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The Forge Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 June 2016 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 this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The Forge Dental Practice is located in the main street and on a bus route. There is a large waiting area providing a comfortable space and two surgeries. Children are provided for with a selection of toys and books. The practice offers private dental treatment and has a small NHS contract for children only. The practice has two treatment rooms, a waiting area and a local decontamination facility away from the treatment rooms. All areas are on the first floor with a stair lift to enable patients with limited mobility to access the practice.

The practice has two dentists, a visiting hygienist who attends the practice once a week, two qualified dental nurses who also fulfil the receptionist role. One of these nurses is also the practice manager as the provider/principle dentist only works in the practice one day a week and lives a considerable distance from the practice. The practice manager has recently taken up this role and is in the process of implementing appropriate quality management and governance arrangements.

The principal dentist is the registered provider who is registered with the Care Quality Commission to manage the service. 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.

Summary of findings

The practice is open Monday to Thursday, 08:30am to 5.00pm Fridays 09.00am – 12.30pm. The practice is closed at weekends. Out of hours number is available via the practice answerphone.

We reviewed 15 CQC comment cards that had been left for patients to complete, prior to our visit, about the services provided. In addition we spoke with five patients on the day of our inspection. Feedback from patients was positive about the care they received from the practice. They commented staff put them at ease, listened to their concerns and provided an excellent service in which they had confidence in the dental care provided.

Our key findings were:

- There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse. However systems for maintaining the required standards of infection prevention and control and responding to medical emergencies required some attention which the practice manager was aware of and took immediate action to address.
- The dental practice had risk management processes including health and safety in place but limited clinical governance processes to ensure the safe management of medical emergencies and supply of prescription only medicines.
- The practice had some system to monitor and improve the quality of the service; including through audits, however these were not operated effectively to ensure adequate quality monitoring of service provision.
- Premises were well maintained and a tour of the building confirmed that cleaning and infection control systems were in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- In one treatment room we saw the X ray arm was broken and were told it was irreparable but it was still in use.
- There were systems in place to check equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- There were usually sufficient numbers of suitably qualified staff who mostly maintained the necessary skills and competence to support the needs of patients. When staff shortages occurred agency staff were employed.
- Most staff were up to date with current guidelines and the practice was led by the principal dentist.
- Staff were kind, caring, competent and put patients at their ease.
- Patients commented they felt involved in their treatment and that it was fully explained to them.
- Common themes from patients spoken with were that they felt they received good care in a clean environment from a helpful practice team.
- Information about how to complain was available and easy to understand. The practice had not received any complaints in the last 12 months.

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

There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, mostly maintaining the essential standards of infection prevention and control and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risks.

There were procedures regarding the maintenance of equipment and the storage of medicines for the safe delivery of care however they were not robust. In the event of an incident or accident occurring; the practice documented, investigated and learnt from it.

No action



Are services effective?

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

The practice kept electronic and paper records of the care given to patients including information about patients' oral health assessments, treatment and advice given. However the records for one practitioner were not detailed or comprehensive and this has been referred to NHS England. Practitioners monitored any changes in the patient's oral health and made referrals to hospital specialist services for further investigations or treatment if required.

The practice provided patients with advice about preventative care and supported patients to ensure better oral health. Comments received from patients spoken with reflected they were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced.

Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan.

No action



Are services caring?

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

We reviewed 15 completed CQC comments and received feedback from five patients about the care and treatment they received at the practice. The feedback was positive with patients commenting on the good service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was explained to them.

No action



Summary of findings

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection and security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

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

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed. The practice supported patients to attend their forthcoming appointment by having a reminder system in place. Patients who commented on this service reported this was helpful.

The practice had completed a Disability Discrimination Act 1995 audit in 2015 and had made adjustments for access to the extent the building would allow. Access into the building was via a steep flight of stairs, however for patients with limited mobility there was a stair lift. We observed the reception desk was compliant with the Disability Discrimination Act 1995 and the Equality Act 2010.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

No action



Are services well-led?

We found this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

The practice assessed some risks to patients and staff however there were not robust systems and practices in place to assess monitor and improve the quality and safety of services provided.

