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Whiteladies Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22nd October 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Whiteladies Dental Care is located in the Clifton area of Bristol and provides mainly NHS and some private treatment. The practice consists of three treatment rooms, although one is not currently in use, and a decontamination room. The premises also has toilet facilities (separate for patients and staff), a reception/ waiting area and a staff room.

The practice treats both adults and children. At present the practice operates only one dental surgery and one hygienist surgery. The practice has recently been refurbished and has moved from another part of the building. There is a reception area with the facility to provide information by video. The practice offers routine examinations and treatment. It is run by one dentist who is also the registered provider.

The practice's opening hours are

8am – 4pm on Mondays, Thursdays and Fridays,

10am – 6pm on Wednesdays and Thursdays.

We carried out an announced, comprehensive inspection on 22nd October 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

Before the inspection we looked at the NHS Choices website. In the previous year there had been four

Summary of findings

negative reviews with comments including, “appalling treatment,” “dreadful” and “worst dentist I have ever visited.” The dentist had not made any response to this negative feedback.

For this inspection 21 people provided feedback to us about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff. Patients told us that the dentist listened to what they said, explained things clearly, involved them in planning their treatment and obtained their consent. They said that the dentist took a medical history and updated it at each visit. They told us that the practice was clean and hygienic. We received no negative comments.

Our key findings were:

• Some safe systems and processes were in place, including a lead for safeguarding and infection control. However, staff were not following guidance about the decontamination of instruments.

• Staff recruitment policies were appropriate and most relevant checks were completed although we saw no evidence that refernces were being taken up. New staff had been provided with an induction into the practice.

• The practice had ensured that risk assessments were in place and that they were regularly reviewed.

• The clinical equipment in the practice was appropriately maintained. The practice appeared

visibly clean throughout.

• The practice maintained appropriate dental care records and patients’ clinical details were updated suitably.

• Patients were provided with health promotion advice to promote good oral care.

• All feedback that we received from patients was positive; they reported that it was a caring and

effective service.

• There were appropriate governance systems in place at the practice including a system of audit.

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

- Make sure that the process for cleaning and decontamination of instruments follows the relevant guidance, HTM01-05
- Ensure that dental care products requiring refrigeration are stored in line with the manufacturer’s guidance and the fridge temperature is monitored and recorded.

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

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

- Make sure all recruitment checks for staff are kept together so that they are available for inspection.
- Follow guidance about hand washing and infection control, including ‘bare below the elbows,’ when selecting work clothing.
- The washer disinfector should be used to add an additional level of cleaning before sterilising of instruments.
- A Legionella risk assessment should be carried out by an independent specialist firm.
- The blood glucose measuring device should be stored with the emergency drugs so that it is readily available in the event of a medical emergency.
- Glucogen injections should be stored in the fridge or if stored out of the fridge the time out of the fridge should be monitored so that it does not exceed eighteen months or exceed the use by date.
- The nurses should receive accredited training about radiography.
- All staff should receive accredited training about health and safety and equality and diversity.
- The dentist should update their training to meet the requirements of NHS England including training about record keeping, claims probity, correct prescription of radiographs, treatment planning, extra-coronal restorations, cast restorations, and planning and carrying out root canal treatments.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were appropriate systems for reporting incidents and for learning from incidents. Staff had received training about safeguarding adults and children. There were policies about safeguarding and whistleblowing and staff knew how to report any concerns.

There were also arrangements for dealing with foreseeable emergencies, for fire safety and for managing risks to patients and to staff. There was a business continuity plan. Hazardous substances were managed safely.

Appropriate checks were being made to make sure staff were suitable to work with vulnerable people, although more attention was needed to evidencing this. The necessary medicines were in place although some were out of date. Some medicines and dental supplies were stored in the fridge and cupboard in the kitchen and should be stored in a separate fridge and cupboard away from food areas. Equipment was regularly serviced. X-rays were dealt with safely although attention was needed to formal training about X-rays for the dental nurse.

