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Lancaster Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 25 November 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 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 thispractice was not 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

The practice is situated close to Lancaster city centre. The practice is staffed by the lead dentist (the provider) and a part-time associate dentist. Dental treatment is provided from Tuesday to Friday each week. There are two part-time dental hygienist who work on a Monday, Thursday and alternate Wednesday and Friday. There are no evening or weekend surgery hours available. There is always a receptionist and a dental nurse in the practice when care is being provided. The practice manager is based at this location but also covers the second practice within Lancaster University Campus.

The dentist is the registered provider for the practice. 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.

The practice was providing care which was effective and caring, in accordance with the relevant regulations. However we found that this practice was not always providing safe, responsive and well led care in accordance with the relevant regulations.

Our key findings were:

- Staff had received safeguarding and whistleblowing training and knew the processes to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.

Summary of findings

- Staff had been trained to handle medical emergencies.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice did not actively seek feedback from patients about the services they provided.
- The practice did not have a system in place which recorded and analysed significant events and complaints and cascaded learning to staff.
- Staff had undertaken training appropriate to their roles and responsibilities. There was no formal system in place to monitor training.
- There was a concern over the practice's infection control procedures and the practice was not following published guidance.
- We could not assure ourselves that patient's care and treatment was planned and delivered in line with evidence based guidelines, and current legislation.
- Patients were treated with dignity and respect and personal confidentiality was maintained but there were concerns regarding the storage of treatment records.
- The practice had some shortfalls in leadership, however staff felt involved and worked as a team.
- Governance systems were not robust. . Clinical and non-clinical audits were not undertaken to monitor the quality of services. Where risk assessments had identified concerns these had not been acted upon.
- Fire safety in the practice did not meet required standards.
- Practice policies and procedures had not been reviewed periodically.

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

- Assess, monitor and mitigate the risks to the health and safety of patients, staff and visitors.
- Ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.
- Ensure that the practice meets fire safety guidance.
- Ensure that the equipment used by the service provider for providing care and treatment to a patient is safe for such use and is used in a safe way.
- Have systems in place for assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.
- Ensure there is an effective approach for identifying where quality and/or safety is being compromised and steps are taken in response to issues. These include all audits and risk assessments undertaken within the practice.
- Establish systems to support communication about the quality and safety of services and what actions have been taken as a result of audits, concerns, complaints and compliments.
- Ensure that audit processes function well and have a positive impact in relation to quality governance, with clear evidence of actions to resolve concerns.
- Establish processes to actively seek the views of patients and should be able to provide evidence of how they have taken these views into account in relation to decisions.

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

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

- Establishing systems which monitor that all staff members receive appropriate support, training and supervision necessary for them to carry out their duties.
- Periodically review all policies and procedures and reflect the protocols in place in the practice.
- Carrying out equipment checks as required and keeping records of these.
- Reviewing procedures for storage of paper records in accordance with the Department of Health's code of Practice for Records Management (NHS Code of Practice 2006) and other relevant guidance about information security and governance.
- Clearly defining job roles and delegating staff relevant responsibilities to involve all staff in the governance framework.

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).

The practice did not have effective systems and processes in place to ensure all care and treatment was carried out safely.

The practice had received one complaint in the last 12 months. Recording of this complaint was not managed effectively to support an audit trail. We did not see any processes in place for lessons being learnt and improvements being made when things go wrong.

Staff had received training in safeguarding and whistleblowing and knew the signs of abuse and who to report them to. However the safeguarding policy did not record outside support contact details which would enable staff to share their concerns with the appropriate people.

Staff were suitably trained and skilled to meet patient's needs. Staff were responsible for their own training portfolio. However we were concerned that although staff had received training, lessons from the training were not implemented into the practice's protocol and procedures. There were sufficient numbers of staff available at all times

Infection control procedures were not in place however all staff had received infection control training. We found that the decontamination of instruments was not performed in accordance with current legislation.