A programme of audits was carried out as part of a system of continuous improvement and learning. Staff told us they felt supported by the principal dentist when they spoke with them.

The principal dentist was remote from the practice and therefore leadership was not visible and there were few arrangements for sharing information across the team. Roles within the practice overlapped for example the dental nurses acted as receptionist and practice manager. Practice meetings were not held regularly however brief notes of any meetings were documented for those staff unable to attend. Staff spoken with told us they felt supported and could raise any concerns with the designated practice manager or provider.

The practice had systems in place to seek and act upon feedback from patients using the service.

Requirements notice



The Forge Dental Surgery

Detailed findings

Background to this inspection

This inspection took place on the 13 June 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider and information we had received from NHS England. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

During the inspection we toured the premises and spoke with practice staff including, the dentists, hygienist, dental

nurses' treatment co-ordinator and receptionists. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

The practice had systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The designated practice manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a recurrence. Staff reported there was mostly an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The principal dentist told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. These included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

We found that a rubber dam was used in root canal treatments. (A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment). We discussed this with the principal dentist and practice staff, and were shown the relevant entry in specific dental care records and

the equipment in place in the treatment rooms. The principal dentist described what alternative precautions were taken to protect the patient's airway during the treatment if a rubber dam was not used.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). The practice was using dental safety syringes which had a needle guard in place to support staff use and to dispose of needles safely in accordance with the European Union Directive; Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

Staff files contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment such as face visors, gloves and aprons to ensure the safety of patients and staff.

Medical emergencies

The practice had suitable emergency resuscitation equipment mostly in accordance with guidance issued by the Resuscitation Council UK. This included an automatic external defibrillator (AED). (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) Oxygen and other related items, such as manual breathing aids, were also available. The emergency medicines equipment were stored in a central location known to all staff.

Staff spoken with told us regular checks were done to ensure the equipment and emergency medicines were in date and safe to use. However the records we saw did not corroborate staff information. Records seen showed the emergency medicines were not checked on the days when the lead nurse was not in the practice.

When checking the emergency drug kit we found the practice did not have all the recommended medicines available for use. For example, we saw they had intravenous diazepam available and not buccal midazolam as recommended by the Resuscitation Council UK. The practice manager told us they would address this issue immediately with the principal dentist.

Records showed all staff had completed training in emergency resuscitation and basic life support. Staff

Are services safe?

spoken with demonstrated they knew how to respond if a person suddenly became unwell. One member of staff was trained in first aid and a first aid box was centrally located and readily available for use in the practice.

Staff recruitment

The practice had some systems in place for the safe recruitment of staff which included seeking proof of identity and checking qualifications, immunisation status and professional registration. We reviewed three staff recruitment files and there were no references available in any of these files. The designated practice manager told us this was because most staff had worked at the practice for a very long time and the principal dentist had taken over the staff when the practice was purchased a few years ago.

The practice had carried out Disclosure and Barring service (DBS) checks for staff however for the visiting hygienist they had used a DBS check from another employer which was more than six months old and did not meet the requirements for safe recruitment of staff. The practice manager took immediate action to address this issue. These DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

When agency staff were used there were no recruitment checks undertaken. The principal dentist and staff told us they assumed the agency had completed these checks and the agency nurse was up to date with all relevant training, for example managing medical emergencies in the dental practice and essential requirements for infection prevention and control. The designated practice manager told us they did not check any identification from the agency nurse when they arrived in the practice. The lack of checks does not meet the requirements for safe recruitment and demonstrated a lack of governance systems and processes. The designated practice manager told us they would seek confirmation from the agency used as soon as possible.

There was an induction available which we were told was used for any agency staff working in the practice to familiarise themselves with the way the practice ran. We were told should any new staff be employed they would have a full induction and discussion with the practice manager.

The practice had a system in place for monitoring employed but not agency staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC). The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date.

Monitoring health & safety and responding to risks

The practice had some systems to monitor health and safety and deal with foreseeable emergencies however the practice manager told us they were working towards a comprehensive system. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. The designated practice manager showed us the plan for implementing a full set of policies and systems to ensure good practice. Records showed that fire detection and fire fighting equipment such as smoke detectors and fire extinguishers were regularly tested.