The surgery had recently been refurbished and was fresh and clean. There was a new decontamination room for storage of medicines and equipment and the cleaning of instruments between patients. This was laid out according to the guidance about decontamination of instruments. However, the process being followed for cleaning of instruments was not in line with the guidance.

Staff wore uniforms which met with guidance, however the dentist wore an ordinary shirt with a white coat over it which is not in line with current guidance about infection control.

Are services effective?

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

The dentist conducted audits to monitor outcomes for patients. They made the appropriate checks and took X-rays at appropriate intervals. All new patients completed a medical history questionnaire and this was updated at each visit. The practice kept up to date with current guidelines and research. They promoted the maintenance of good oral health through information about effective tooth brushing. The dentist discussed health promotion with individual patients according to their needs.

The practice had sufficient staff to have two staff available at all times and if necessary they obtained cover from a dental nursing agency. Staff told us that they received professional development and training. There was online training and in-house training provided by the dentist. There was no formal training about health and safety and equality and diversity. We received concerns about the dentist's training. The dentist told us that they were putting together a personal development plan but this was not in place at the time of the inspection.

The practice had suitable arrangements for working with other health professionals and making appropriate referrals to ensure quality of care for their patients. Patients told us that they were asked for written consent to treatment. Staff were aware of the Mental Capacity Act (MCA) and they had all received training so that they would know what to if an adult lacked the capacity to make particular decisions for themselves.

Summary of findings

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations. Staff in the practice were polite and respectful when speaking to patients. Patients' privacy was respected and treatment room doors were closed during consultations. The practice used an electronic record system and the computer screens in reception were shielded so that they could not be seen by patients.

We noted that there had been four negative comments, from patients, about the practice, on NHS Choices website. However patients who gave us feedback were positive about the care they received from the practice. They reported that staff explained things clearly to them, involved them in decisions and treated them with respect and kindness. People commented that they would recommend the practice to family and friends. They said that they were involved in their treatment planning and the dentist explained things well.

Are services responsive to people's needs?

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

The practice had a system to schedule enough time to assess and meet patients' needs. People also said that they could get an appointment easily. Emergencies were usually fitted in on the day they contacted the practice. The practice actively sought feedback from patients on the care being delivered. There was a procedure about how to make a complaint and the process for investigation. We saw evidence that the practice responded to feedback and complaints made direct to the practice and made changes when necessary.

There was an equality and diversity policy but further work was needed to put it into practice. The dentist told us that they spoke Swedish, English and Persian and most of the patients spoke English or brought their own translator so translators had not been needed. The practice had recently been refurbished and everything was not yet in place. For example, there was level access for wheelchair users and a disabled toilet but there was no loop system or braille for people who were deaf or blind. Information for patients was limited as sources of information had not yet been organised in the waiting room. A new website was being developed to provide information.

Are services well-led?

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

The service was incorrectly registered and action is needed to address this. The practice had systems for clinical governance and the dentist was the lead. There were audits of infection control, record keeping, radiographs, patient involvement and consent and complaints. There were checks of equipment such as the instrument steriliser. A set of new policies had been adopted which reflected current practice and guidance and these were being kept up to date.

The dentist was the lead for the practice. Staff referred to the dentist if they had an issue or needed to know something about how the practice was managed. We saw a whistleblowing policy and information for staff about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no incidents where a patient suffered harm.

There were monthly team meetings where staff discussed developments in the practice such as the refurbishment. Further improvements were planned such as providing information in reception and on the website. Staff were responsible for their own continuing professional development and kept this up to date. They also had training within the practice some of which was provided by the dentist. However, we found some issues with the dentist's own learning. Following concerns raised by NHS England they needed to put together a development plan to update their skills.

Summary of findings

The dentist had used the friends and family test to obtain feedback and intended to reintroduce this. They obtained feedback through a quarterly patient satisfaction survey. As a result of feedback from the last survey the dentist extended the surgery opening hours, and was explaining the NHS and private fees to patients more clearly. Results of feedback were shared with staff in a team meeting.

Whiteladies Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 22nd October 2015. The inspection took place over one day.