Emergency medicines in use at the practice were stored and checked to ensure they did not go beyond their expiry dates. Other equipment required for use in a medical emergency, for example the correct size portable oxygen and a defibrillator, were not available. (A defibrillator is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Are services effective?

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

Patients received an assessment of their dental needs including taking a medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained. On review of treatment records, write up of treatments could not demonstrate that consultations were carried out in line with good practice guidance from the National Institute for Health and Care Excellence (NICE). However patients where recalled after an agreed interval for an oral health review, during which their medical histories and examinations were updated and any changes in risk factors noted.

Staff were supported through training; however there was no formal system in place for appraisals and identifying opportunities for development.

Patients were referred to other services in a timely manner. Dental nurses had received training in and understood the Mental Capacity Act 2005 in line with requirements in the dental practice.

Are services caring?

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

Summary of findings

Patients were treated with dignity and respect and their privacy was maintained. Patient information and data was handled confidentially but filing cabinets used for the storage of patient records were not kept locked and were out of the line of sight of the receptionist. This presented a risk that records could be accessed by other patients or visitors.

Treatment was clearly explained to patients but all investigations and information were not recorded in the patient's treatment records.

We spoke to one patient who told us they were happy with the care they received. The practice did not proactively seek the views of its patients.

Are services responsive to people's needs?

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

The practice did not offer extended opening hours to support patients in arranging appointments in line with other commitments. The practice did not audit the suitability of the premises annually and identify any changes they planned to make to support patients.

The system for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients was not effective. There was no documentation trail in place. Information for patients about how to raise a concern or offer suggestions was not available in the waiting room. The complaints procedure did not include contact details of other agencies if a patient was not satisfied with the outcome of the practice investigation into their complaint.

People with urgent dental needs or experiencing pain were responded to in a timely manner, often on the same day.

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 section at the end of this report).

The practice staff were involved in delivering effective care but there was a lack of leadership.

Staff were encouraged to maintain their professional development and skills but there were no formal systems in place to monitor this.

Clinical and non-clinical audits were not taking place. Care and treatment records were not audited to ensure standards had been maintained. The practice was not proactive in seeking the views of patients both with a formal audit and informally. Health and safety risks and fire safety risks had not been assessed and managed.

Lancaster Dental Clinic

Detailed findings

Background to this inspection

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.

The inspection took place on the 25 November 2015 and was conducted by one CQC inspector who was accompanied by a dental specialist advisor.

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.

We undertook this inspection following concerns raised on the inspection of the sister practice, Lancashire University Dental Care. During the inspection we spoke with the dentist, one dental nurse, the receptionist, the practice manager and one patient. We reviewed policies, procedures and other documents.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We could not assure ourselves that the practice had procedures in place to investigate and respond to significant events. We did not see any policy or procedure for dealing with significant events; however we were told that there had been no safety or significant incidents in the last year.

Staff were aware of the reporting procedures in place and encouraged to bring safety issues to the attention of all staff. The practice had a no blame culture and policies were in place to support this. We could not assure ourselves that staff understood the process for accident and incident reporting including their responsibilities under the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager told us that any accident or incidents would be discussed at practice meetings or whenever they arose. We saw that the practice maintained an accident book; this documented one accident in the last 12 months which was fully recorded.

There were limited procedures in place for investigating and responding to complaints. These set out how complaints and concerns would be investigated, responded to and how learning from complaints would be shared with staff. We saw that the practice had received one complaint during the last 12 months which was acted upon by the practice. However there was no supporting documentation regarding the actual complaint or the practices response.

Reliable safety systems and processes (including safeguarding)

The practice had limited policies and procedures in place for recognising and responding to concerns about the safety and welfare of patients. For example, we did not see evidence of a whistleblowing policy; however staff spoken with on the day of the inspection told us that they felt confident that they could raise concerns without fear of recriminations. Records we reviewed demonstrated that all staff at the practice were trained in safeguarding adults and children. The dentist had a lead role in safeguarding to provide support and advice to staff and to oversee safeguarding procedures within the practice. There had been no safeguarding concerns raised by the practice in the last three years. On review of the safeguarding policy we found that there was no information about the reporting process contact details of outside agencies.

