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Hewlett Road Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 February 2017 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

Hewlett Road Dental surgery is located in the centre of Cheltenham and provides private treatment to adult patients and NHS treatment to children. The practice consists of two treatment rooms, toilet facilities for patients and staff, a reception/ waiting area, office and a staff room. The practice offers routine examinations and treatment.

There are three dentists and two hygienists; three dental nurses; one trainee dental nurse; a decontamination technician and three part time receptionists. The practice is located on the first floor of the building and has a stair lift to enable patients with mobility difficulties to access the practice. The provider has a second practice nearby which is fully wheelchair accessible and arrangements can be made to be seen at that practice.

Fees for private treatments were displayed in information leaflets for patients available in the practice and on the practice website. There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. This is provided by an out-of-hours service and the arrangements are displayed in the practice and on a telephone answering service.

The principal dentist is the registered provider. 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 –Thursday 8.00am - 5.30pm, Friday 8.00am – 4.00pm. The practice is closed at weekends but the out of hours emergency arrangements are displayed on the website. Contact information is also available from the practice telephone answering service. Emergency appointments are made available each day for patients with dental pain.

We reviewed 20 CQC comment cards that had been left for patients to complete prior to our visit. In addition we spoke with six patients on the day of our inspection.

Feedback from patients was positive about the care they received from the practice. They commented the staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided.

Patients we spoke with and the comment cards told us staff were kind, caring, competent and put patients at their ease. However some patients told us they were unhappy about the difficulties with appointments being changed or cancelled at short notice in recent months. Staff told us this had now been rectified.

Our key findings were:

- We found that the ethos of the dentists and the dental hygienist was to provide patient centred dental care in a relaxed and friendly environment.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The dental treatment rooms appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Infection control procedures were effective and the practice followed published guidance.
- Premises appeared well maintained and visibly clean. Good cleaning and infection control systems were in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- The practice had processes in place for safeguarding adults and children living in vulnerable circumstances. However not all staff had received appropriate training.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- Patient dental care records were electronic, detailed and comprehensive.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required with information for out of Hours service clearly available.
- We were told staff received training appropriate to their roles and were supported in their continued professional development (CPD). However there was no effective system in place to monitor staff had undertaken or received appropriate training for their roles.
- Patient feedback during our inspection gave us a positive picture of a friendly, caring, professional and high quality service.
- The practice had clinical governance and risk management structures in place, but we found several shortfalls in systems and processes underpinning the quality of care provided.

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

Summary of findings

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure the practice recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure the training, learning and development needs of staff members are monitored to ensure they undertake appropriate training, collated and reviewed at appropriate intervals.

- Ensure a performance review system is established and provides an effective process for the on-going assessment, appraisal and supervision of all staff.

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

- Review the practice infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance with particular attention to the Annual Infection Control statement.
- Review maintenance records regarding the electrical hard wiring of the practice.

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 some systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. Systems were not robust. For example there was a fire system in place but regular testing of the system did not happen and appointed fire marshals' had not received training. The practice manager agreed to rectify this situation immediately.

We found the practice identification of environmental risks was limited. Risk assessments had been completed but not all actions to mitigate risks had been identified or implemented.

Recruitment of staff did not follow the legislative guidance for safe recruitment. The principal dentist agreed to review recruitment practices for the protection of patients.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

No action



Are services effective?

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

The practice kept detailed electronic records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. They monitored any changes in the patient's oral health and made referrals as appropriate to primary and secondary care providers such as hospital specialist services for further investigations or treatment as required.

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. Good patient outcomes were achieved.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition. (DBOH) Comments received via the CQC comment cards and patients interviewed reflected patients

No action



Summary of findings

were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced. In the waiting room we saw evidence of health promotion information and patients could purchase dental products at reception to assist in maintaining good oral hygiene.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals.

Are services caring?

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

We reviewed 20 completed CQC comments and received feedback on the day of the inspection from two patients about the care and treatment they received at the practice. The feedback was positive with patients commenting on the excellent service they received, professionalism and caring nature of the staff.

Some patients reported difficulty with appointments being disrupted in recent months. All spoke of ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was fully explained to them by friendly, helpful staff.

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, security and confidentiality were in place and staff were aware of these.

No action



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 service was aware of the needs of the local population and took these into account in how the practice was run.