The practice had a risk management process to ensure the safety of patients and staff members which they were working on to ensure all necessary risk assessments had been completed. For example, we saw a fire risk assessment and a practice risk assessment had been completed. They identified significant hazards and the controls or actions taken to manage the risks. The practice manager told us the risk assessments would be reviewed annually. The practice had a comprehensive file relating to the Control of Substances Hazardous to Health (COSHH) 2002 regulations, including substances such as disinfectants, blood and saliva.

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

Infection control

There were systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene,

Are services safe?

segregation and disposal of clinical waste. However this policy document had not been signed by the associate dentist or the hygienist to confirm they had read the policy and agreed to implement it.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05)'. This document and the practice policy and procedures for infection prevention and control were accessible to staff.

There was a dedicated decontamination area in the practice which was used for cleaning, sterilising and packing instruments. There was clear separation of clean and dirty areas in the treatment rooms and the decontamination room with signage to reinforce this. However there was only one sink for washing and rinsing instruments in the decontamination room. Staff told us they used a separate bowl for rinsing instruments but this was not seen on the day of inspection. These arrangements mostly met the HTM01-05 essential requirements for decontamination in dental practices.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean instruments between the treatment rooms and decontamination room. The practice used an ultra-sonic cleaning bath for the initial cleaning process; then following inspection with an illuminated magnifier the instruments were placed into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. Staff told us all pouches were dated with an expiry date in accordance with current guidelines. However in one treatment room we found several instrument pouches without any date.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

We observed how waste items were disposed of and stored. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of

waste were appropriately segregated and stored at the practice. Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

We looked at the treatment rooms where patients were examined and treated and observed the rooms and all equipment appeared clean, uncluttered and well-lit with good ventilation however we observed the X-ray unit arm was broken and the principal dentist told us it could not be repaired but they continued to use it because by holding it they ensured it did not move when taking x rays. This put them at risk from radiation exposure but protected the patient from unnecessary radiation exposure.

Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near to the sink to ensure effective decontamination. There were good supplies of protective equipment for patients and staff members.

A legionella risk assessment had not been completed for this practice in accordance with the regulation HTM01 – 05 & HTM 01-04. The practice manager took immediate action and arranged for this to be completed as soon as possible. The practice had some processes in place to prevent legionella contamination such as flushing of dental unit water lines. The lack of a risk assessment and regular testing of the water quality demonstrated preventative measures had not been taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

There was a good supply of cleaning equipment which was mostly stored appropriately. We observed the cleaning equipment was not wholly following the National Patient Safety Association guidance of colour coding equipment to prevent the risk of infection spread. We also observed the mops were inappropriately stored. There was no cleaning schedule to ensure and evidence all areas of the practice were cleaned with the appropriate equipment.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. The practice manager had a system for monitoring the immunisation status of each member of staff for the safety and protection of patients and staff.

Equipment and medicines

Are services safe?

There were systems in place to check equipment had been serviced regularly, including the compressor, autoclaves, X-ray equipment and fire extinguishers. The practice manager showed us some records which evidenced contracts were in place for servicing of the fire extinguishers and electrical appliances.

The manager told us they were in the process of arranging servicing and maintenance contracts for the X-ray and ultrasonic bath (used in decontamination) equipment to ensure servicing occurred in a timely manner. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use.

The practice had a brief policy regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The system in place for the management of medicines, prescribing and supplying, was not compliant with the legal requirements of medicines management in dental practices and did not meet the requirements of the Medicines Act 1968 and the Human Medicines Regulations 2012.

We asked the practice manager to show us the system for checking the amount of medicines in the practice and how they were supplied to patients. Documentary evidence seen showed there was no audit trail of medicines entering and leaving the practice. We also observed medicines had been supplied to patients without a prescription from a dentist and little documentation in the patient's dental care record.

We discussed the management of medicines and the requirements of the Medicines Act 1968 and the Human Medicines Regulations 2012 with the practice manager who told us they would take action to implement an appropriate system. The dentists used the on-line British National Formulary to keep up to date about medicines. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records.