Medical emergencies

The practice had basic procedures in place for staff to follow in the event of a medical emergency and all staff had received basic training in life support.

Emergency medicines were available. The practice did not have all the required equipment available for use in the event of an emergency as recommended by the 'Resuscitation Council UK' and 'British National Formulary' guidelines. For example there were no paediatric airways, no child size self-inflating air bag and a lack of facial oxygen masks for children. The oxygen cylinder was not of the recommended size to be classed as portable, however there was oxygen available when patients received conscious sedation. There was portable suction but a defibrillator was not available. However the manager did show us that a new defibrillator was on order. This meant that the practice could not ensure that if a patient collapsed and required the use of a defibrillator this could not be accessed with the recommended three minute timeframe.

There was no formal system in place for staff to check medicines and equipment to monitor stock levels, expiry dates and ensure that equipment was in working order. Any checks performed were not recorded; however we did not find anything out of date or not in working order on our inspection.

Staff recruitment

As all staff recruitment was managed at this provider's practice. We reviewed four recruitment files We found that employment files were not complete and documentation could not be easily located. The practice did not have a robust recruitment policy. When we asked the practice manager they could not confirm which staff members had received a Disclosure and Barring Service (DBS) check. We were not shown any documentation which outlined which staff required a DBS check, however we did see that some staff had put proof of their DBS check in their training file

We found that the newest member of staff, recruited in 2014, had been employed without the full range of documentation and employment checks as required under

Are services safe?

Schedule 3 of the Health and Social Care Act 2008 and associated Regulations. There was no proof of identity or any references available. There was also no proof of each member of staff's Hepatitis B virus (Hep B) status. Hep B is a type of virus that can infect the liver. This virus can be contracted by health care personnel and others as a result of a needle stick injury if they have not been immunised against the virus.

There were sufficient numbers of suitably qualified staff working at the practice. If there were absences the practice manager would endeavour to get staff from the sister practice to cover extra shifts.

Monitoring health & safety and responding to risks

Although requested we did not see a general health and safety policy. A health and safety risk assessment had not been undertaken and could therefore not be reviewed and monitored. There were, however, limited policies and procedures in place to manage risks at the practice in the areas of infection prevention and control and the control of Legionella.

On the day of our inspection we were very concerned about the fire safety procedures in the practice. A fire risk assessment had been undertaken in 2012 and repeated in November 2015, however actions required which were identified in both assessments had not been actioned. Fire exists were not clearly marked, there were limited fire detection equipment and there was no emergency lighting or appropriate safeguards put in place. Although there were fire extinguishers throughout the building, staff had not been trained to use them. Records required to demonstrate that staff checked fire safety in the premises were not available. We saw there had been no recorded fire drills. As part of this inspection we asked the Fire Safety Officer from the local fire service to visit the premises. They agreed with our concerns and would be dealing with the provider under the Regulatory Reform (Fire Safety) Order 2005.

We did not see evidence that the practice had maintained a Control of Substances Hazardous to Health (COSHH) folder. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way.

Infection control

The practice appeared visually clean and tidy. There was a basic infection control policy in place. There was no designated lead for infection prevention and control at the practice. A cleaning schedule and checklists were available for staff to follow. . We saw that the practice had not completed an infection control audit to ensure compliance with HTM 01-05 guidance; however we saw from staff records that all staff had received infection control training.

The premises consist of two treatment rooms, a decontamination room and waiting/reception area. Separate staff facilities for staff for changing or taking breaks in was the practice managers office.

We found that there were adequate supplies of liquid soaps and hand towels in the premises. Staff confirmed these were always readily available. Posters describing proper hand washing techniques were displayed in the treatment room and the toilet facility. Sharps bins were properly located, signed, dated and not overfilled.

A clinical waste contract was in place and we found that waste matter was handled and stored securely until collection.