There was a flight of stairs into the building which could be traversed by stair lift for patients with limited mobility. There was a waiting room and two treatment rooms on the first floor level, and the area was spacious enough to manoeuvre with walking aids. We observed the reception desk was compliant with the Equality Act 2010. The practice did not have a hearing loop at reception or access to translation services for patients whose first language was not English.

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

No action



Summary of findings

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

The clinical care provided by the dentists and the dental hygienist led to good patient outcomes.

The practice had accessible and visible leadership with some arrangements for sharing information across the team. There were few staff meetings and they were not always well documented. There was no system for ensuring staff absent from meetings received information.

Staff told us they felt more supported in recent weeks and could raise concerns with the principal dentist.

The practice management structure was not operated effectively to ensure the assessment, monitoring, mitigation of risk and quality of service was effectively managed. Additionally practice policies had not been fully implemented or reviewed to reflect current guidance and legislation.

The provider had limited governance arrangements in place to ensure risks were identified and action taken to mitigate them. Audits had been completed for radiography, clinical record keeping, and the quality of root canal treatments.

The practice did not have effectively operated systems in place to seek and act upon feedback from patients who used the service.

Requirements notice

Hewlett Road Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 10 February 2017. Our inspection was carried out by a lead inspector and a dental specialist adviser.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Prior to the inspection, we asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of seven members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records.

Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

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 dentists were aware of the Duty of Candour. They told us they were committed to operating in an open and transparent manner; they would always inform patients if anything had gone wrong and offer an apology in relation to this. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The practice maintained a significant event folder. There had been two incidents in the previous 12 months. We saw the documentation for incident recording included sections for a detailed description, the learning that had taken place and the actions taken by the practice as a result.

The principal dentist knew when and how to notify CQC of incidents which cause harm. Staff reported there was 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 clinicians 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 systems in place should members of staff encounter a child or adult safeguarding issue. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there

was a need, such as the local authority responsible for investigations. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities.

There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Not all staff had undertaken safeguarding training or child protection training to the required level. In discussion with staff they had some knowledge but told they would wait for the dentist to identify any concerns. 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 spoke with staff about the prevention of needle stick injuries. They explained the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases.

The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive about the use of safer sharps.

We asked the staff how they treated the use of instruments used during root canal treatment. They explained these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

Staff files contained some evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids

Are services safe?

such as; blood and saliva) and there were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automated 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).

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice staff had access to medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. The emergency medicines and equipment were stored in a central location, clearly labelled and known to all staff.

Staff showed us documentary evidence which demonstrated checks were done to ensure the equipment and emergency medicines were in date and safe to use, however there were some gaps in recording.

Records showed most but not all staff had completed training in emergency resuscitation and basic life support. Staff demonstrated they knew how to respond in the event of a medical emergency.

Staff recruitment

The practice had some systems in place for the safe recruitment however the policy did not reflect current legislative guidance with regard to all relevant checks. The policy did state they included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was not identified in the practice policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff. These 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.

Records seen demonstrated practice policy had not been followed and not all these checks were in place. We checked four staff files; two contained appropriate

recruitment documentation. We noted two files had no DBS check and no references. We also looked to see if staff had received appropriate immunisations including Hepatitis B. In one record we saw there was no hepatitis B status for the clinical member of staff or any risk assessment for the safety of the individual and patients.

The principal dentist told us they offered a form of induction for new staff to familiarise them with the way the practice operated, however there was no documentary evidence of this. We were told all newly employed staff met with the principal dentist to ensure they felt supported to carry out their role.

The practice had a system in place for monitoring 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 and on-going.

Monitoring health & safety and responding to risks

The practice had some systems to monitor health and safety and deal with foreseeable emergencies. There were limited health and safety policies and procedures in place to support staff and patient safety. Records showed that fire detection and fire fighting equipment such as the fire alarm and fire extinguishers were not regularly tested.

While a fire risk assessment had been completed in 2015 there was no floor plan and the assessment had not been reviewed. Similarly we were shown the health and safety risk assessment of the practice which had been completed in 2015 and not reviewed since that date.

The practice had a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva. This appeared to be a new file that contained only a limited number of substances subject to COSHH regulations.

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

Are services safe?