The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the local Healthwatch and NHS England that we were inspecting the practice; NHS England raised some concerns about the dentist's training and continual professional development.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with three members of staff and the dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed a dental nurse and the hygienist carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

21 people provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system for reporting and learning from incidents. We saw a policy which described the actions that staff needed to take in the event that something went wrong or there was a 'near miss'. The policy confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result. There had been no incidents. We also saw a record template entitled Accident, treatment and investigation record, which provided a framework to follow in the event of an accident. Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any accidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for child protection and safeguarding adults. This included contact details for the local authority social services. The principal dentist was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed safeguarding training and said that they felt confident that they would recognise potential signs of abuse. They would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager.

Medical emergencies

The practice had arrangements to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support. The staff we spoke with were aware of the practice procedures for responding to an emergency. The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and 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 oxygen cylinder was in date and the AED was functioning. The oxygen cylinder was being routinely checked for effectiveness and we saw records for these daily tests. We reviewed the contents of the emergency medicines kit.

We saw records of weekly checks of the medicines and equipment and all the emergency medicines were in date. We found that the glucagon injections were not being stored in the fridge. They were well within their expiry date of February 2018 but we saw no information about how long this medication had been stored out of the fridge. There was no blood glucose measuring device with the emergency medicines and equipment but the dentist told us that there was one although we did not see this.

Infection control

There were systems to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The dentist was the infection control lead. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms, the decontamination room and the toilet. The nurse and hygienist wore uniforms in the clinical areas and they were responsible for laundering these. However, the dentist wore an ordinary shirt with a white coat over the top. This is not in line with best practice in infection control as they were wearing everyday clothing worn outside the practice and they were not bare below the elbows.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' when setting up their decontamination room. In accordance with HTM 01-05 guidance dirty instruments were carried from the surgery to the decontamination room in a designated sealed box to ensure the risk of the spead of infection was minimised.

Are services safe?

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room with a clear flow from 'dirty' to 'clean.' We saw that there was a washer disinfector machine. The hygienist told us that they did not use this because their instruments were never heavily soiled. The dental nurse said that they would only use this if the instruments were soiled after a surgical procedure. The dental nurse and the hygienist demonstrated how they cleaned the instruments manually. They both wore personal protective equipment (PPE) including gloves and changed their gloves at appropriate points in the process. They used domestic style gloves for washing instruments. They lubricated the hand pieces in a special machine. However the process they followed for cleaning the instruments was not in line with the HTM 01-05 guidance. For example, they both scrubbed the instruments under running water in the washing sink. Neither of them tested the water temperature before washing the instruments. The hygienist rinsed the instruments in the washing sink and did not check them before placing them on a tray and placing them in the autoclave to sterilise them. The nurse rinsed the instruments in the rinsing sink and checked them under an illuminated magnifying glass in line with guidance before placing them on a tray. However the autoclave was full so they left the washed instruments in the dirty area to the left of the washing sink while the autoclave was in use. This is contrary to the guidance relating to maintaining a flow of instruments from dirty to clean. They cleaned down the work surfaces, the box for carrying the instruments and the hand piece machine before removing their PPE.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. There was a washer disinfector but the dentist told us this was new and had not been used yet so there were no regular checks. The washer disinfector and the compressor had not yet been serviced because they were both new. Records were seen of servicing of the autoclave. The last service was on 17th September 2014 so this was due again.

The practice had carried out infection control audits every six months. The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. A Legionella risk assessment was carried out in February 2014 and was reviewed in February 2015. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). However, this was done internally and it would be good practice to have the Legionella risk assessment conducted by a specialist firm. The nurse told us how they flushed the dental water lines in accordance with current guidance in order to prevent the growth of Legionella.

The premises appeared clean and tidy. The practice had cleaning schedules that covered all areas of the premises. The nurses cleaned the surgeries. Eight patients who commented said that the practice was always clean and hygienic.