We looked at the procedures in place for the decontamination of used dental instruments. The practice did have a dedicated decontamination room but this was not set out as recommended in the HTM 01-05 guidance. For example, there was no separate hand wash sink and the sink used for cleaning and rinsing instruments was situated very close to the autoclave. There were no clear lines for instruments to be transferred from dirty to clean areas.

Although instruments were being decontaminated, the process wasn't in line with HTM 01-05 guidance. On the day of our inspection, the dental nurse explained the decontamination process to us. The practice cleaned their instruments in an ultrasonic cleaning bath but then instruments were not examined visually with a magnifying glass for cleanliness before being sterilised in an autoclave. At the end of the sterilising procedure all the instruments were correctly packaged, sealed and stored but some were not stamped with their expiry date that met the recommendations from the Department of Health.

Are services safe?

The equipment used for cleaning and sterilising was maintained and serviced in line with the manufacturer's instructions However there was a lack of daily, weekly and monthly checks kept of decontamination cycles to ensure that equipment was functioning properly.

There was a Legionella risk assessment in place. A Legionella risk assessment is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place. We found that water lines were not flushed at least twice a day as recommended. Water lines in the practice were only flushed at the end of the day. Water temperatures were checked monthly but at certain times the temperature was lower than 45 egrees as recommended in Health Technical Memorandum 01 05 When we discussed this with staff they seemed unaware of the recommendations.

Equipment and medicines

The practice had a system for the monitoring of service contracts. Records we viewed reflected that all equipment in use at the practice was regularly maintained and serviced in line with manufacturer's guidelines. Portable appliance testing (PAT) for all portable electrical equipment had recently been renewed. Fire extinguishers were checked and serviced regularly by an external company but staff had not been trained in the use of equipment.

There were sufficient stocks available for use. Emergency medical equipment was monitored to ensure it was in working order and in sufficient quantities.

On the day of inspection we found that local anaesthetic syringes had been preloaded and stored in a draw in the treatment room. There was no date on these to demonstrate how long they had been there; this could result in bacteria accumulating in the syringe before used on a patient. We sought advice regarding this. Syringes can be preloaded before each surgery session but not stored for longer than 24 hours prior to use. There were 10 – 15 syringes pre-loaded. We could not be guaranteed that they were prepared that morning or for use on that specific day and staff could not confirm when they had been prepared.

Radiography (X-rays)

X-ray equipment was situated in the treatment room and the OPG machine was on the first floor of the premises. Orthopantomogram (OPG) is a panoramic scanning dental X-ray of the upper and lower jaw. This meant that patients who had limited ability to manage stairs would have to go to the other practice for this investigation.

The practice was not compliant with the Ionising Regulations (Medical Exposure) Regulations 2000 (IR(ME)R 2000) and associated regulations**.** This legislation is intended to protect the patient from the hazards associated with ionising radiation for example dental X-rays. The practice had prepared their own local rules for the safe use of equipment. These were not dated and did not show who was the designated radiation protection advisor to ensure that the equipment was operated safely and by qualified staff only. A Radiation Protection Adviser (RPA) must be appointed for a dental practice to provide advice on complying with legal obligations under IRR 99 and IRMER 2000 including the periodic examination and testing of all radiation equipment, the risk assessment, contingency plans, staff training and the quality assurance programme.

We saw the necessary documentation demonstrating the maintenance of the X-ray equipment at the recommended intervals. A specialist company attended at regular intervals to calibrate all X-ray equipment to ensure they were operating safely. Where faults or repairs were required these were actioned in a timely fashion.

The dentist recorded the quality of the X-rays images on a regular basis and records were being maintained. However there was no formal audit of x-rays undertaken to ensure that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays as in accordance with guidance. Patients were required to complete medical history forms and the dentist considered each person's circumstance to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients attending the practice for a consultation received an assessment of their dental health after providing a medical history covering health conditions, current medicines being taken and whether they had any allergies.

The staff we spoke with told us that each person's diagnosis was discussed with them and treatment options were explained. Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included smoking cessation advice and general dental hygiene procedures.