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place an infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that 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)' and complied with the essential quality requirements. We were shown an audit of infection control processes carried out in October 2016 which confirmed compliance with HTM 01-05 guidelines.

We saw the three dental treatment rooms; waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of two treatment rooms were inspected and these were ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01-05 guidelines.

We saw a Legionella risk assessment had been carried out at the practice by a competent person in February 2016. Most of recommended procedures contained in the report had been completed and logged appropriately. The only

recommendation yet to be instigated was the microbiological testing of the quality of water. These measures ensured patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for the pre-sterilisation cleaning, sterilisation and packaging of dental instruments. This room was staffed by a dedicated decontamination operative for three days per week. They demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of manual scrubbing and an ultrasonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. We were shown the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. All recommended tests utilised as part of the validation of the ultrasonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers and clinical waste bags were properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked container adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. The practice had equipment that was stored in accordance with current national guidelines.

Equipment and medicines

Are services safe?

There were systems in place to check all equipment had been serviced regularly and in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in January 2017.

The practice X-ray machines had been serviced and calibrated as specified under current national regulations in July 2013 and were due to be tested again in July 2017. Portable appliance testing (PAT) had been carried out in January 2017. 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 policies and procedures regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The batch numbers and expiry dates for local anaesthetics were recorded in patients' dental care records. The local anaesthetic cartridges were stored safely.

We observed the practice had equipment to deal with minor first aid problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor, the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment.

Included in the file was a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown a radiological audit for each dentist had been carried out in 2016. Dental care records seen where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. These findings showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. The radiation protection file showed staff where appropriate, had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. Both dentists we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records seen demonstrated the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment. The dental care records seen were accurate, detailed and fit for purpose.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed two dental hygienists to work alongside of the dentists in delivering preventative dental care.

A dentist explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

We spoke with the dental hygienist who described the advice they gave which included tooth brushing techniques explained to patients in a way they understood. Dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines about prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated the dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The principal dentist planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The practice had not replaced the practice manager who left last year which meant records of all training completed by staff had not been fully completed or reviewed to ensure they had the right skills to carry out their work.

We saw mandatory training included basic life support; hand hygiene, fire safety and infection prevention and control had been completed by most, but not all, staff within the last 12 months. Two staff spoken with told they had not received any training in the last 12 months.

New staff to the practice had a limited induction to the practice as there was no designated person to provide this. Dental nurses received day to day supervision from the dentists with which they worked. However there was no formalised system of supervision and support for staff.

The dental hygienists did not work with chair side support as required by the GDC standards in principle 6.2.1. In

Are services effective?

(for example, treatment is effective)

discussion with the principal dentist we ascertained that no risk assessment for this practice had been completed. They told us they would review this working practice with immediate effect.

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 (GDC). Records showed professional registration was up to date for all staff.

We asked for evidence to demonstrate staff were being managed in the practice for the safety and improvement of quality services. We were shown limited evidence of appraisal for one member of staff and some evidence of induction for another member of staff. However neither of these documents was comprehensive and did not demonstrate staff were being appropriately managed to ensure they were able to carry out their duties effectively.

There was no appraisal system in place to identify training and development needs. The principal dentist told us they had not yet implemented a system to monitor and actively manage staff training and development needs.

Working with other services

The practice worked with other professionals where this was in the best interest of the patient. For example, dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice.

The practice completed a detailed proforma and referral letter to ensure the specialist service had all the relevant information required.

Dental care records contained details of the referrals made and the outcome of the specialist advice.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. Both dentists spoken with explained

how they implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

The dentists further explained how they would obtain consent from a patient who suffered with any mental impairment that may mean they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process.

This followed the guidelines of the Mental Capacity Act 2005. We asked to see evidence dental nurse and non clinical staff had completed specific training about the Mental Capacity Act 2005 but the provider told us they had none. Staff spoken with told us they had not undertaken this training and some demonstrated little knowledge or understanding of the principles of the Act.

Dentists were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16 years of age. Gillick competence 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. Consent to treatment was recorded. Feedback in CQC comment cards and from patients spoken with confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed 20 completed CQC comments cards and spoke with six patients during the inspection. Comments from patients were consistently 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, reassuring and helpful. Patients indicated they felt comfortable and relaxed with their dentist and they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

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

Treatment rooms were situated away from the main waiting areas and we saw doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy.