Recruitment

The practice staffing consisted of a principal dentist, a hygienist, a dental nurse and a receptionist who was also the practice manager. They were planning to recruit a full time receptionist so that the current receptionist could focus on being the practice manager. The dental nurse had worked at the practice for several months and did not have a qualification but planned to enrol on a dental nursing course in the New Year. There was a recruitment policy which stated that appropriate checks would be carried out to ensure new staff were suitable and competent for their role. This included an interview, a review of employment and medical history, checking of qualifications, identification, references and a check of the right to work in the UK. We looked at the recruitment checks of the dental nurse, who was the most recent employee. They had had a disclosure and barring (DBS) check and had a copy of their passport as proof of identity and right to work in the UK. There was a record of their immunisation status. However, there were no written references in the file. The dentist said that they were in the previous practice accommodation upstairs and all information had not yet been transferred. We reviewed the staff files for the dentist and hygienist. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out.

Monitoring Health and Safety and responding to Risk

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy. The practice had a fire risk assessment and there were certificates showing that the fire alarm system and emergency lighting had been serviced. There was a fire safety action plan which was updated in July 2015. There

Are services safe?

were risk assessments for the instrument steriliser, biological agents, display screen equipment, slips, trips and falls and waste disposal. These included the action to be taken to manage risk.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) Regulations. There was a COSHH file which described the regulations and the need to assess risks to patients, staff and visitors associated with hazardous substances. There was a list of all hazardous substances used in the practice, dated January 2015.

The practice followed national guidelines on patient safety. For example, the practice used a rubber dam for root canal treatments. 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.

The practice had a business continuity plan to ensure continuity of care in the event that the practice's premises could not be used for any reason.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. The surgery had been refurbished and most of the portable electrical appliances were new. As a result portable appliance testing (PAT) had not yet been completed for these items. PAT is the name of a process during which electrical appliances are routinely checked for safety. We saw a PAT testing certificate dated February 2015 for the decontamination equipment. There was a certificate to show that a check of the electrical wiring installation took place in February 2015.

Some medicines were stored securely and away from patients in a locked metal cabinet in the decontamination room. Batch numbers and expiry dates for local anaesthetics were recorded. Some other medicines and some dental materials were stored in a cupboard in the kitchen and in the fridge in the kitchen together with food. It would be good practice to store these in a separate fridge in the decontamination room. Some of the medicines, for example amoxicillin, were out of date.

Radiography (X-rays)

There was one hand held X–ray unit. There were suitable arrangements in place to ensure the safety of the equipment. The dentist said that this had to be checked every three years and certificates of checks were seen for April 2011 and May 2013. The local rules relating to the equipment were available. The name of an external radiation protection adviser (RPA) was made available and the dentist was the radiation protection supervisor (RPS). X-rays were graded as they were taken. There was an audit of the radiographs in January 2015. The HSE was notified of the X-ray equipment in 2004. The dentist said that they were not required to notify them of the practice move as they were still at the same address. A certificate was seen to show that the dentist had 5 hours of radiation training in April 2014. The nurse said that she had received training from the dentist but there was no evidence of formal training about dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist conducted some audits to monitor outcomes for patients. In January 2015 they conducted audits for record keeping and radiography. They identified no improvement areas so there were no action plans for improvement.

We reviewed dental care records with the dentist. We found that the dentist regularly assessed patient's gum health and soft tissues (including lips, tongue and palate). The dentist took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice

(FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken. The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.) Patients' BPE scores were recorded in their notes.

The dentist said that all new patients completed a medical history questionnaire. The information was entered on the computer and reviewed at every visit. The people we spoke with said that they had completed a medical history form and they were asked about any changes at each visit. This kept the dentist reliably informed of any changes in people's physical health which might affect the type of care they received.

The practice kept up to date with current guidelines and research in order continually to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients. The dentist said that they set the computer to recall each patient after 6 months then changed this for each patient according to their needs and the guidelines. The dentist was also aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients.

Health promotion & prevention

The practice promoted the maintenance of good oral health through information about effective tooth brushing. The dentist said that they discussed health promotion with individual patients according to their needs. This included discussions around smoking and sensible alcohol use. The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there was some information about tooth brushing displayed in the waiting area. This could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. The practice manager said that more information would be displayed and be put on the website which was in the process of being built. A range of toothpastes, toothbrushes and oral hygiene aids were available for purchase.