Prescriptions pads were stored securely and details were recorded in patients' dental care records of all prescriptions issued.

Radiography (X-rays)

The practice radiation protection file was not maintained in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IR(ME)R). It demonstrated the practice did not have a radiation protection adviser and this was corroborated by the principle dentist who told us they would appoint one as soon as possible. They supplied the evidence one had been appointed with 48 hours of our inspection visit. There was an up to date inventory of all X-ray equipment and maintenance records.

The X-ray unit arm in one treatment room was broken and the principal dentist told us it could not be repaired but they continued to use it. There were no plans to replace this and the equipment had recently been serviced but no report was available during the inspection.

X-rays were digital and images were stored within the patient's dental care record. We asked to see how the practice monitored the quality of radiographs so patients did not receive unnecessary exposure to radiation. For example, local rules relating to each X-ray machine were maintained. We were not shown a radiation risk assessment and the quality justification and grading of the X-rays were not monitored through an audit process.

Records seen indicated X-rays were not taken in accordance with the Faculty of General Dental Practice (FGDP) Good Practice Guidelines. The justification for taking X-rays the quality of the X-rays and findings were not always recorded in dental care records to evidence the potential benefit and/or risks of the exposure had been considered. Staff authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended appropriate training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept paper and electronic records of the care given to patients. We reviewed the information recorded in patient dental care records to corroborate information received from the principal dentist. We observed some records did not always meet the General Dental Council (GDC) standards for record keeping.

For example, in some records seen there was no treatment plan, no record of consent to treatment, no record of treatment options having been discussed. Several of the records showed the patient's medical history information had not been updated for a significant period of time and there was little evidence of oral health advice being given to patients. We have referred the above concerns to the principal dentist and discussed with them the requirement to appropriately manage the practice for the safety and wellbeing of patients.

Comments received from patients we spoke with reflected they were satisfied with the assessments, explanations and the quality of the dentistry and outcomes.

Health promotion & prevention

The practice made some references to preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health toolkit' (Delivering better oral health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England. The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

The practice provided health promotion information to support patients in looking after their general health using leaflets, posters, a patient information file and via their noticeboard situated in the waiting room. This included making patients aware of the early detection of oral cancer. Patients reported they felt well informed about every aspect of dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

The practice team consisted of two dentists, one dental hygienist and two dental nurses. The dental nurses also covered the roles of receptionist and practice manager. The practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The practice manager kept a record of all training carried out by staff to ensure they had the right skills to carry out their work. Mandatory training included basic life support and infection prevention and control.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was a limited appraisal system in place to identify training and development needs. The practice manager showed us they had this in their practice development plan and had started to implement a system. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs.

Working with other services

The practice worked with other professionals where this was in the best interest of the patient. For example, referrals were made to hospital dental services for further investigations or specialist treatment. The practice completed a referral letter to ensure the specialist service had all the relevant information required.

Dental care records mostly contained details of the referrals made and the outcome of the specialist advice. The practice used their IT system to provide information about referrals which could be used as part of their on-going programme of record keeping audits.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. However we observed in dental care records seen consent was not always obtained prior to treatment. We were told consent was assumed because the patient sat in the dental chair. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Are services effective?

(for example, treatment is effective)

Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and their responsibilities to ensure patients had enough information and the capacity to consent to dental treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met. Staff had received specific MCA training and had a good working knowledge of its application in practice.

The staff we spoke with were also aware of and understood the use of the Gillick competency test in relation to young

persons (under the age of 16 years). The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We reviewed dental care records to corroborate our information. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan and consent to treatment was recorded in some records seen but not in all. Patient feedback confirmed patients were provided with sufficient information to make decisions about the treatment they received from both dentists working in the practice.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments from patients we spoke with were positive about how they were treated by staff at the practice. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients on the telephone.

The principal dentist told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

The waiting area was separate to the reception and staff were aware of the importance of providing patients with privacy. All treatment room doors remained closed during consultations.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected.

Staff described to us how they involved patient's relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Some of the dental care records we looked at corroborated and reflected this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet. The services provided include prevention advice and treatment alongside the specialist dental care.