Dental care records were stored mainly as electronic records. Computers which contained patient confidential information were password protected and regularly backed up to secure storage.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

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. Dental care records we looked at corroborated and reflected this.

Both dentists we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Patients were given a copy of their treatment plan and associated costs. This gave patients clear information about the different elements of their treatment and the costs relating to them. They were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

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 on noticeboards in reception and on their website. During the inspection we looked at examples of information available to patients.

We saw the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements about how to make a complaint. The practice website also contained useful information to patients such as how to provide feedback to the practice, details of out of hours' arrangements and the costs of private care.

We observed the appointment diaries were not overbooked and this provided capacity each day for patients with dental pain to be provided with urgent care when required. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had an equality, diversity and human rights policy in place and staff demonstrated some understanding of how to meet the diverse needs of patients.

They had completed a Disability and Discrimination assessment as required by the Equality Act 2010 and made adjustments, for example to accommodate patients with limited mobility.

There was a stair lift to access the practice and waiting area on the first floor and hand rails to assist in managing a

single step in the corridor. For patients who were unable to access the practice using the stair lift the principal dentist had arrangements in place for them to be seen at their other practice nearby. Access to translation services was not available and there was no hearing loop at the reception desk.

Access to the service

The practice displayed its opening hours on the website, in the waiting room and in leaflets.

The emergency contact numbers to be used when the practice was closed were displayed on their website. Contact information was also available from the practice telephone answering service. If patients had an emergency the practice would try to see them the same day.

The 20 CQC comment cards seen, and six patients spoken with, reflected patients felt they had improved access to the service in recent months 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.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient.

Are services well-led?

Our findings

Governance arrangements

Although the clinical care provided by the dentists and the dental hygienist led to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care.

The practice had some governance arrangements in place to identify risks however they were not comprehensive and not all potential risks had been identified and managed to mitigate the risk. We asked for a practice risk assessment of all potential hazards and were shown one that had been completed in 2015 along with a Health and safety assessment but these had not been reviewed or updated in accordance with changes in the practice.

The principal dentist had completed a fire risk assessment in 2015 but there was no floor plan of the building, fire doors of fire alarm points and extinguishers. The assessment had not identified actions to mitigate risks. We asked for evidence the fire alarms were regularly tested and were told this had not been completed three monthly in accordance with practice policy.

We were also told the emergency lighting had not been tested in accordance with current guidance. Staff told us they had received fire training and felt they would know what to do in such an event.

Practice policies were in place however they had not been reviewed since 2015 and did not reflect current guidance where this has changed. The policies included guidance about confidentiality, record keeping, inoculation injuries and patient safety. We were told there were infrequent practice meetings to discuss practice arrangements, audit results and any other practice related issues.

Leadership, openness and transparency

The practice had a statement of purpose that described their vision, values and objectives.

The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. The staff spoken with described a transparent culture which encouraged candour, openness and honesty. Staff said

they felt comfortable about raising concerns with the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did.

Staff told us they had not always felt supported and there was no system of regular meetings together or individually to discuss issues. However they said this was improving.

Learning and improvement

The practice had an understanding of the need to ensure staff had access to learning and improvement opportunities however there was no system in place to identify these needs and monitor staff uptake of training. Staff spoken with told us they had received little training in the last 12 months.

One member of staff told they had not received any training except basic life support since they commenced in the practice three years ago. The staff team were not proactive in seeking out training for themselves and told us this was not managed or monitored by the practice. Records showed professional registrations were up to date for all staff.

We saw evidence of a programme of clinical audit. The practice carried out a wide range of audit including; the quality of dental radiographs, root canal treatment provided, record keeping, diagnosis of disease and the use of the BPE scoring tool. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

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

The practice had limited systems in place to seek and act upon feedback from patients using the service. However we saw and were told formal feedback from patients had not been undertaken since 2013.

Results of the 2013 patient satisfaction review indicated patients who completed the survey were happy with the quality of care provided by the practice and patients were likely to recommend the practice to family and friends.

Comments seen in the CQC comment cards reflect patients were positive about the service they received.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• 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. <p>Regulation 17(1)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to carry out.• There was limited evidence of appraisals and limited evidence of induction for new staff when they started working at the practice. <p>Regulation 18 (1) (2) (a)</p>