting time for a routine appointment was around four weeks to see a dentist.

The practice displayed its opening hours in the premises and on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The staff took part in an emergency on-call rota to see patients out of hours. NHS patients had access to NHS 111.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed.

Listening and learning from concerns and complaints

The practice manager 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. Information was made available to patients that explained how to make a complaint. This included on the practice's website.

The practice manager was responsible for dealing with complaints. Staff would tell the practice manager 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. 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 complaints the practice received within the previous 12 months. These showed the practice responded to concerns appropriately. We were not provided with evidence to show how outcomes were discussed with staff to share learning and improve the service. Practice meeting minutes did not refer to specific complaints received or staff discussion regarding them.

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). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The dentists had capacity and skills to deliver clinical care for patients. However, we found a significant number of improvements could be made to improve the service and ensure that all risks were identified and suitably managed.

Following our visit, we noted that staff were making efforts to rectify some of the shortfalls we identified. This included obtaining replacement X-ray plates to improve the quality of images and purchasing glucagon to ensure staff could respond to a medical emergency, if this may be required.

We were told that the principal dentist was approachable. Staff told us they worked closely with them.

We noted that the provider was planning for the future of the practice; this was reflected in their attempts to recruit a new dentist following the current associate who was due to leave.

Vision and strategy

The provider had a statement of purpose that included their aim to provide routine and general dental care needs for their patients. They sought to achieve high levels of oral health through adopting a preventative approach.

Staff planned the services to meet the needs of the practice population. For example, the provision of general dentistry, orthodontics, implants and sedation to those who would benefit.

Culture

Staff stated they enjoyed working with their patients as well as other colleagues.

There was a duty of candour policy in place. Openness and transparency were demonstrated when responding to complaints, although we did not see how any learning outcomes were shared with staff when complaints/ incidents had been recorded. Not all incidents that had occurred, had been identified as such.

Staff could raise concerns, but these were not always addressed. We noted that when some issues had been raised with the provider, prompt action had not been taken to address them. For example, X-ray plates that required replacement and some staff who did not have their immunity levels to Hepatitis B recorded.

Governance and management

The principal dentist was the registered manager and 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. They also worked as a dental nurse and had limited time to complete associated practice management tasks. Staff knew the management arrangements and their roles and responsibilities.

The provider's system of clinical governance which included policies, protocols and procedures required immediate review as some were not in place or were not sufficient to support the operation of the service.

We noted that not all appropriate risk assessments had been completed, for example, sharps and for the hygienist who worked alone. A basic fire risk assessment had been undertaken by a member of staff who had not been trained to complete it. The practice did not have access to the emergency medicine glucagon at the time of our visit, although we noted that efforts had been made to obtain this.

We found there was scope to improve governance arrangements. Whilst there was a staff sign off sheet to state that staff had read policies, we found that not all staff who worked in the practice had signed this.

There were not always clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

We did not see that staff always acted on appropriate and accurate information. For example, recommendations made for management training in legionella.

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

Engagement with patients, the public, staff and external partners

Are services well-led?

The practice invited patients to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. There had not been any other patient surveys for the provider to gauge patient satisfaction overall.

Staff said they could provide feedback, but we did not view any examples of this or suggestions made.

Continuous improvement and innovation

The systems and processes for learning, continuous improvement required review as they were limited within scope.

An audit of radiographs we viewed did not identify aims, objectives, analysis or action plan. Whilst infection prevention and control audits were completed, these did not include when any actions identified would be addressed. The practice had not undertaken an antibiotic prescribing audit. There was no evidence of discussion or peer review undertaken between clinical staff.

Audit processes did not seek to drive improvement.

Staff did not have evidence of documented appraisals undertaken.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. There was also documentation regarding staff CPD completed.

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. 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: • The systems and processes for incident reporting were not always working effectively. There was limited evidence to show that staff learned when things went wrong. • Safeguarding procedures did not include most up to date contact information for reporting concerns externally and the practice did not hold details following a concern that had previously arisen. • A systematic comprehensive approach had not been implemented for staff appraisals. • There were limited systems for monitoring and improving quality. For example, radiography audit. • X-ray plates worn had not been replaced. 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: • Risk assessments were inadequate or had not been implemented in relation to safety issues including: • Sharps.

This section is primarily information for the provider

Requirement notices

- Not holding staff immunity status for Hepatitis B.
- DBS checks that had been accepted from staff previous employers.
- Lone working for the hygienist.
- Fire.
- 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 and a DBS check for a clinical member of the team.
- The registered person had not ensured that recommendations regarding management training in legionella were followed.
- The registered person had not ensured that all medicines that may be required in the event of a medical emergency were held, eg; glucagon.
- The registered person had not ensured that there was a structured and robust approach to responding to medical and safety alerts such as MHRA.

Regulation 17 (1)