We reviewed a selection of patients' dental records. They were not completed in accordance with guidance from the Faculty of General Dental Practice (FGDP) – part of the Royal College of Surgeons that aims to promote excellent standards in primary dental care. For example, although medical histories had been up dated prior to each treatment; soft tissue examinations, diagnosis and consent were not recorded in addition to other information such as alerts generated by the dentist to remind them that a patient had a condition which required additional care and advice.

Patients requiring specialised treatment such as orthodontics were referred to other dental specialists. Their treatment was then monitored after being referred back to the practice after it had taken place to ensure they received a satisfactory outcome and all necessary post – procedure care.

The practice did offer conscious sedation for nervous patients. This was carried out by an appropriately trained anaesthetist. We found that robust governance systems were not in place to underpin the provision of conscious sedation. We were unable to observe the systems and processes followed were in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.The governance systems supporting sedation must include pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training. There was a general trained nurse supporting the dentist and the anaesthetist but it was not clear if they had received the appropriate training to do this.

Health promotion & prevention

The waiting area contained a range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. This included information on how to maintain good oral hygiene both for children and adults and the impact of diet, tobacco and alcohol consumption on oral health. Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health.

Staffing

We checked that all staff were registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration as a dental professional and its activity contributes to their professional development. The staff training files we looked at showed details of the number of hours training they had undertaken and training certificates were also in place. However there were no formal procedures in place for the practice manager to review and monitor registration or training. Staff we spoke with told us that they were supported in their learning and development and to maintain their professional registration, however we had concerns that although staff had received training learning had not been implemented in the practice.

The practice did not have formal procedures in place for appraising staff performance. Staff spoken with said they felt supported and involved in discussions about their personal development on an informal basis. They told us that the dentist was supportive and always available for advice and guidance.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice.

The care and treatment required was explained to the patient and they were given a choice of other dentists who were experienced in undertaking the type of treatment

Are services effective?

(for example, treatment is effective)

required. A referral letter was then prepared with full details of the consultation and the type of treatment required. This was then sent to the practice that was to provide the treatment so they were aware of the details of the treatment required. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. Where patients had complex dental issues, such as oral cancer, the practice referred them to other healthcare professionals using their referral process.

Consent to care and treatment

Staff we spoke with demonstrated an awareness of the Mental Capacity Act (MCA) 2005 and its relevance to their role. The MCA provides a legal framework for acting and making decisions on behalf of adults who may lack the capacity to make particular decision. We saw that all staff had received MCA awareness training within the last 12 months.

Following the concerns we highlighted regarding consent at the sister practice two weeks ago; consent procedures had been adapted to reflect Department of Health guidelines.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patient's privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity and respect and maintained their privacy. Staff members we spoke with told us that they never asked patients questions related to personal information at reception to maintain patient confidentiality.

A data protection and confidentiality policy was in place. This policy covered disclosure of, and the secure handling of, patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. However we saw that patient records were not held securely. Patients' paper records were stored in two filing cabinets in the alcove at the top of the stairs. Patient information and data was handled confidentially but filing cabinets used for the storage of patient records were not kept locked and were out of the line of sight of the receptionist. This presented a risk that records could be accessed by other patients or visitors. When we asked about this we were told that they were kept open during the day so that the receptionist could easily access the files.

Involvement in decisions about care and treatment

The practice did not actively seek the views of its patients. There were patient satisfaction surveys available the staff were not proactive in using these. We were told that patient satisfaction was monitored informally through discussions with the patient and verbal comments received. There was a comments book, with the receptionist, so they could record anything either positive or negative that patients told them. This was introduced in the practice very recently following feedback from the inspection of the providers other practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

Due to the size of the reception and waiting area there was very little space to display information. Although information was available this was not readily identifiable and accessible for patients.