Staffing

There was a practice manager who was also the receptionist, a full time nurse, a part-time nurse and a dental hygienist who worked two days a week. The practice manager said that they were recruiting for a full time receptionist so that they could concentrate on being the practice manager. They said that they had sufficient staff to have two staff available at all times and if necessary they obtained cover from a dental nursing agency.

Staff told us that they received professional development and training. The hygienist said that they were responsible for their own continuing professional development (CPD.) They did online training and attended conferences for verifiable CPD and kept their certificates at home. They logged all their training hours online with the General Dental Council (GDC.) The dental nurse told us that they had online training and in-house training provided by the dentist. They said that they had completed training about medical emergencies, first aid and safeguarding adults and children. They were not a qualified dental nurse and were going to start the dental nursing course in the New Year. We saw training certificates for the nurse, dentist and practice manager for safeguarding, the Mental Capacity Act and Cardio Pulmonary Resuscitation. We saw no evidence of training in health and safety and equality and diversity. The dentist said that this training was internal and staff read the policy folder.

Before the inspection NHS England sent us some information raising concerns about the dentist's training and CPD and they imposed conditions in relation to these. We looked at the dentist's training record and saw that they had completed training about, infection control,

Are services effective?

(for example, treatment is effective)

safeguarding, medical emergencies, the Mental Capacity Act, radiography and IRMER. The dentist told us that they were putting together a personal development plan to meet the requirements set by NHS England. This included training about record keeping, claims probity, correct prescription of radiographs, treatment planning, extra-coronal restorations, cast restorations, and planning and carrying out root canal treatments.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for oral surgery, orthodontics, endodontics or implants. The practice completed referral forms or letters to ensure the specialist service had all of the require information about each patient, including their medical history and x-rays.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. The dentist discussed treatment options, including risks and benefits, as well as costs, with each patient. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent. We saw that forms were signed by the patient and the dentist for specific treatments such as tooth extraction, root canal treatment and fillings. Three patients we spoke with said that they had signed a form to give consent to treatment.

There was a policy about the Mental Capacity Act (2005) (MCA) which discussed assessing capacity and making decisions in a person's best interests. Staff we spoke with were aware of the MCA and they had all received training. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patient confidentiality was respected. The practice used an electronic record system. We noted that the computer screens in reception were shielded so that they could not be seen by patients.

Patients were afforded appropriate privacy as the dentist and hygienist treatment room doors were closed during consultations. Conversations could not be heard from the other side of the door. The waiting room was away from the consulting rooms. We observed that staff in the practice were polite and respectful when speaking to patients.

We saw reviews of the practice on the NHS Choices website. In the previous year there had been four negative reviews with comments including, “appalling treatment,” “dreadful” and “worst dentist I have ever visited.” The dentist had not made any response to this negative feedback. 21 people provided feedback about the service for the inspection and we received no negative comments. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. Patients reported that staff explained things clearly to them, involved them in decisions and treated them with respect and kindness. Four people commented that they would recommend the practice to family and friends.

Involvement in decisions about care and treatment

The practice provided clear NHS treatment plans to their patients. There were also treatment plans for private patients which gave options for treatment and indicative costs. Where treatments were complicated the practice used visual aids to explain to them. Patients reported that they were involved in their treatment planning and the dentist explained things well.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' needs. People commented that the staff listened and they received the time they needed. They also said that they could get an appointment easily and they received text reminders. The practice actively sought feedback from patients on the care being delivered. We saw evidence that the practice responded to feedback that they received directly. Following analysis of some feedback forms they had extended the opening hours and considered that the NHS and private fees needed to be explained more clearly. However, there was no record of a response from the dentist to the negative comments on the NHS choices website.

Tackling inequity and promoting equality

There was an equality and diversity policy but this was still in the process of being put into practice. The practice manager said that there was no access to translators. The dentist told us that they spoke Swedish, English and Persian and most of the patients spoke English or brought their own translator so translators had not been needed.