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival who kept patients informed if there were any delays to appointment times.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place and provided training to support staff in understanding and meeting the needs of patients.

They had completed a Disability and Discrimination Act (DDA) 1995 assessment in 2015 and made adjustments, for example a stairlift to accommodate patients with limited mobility. There was no wheelchair access to the practice. Parking was available nearby. For any patients who became unable to access the practice arrangements had been made with a nearby practice to see the patients.

Access to the service

The practice displayed its opening hours on the door to the practice, in the premises and in the practice information

leaflet. The practice is open Monday to Thursday, 08:30am to 5.00pm Fridays 09.00am – 12.30pm. The practice is closed at weekends. An out of hour's number was available via the practice answerphone.

Patients we spoke with felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the practice manager or principal dentist these were responded to appropriately and in a timely manner.

The practice had received no complaints in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We observed there was a system in place, if followed, which ensured a timely response and sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient. We were unable to corroborate this as no complaints had been received.

Information for patients about how to raise a concern or offer suggestions was available in the reception area and practice information leaflet.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements in place to ensure risks were identified, understood and managed appropriately. The practice manager showed us their improvement plan for ensuring good governance arrangements however this was yet to be fully implemented and did not have timeframes by which the actions would be completed. We saw risk assessments and the control measures were mostly, but not always, in place and followed to fully manage clinical risks. Staff we spoke with were aware of their roles and responsibilities within the practice.

The principal dentist / provider confirmed they were only in the practice one day a week and lived a significant distance away from the practice. We discussed with the principal dentist the legal requirement for them to manage all staff within the practice to ensure national guidance and all legislative requirements are met by the staff working in the practice and providing the regulated activities. We identified a specific area where management oversight and guidance was lacking and this related to record keeping.

Some health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members in a timely way.

There were relevant policies and procedures in place to govern activity. Policies and procedures in use at the practice were accessible to staff in paper files. Staff spoken with told us they were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. There were some practice meetings to discuss practice arrangements and any issues of concern staff wished to

discuss. However they were not regular with all staff present and full minutes were not always taken and distributed to staff with a mechanism to ensure they had been read and would be implemented.

Leadership, openness and transparency

There was little evidence on the day of inspection of clear leadership in the practice. Staff told us there were few formal practice meetings and they mostly discussed things informally when they were in the practice as most staff employed were part time. Staff we spoke with reported there was not always an open and transparent culture at the practice although the principal dentist sought to encourage it when in the practice. Staff felt confident they could raise issues or concerns at any time with the practice manager and / or principal dentist who would listen to them.

We observed and staff told us the practice was a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff we spoke with felt well supported by the practice manager and principal dentist and told us they worked as a team toward the common goal of delivering high quality care and treatment. However the principal dentist did not work in the practice on the days the associate dentist worked which, we were told led to compromised communication, oversight and interaction between the principal dentist and these members of staff.

The principal dentist was aware of and complied with the requirements of the Duty of Candour. The principal dentist encouraged a culture of openness and honesty when in the practice but had little management influence on the four days of the week he was not in the practice. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

Are services well-led?

We saw there was a limited system to monitor and continually improve the quality of the service. Audit of some areas of practice had been undertaken, for example infection control; however this was not dated; there was no action plan to address areas of non compliance and no planned re-audit date to assess and monitor quality and improvements.

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

The practice had systems in place to seek and act upon feedback from patients using the service. The practice had a compliments book in the waiting area which had a

number of very positive comments recorded. These included the following words and phrases: excellent care and treatment. Professional and courteous. Terrific dentist gentle and attentive. Results of treatment couldn't be more satisfactory. Patients spoken with on the day of inspection corroborated these.

The practice regularly asked patients for feedback at the end of treatment and the results seen corroborated the comments received from patients during the inspection. We saw the results of the Friends and Family Test which demonstrated 96% of patients would recommend this practice.

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 How the regulation was not being met: • The provider did not have effective governance systems in place which assessed, monitored and improved the quality and safety of services provided. • The provider did not have fully effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. • Records relating to the provision and management of regulated activities were not created and, amended appropriately in accordance with current guidance.