Appointment times and availability met the needs of patients. The practice was open Monday to Friday 9.00am – 5.00pm. There were no evening or weekend surgery hours available. There had been no complaints made by patients regarding the opening times. Patients with emergencies were seen within 24 hours of contacting the practice, usually the same day. If the dentist was not available patients were advised, if urgent, to contact the providers other practice or the local NHS dental service at the hospital.

Tackling inequity and promoting equality

The practice had policies for anti-discrimination and promoting equality and diversity. Staff we spoke with were aware of these policies. There was only one of the treatment rooms which was fully accessible. The reception, the second treatment room and patient toilet were on the first floor of the property only accessible by a steep and narrow stair case.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen usually within hours of their phone call or referred to the sister practice. Staff we spoke with told us that patients could access appointments when they wanted them.

Concerns & complaints

The practice did not have a full complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. It did not included the details of other external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly. Information for patients about how to raise complaints was not visible in the reception area. Staff we spoke with were aware of the procedure to follow if they received a complaint.

There had been one complaints made to the practice during the last 12 months. A complaints book was maintained by the practice manager. On review of this book we saw that complaints and outcomes were recorded in pencil. There was no documentation to back up the handling or outcome of any of the complaints recorded.

Are services well-led?

Our findings

Governance arrangements

The practice did not have formal arrangements in place for monitoring and improving the services provided for patients. There were limited governance arrangements in place and staff we spoke with were not fully aware of their roles and responsibilities within the practice. We found that staff did not have clearly defined roles in which to participate in governance activities such as audits and quality monitoring.

There were no formal systems in place for carrying out clinical and non-clinical audits within the practice. There was no evidence that findings from audits had been used to change and improve practice. Health and safety related audits and risk assessments were not in place to ensure that patients received safe and appropriate treatments.

There was not a full range of policies and procedures in use at the practice. Policies seem to have been written by the practice but there was little evidence to support they had been reviewed at regular intervals; however staff were aware of the policies and where they were available for them to access. We found that policies were available in a folder in the practice manager's office.

Leadership, openness and transparency

The culture of the practice was informal which supported openness and honesty. Staff told us that they could speak with each other if they had any concerns. All staff were aware of whom to raise any issue with and told us that the dentist would listen to their concerns and act appropriately.

The practice manager continued to operate as a dental nurse in the surgery. There was no designated time for management duties. There seemed a lack of coherent leadership throughout the practice.

We were told that there was a no blame culture at the practice and that the delivery of high quality care and patient satisfaction was part of the practice ethos. However there was no formal system at the practice for raising concerns, for example staff meetings, taking place. We saw evidence that staff meetings were held but there was no standard agenda and no evidence of learning through these meetings.

Management lead through learning and improvement

The statement of purpose told us that the management of the practice was focused on achieving high standards of clinical excellence and improving outcomes for patients and their overall experience. However the required paperwork and audit systems were not in place to support this. Most of the staff had worked at the practice for a long time and were happy for things to continue as they were if a problem was not identified. There were no clear lines of responsibility for tasks which ensured that these were performed and documented.

The dentist and dental nurses who worked at the practice were registered 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 UK. Staff were encouraged and supported to maintain their continuous professional development (CPD) as required by the GDC.

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

We were told that patients could give feedback at any time they visited. There was a comments and suggestion box available for patients. However staff we spoke with told that patients seemed reluctant to give feedback. There had been no proactive work by the practice to seek patient views.

Staff supervision and documented appraisals had not been undertaken. We were told, and saw that staff shared information and that their views, comments and training needs were sought informally but there was no evidence that their ideas were adopted. Staff did tell us that they felt part of a team and enjoyed working at the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12: Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must: Assess the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks; Ensure that the premises used by the service provider are safe to use for their intended purpose. Ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use. Assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12 (1) (2) (a) (b) (d) (e) (h)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation: 17 Good Governance The provider did not have systems or processes to enable the registered person to— Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

Requirement notices

Assess, monitor and mitigate the risks relating to infection control, the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

Maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity.

Regulation 17 (1)(2)(a)(b)(d)(e)(f)