The practice had recently been refurbished and everything was not yet in place. For example, there was level access for wheelchair users but there was no loop system or braille for people who were deaf or blind.

Access to the service

Patients told us that they had no difficulty getting appointments. Emergencies were usually fitted in on the day they contacted the practice. The practice manager said that there was limited information for patients as the website was being rebuilt and the screen based system for information in the surgery was not up and running. At the time of the inspection it was only showing information about electric toothbrushes. There was no information about surgery opening times in reception but the practice manager said that there was a plan to provide this in the waiting room and on the new website. There was information about opening times on the NHS choices website.

Concerns & complaints

There was a procedure about how to make a complaint and the process for investigation. We saw information about one complaint which had been investigated and which demonstrated that learning had taken place and changes had been made. Clearer information for patients had been produced about hygienist appointments and costs.

Are services well-led?

Our findings

Registration

We noted that the service was incorrectly registered and action is needed to address this. The statement of purpose states that the practice is registered for the regulated activities diagnostics and screening, treatment of disease disorder and injury and surgical procedures. However, our records show that they are only registered for the regulated activity of treatment of disease, disorder and injury. We discussed this with the dentist who said that they will apply to add on the regulated activities diagnostics and screening and surgical procedures.

Governance arrangements

The practice had systems for clinical governance and the dentist was the lead. The dentist conducted six monthly audits of infection control and we saw annual audits of record keeping, radiographs, patient involvement and consent and complaints. All the audits were scored at 100% so there were no action plans.

There were checks of equipment. We saw evidence that the autoclave was serviced in September 2014 and was due again. A new compressor was fitted in July 2015. A nurse told us that they conducted daily checks of the autoclave and we saw records of these tests in a log book. There was a new washer disinfector but this was not yet in use. We saw evidence that portable appliance testing for this equipment took place in February 2015.

We saw that there was a folder of new policies which the practice had adopted. These were provided by a company and reflected current practice. The company provided updates so that they would remain relevant.

Leadership, openness and transparency

The dentist was the lead for the practice. The staff we spoke with referred to the dentist if they had an issue or needed to know something about how the practice was managed. The practice manager was new in post and said that they were slowly learning aspects of the management of the practice which they could take over from the dentist. So far they had taken over payments and fees. We saw information for staff in the policy folder about the duty of candour and the need to be open if an incident occurred where a patient suffered harm. So far there had been no such incidents. We saw a whistleblowing policy which was made available to staff.

Management lead through learning and improvement

The practice manager told us that there were monthly team meetings. We saw the minutes of the last meeting which showed that staff discussed developments in the practice such as the refurbishment. The manager told us that further improvements needed to take place such as providing information in reception and on the website. The nurse and the hygienist told us that they were responsible for their own continuing professional development and kept this up to date. They said that they also had training within the practice and we saw certifcates to show that relevant training had taken place, for example for safeguarding and the Mental Capacity Act. Some training was also provided by the dentist such as health and safety and radiography. However, we found some issues with the dentist's own learning following concerns raised by NHS England. The dentist was putting together a development plan to meet the requirements set by NHS England.

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

The dentist said that they had used the friends and family test to obtain feedback but they had suspended this during the surgery move. They intended to reintroduce this. There was also a suggestion box ready to display in reception. There were patient satisfaction surveys and these were analysed once a quarter. We saw the results for the survey in October 2015. Questions included, information availability, appointment booking time, value for money, accessibility, cleanliness and comfort, private area available for discussion, confidence in team abilities, treated with dignity and care, and patient opinion taken into account. The questions all scored highly for satisfaction but some areas for improvemet were identified. As a result the dentist extended the opening hours, and was explaining the NHS and private fees to patients more clearly. The dentist told us that they had discussed the results with staff in a team meeting.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered provider must make sure that the process for cleaning and decontamination of instruments follows the relevant guidance, HTM01-05**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider must make sure that dental care products requiring refrigeration are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.**