Mr Alan Jones

Alan Jones Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 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 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

Alan Jones Dental Surgery is located in the seaside town of Hornsea, in the East Riding of Yorkshire. The premises are situated in the town centre, close to car parking facilities. The practice provides a service to private patients.

The practice is open:

Monday - Wednesday 08:30 - 17:30

Thursday 09:00 - 16:30

Friday 08:30 - 14:00

CQC previously inspected the practice on 22 May 2013 and 2 October 2013 and asked the provider to make improvements regarding the care and welfare of people who use the service, infection prevention and control and to monitor the quality of service provisions. We checked these areas as part of this comprehensive inspection and found this had not been embedded in the practice.

The practice owner is the registered provider. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. 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.

During the inspection we spoke to four patients who used the service. We sent CQC comment cards to the practice

Summary of findings

two weeks prior to our visit for patients to tell us what they thought about the practice. We did not receive any written CQC comment cards and observed the cards and the box at the reception area. However all the comments were positive about the staff and the services provided. Comments included: the practice was safe and hygienic; staff were very caring and polite and they were impressed with the services.

Our key findings were:

- The practice did not have emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- The practice did not have access to an automated external defibrillator and the medical oxygen cylinder available on the premises had no supporting evidence that it had been serviced or replaced.
- Governance arrangements were in not place for the smooth running of the practice; the practice did not have a structured plan in place to audit quality and safety including infection control, radiographs and patient care records.
- Staff had not received safeguarding training, however they knew how to recognise signs of abuse but not how or who to report it to.
- A legionella risk assessment had had not been completed.
- Staff had been trained to manage medical emergencies, however this training was completed in November 2013.

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

- Ensure availability and checks of all medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK).
- Ensure the practice's 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 practice's protocols are reviewed for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) 2000.
- Ensure audits of various aspects of the service, such as radiography and dental care records, are undertaken at regular intervals to help improve the quality of service. The practice should also ensure all audits have documented learning points so the resulting improvements can be demonstrated.
- Review its audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Ensure that the practice is compliant with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure a risk assessment for legionella testing is completed and action plan implemented in accordance with the findings.
- Ensure all staff have CPR and medical emergency training.
- Ensure all staff receive necessary training and performance appraisals and are suitably supported in undertaking their activities.

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:

- Adopt an individual risk based approach to patient recalls having regard to National Institute for Health and Care Excellence (NICE) guidelines.
- Review the practice protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention.
- Review at appropriate intervals the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff.

Summary of findings

- Maintain accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users also ensure this is easily accessible to patients.
- Review the storage of dental care records to ensure they are stored securely.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification are requested and recorded suitably.

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 Enforcement section at the end of this report).

The practice did not have effective systems and processes in place to ensure that all care and treatment was carried out safely. For example, emergency equipment and medicines were not all in date including epinephrineadrenaline for allergic reactions and glucagon for diabetes. The oro-pharyngeal airways were out of date as were the syringes and needles. This was not in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. The practice did not have a portable suction unit. The medical oxygen cylinder had never been serviced or replaced and there was no date on the cylinder so it was difficult to determine if this was still in date. This was brought to the attention of the registered manager and new equipment was ordered whilst the inspection was taking place and evidence of this was seen.Spare equipment was sourced from a local practice until the equipment arrived.

There was no evidence staff had received any training in safeguarding patients. However they knew how to recognise the signs of abuse but not who or how to report them. There was no evidence staff had received training in infection prevention control. There was a decontamination room and guidance for staff to provide effective decontamination of dental instruments.

Patient's medical histories were obtained verbally before any treatment took place. This provided the dentist with up to date information about any health or medication issues which could affect the planning of treatment. This was not always recorded in the patients' dental care records. We looked at 10 patient dental care records and the last time medical histories were updated was in 2013.

The practice did not have a recruitment policy to ensure suitably trained and skilled staff met patients' needs. The last member of staff to join the practice was in 1999. There was not sufficient numbers of staff available at all times. If staff were absent, patients treatment had to be cancelled or they were seen as an emergency at a local practice.

The practice had never undertaken a legionella risk assessment; this was brought to the attention of the practice owner on the day of the inspection to implement as soon as possible.

The registered provider was made aware of these findings on the day of the inspection and they were formally notified of our concerns immediately after the inspection. They were given an opportunity to put forward an urgent action plan with remedial time frames, as to how the risks could be ameliorated. The registered provider responded appropriately within the required time frame to inform us of the urgent actions they had undertaken to mitigate the risks.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. However we found areas that required improvements relating to the effective provision of treatment.

Patients dental care records did not always provide comprehensive information about their current dental needs. Dental care records which we reviewed during the inspection were not thorough, did not include discussion about treatment options, X-rays were not justified, graded or reported on and there was no evidence of consent being given to treatment.

Summary of findings

Consultations were carried out in line with best practice guidance from the Faculty of General Dental Practice (FGDP). For example, patients were recalled after an agreed interval, for an oral health review, during which their medical histories were verbally updated but not recorded and examinations were updated and recorded. Any changes in risk factors were also discussed although this was not always recorded.

Patients were referred to other specialist services in a timely manner and all returning information was reviewed. Patients' were offered a follow up appointment at the practice to ensure continuity of care.

Staff were supported in delivery of effective care through training and development. The clinical staff could not provide clear evidence to support their continuous professional development (CPD). They were supported to meet the requirements of their professional registration however no systems were in place to monitor this.

Are services caring?

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

Comments from the four patients we spoke to on the day of the inspection included statements saying the staff were caring, friendly, helpful and professional.

We observed patients being treated with respect and dignity during interactions at the reception desk and over the telephone.

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. However we found areas that required improvements relating to the responsive provision of treatment and patients.

Patients could access routine treatment and urgent care when required. However, there was evidence of a number of cancellations in patient dental care records. The practice did offer daily access for patients experiencing dental pain which enabled them to receive treatment quickly.

The practice had a complaints process however this was not practice specific or accessible to patients who wished to make a complaint. The policy did not include who to contact within the practice or how long it would take to respond to a complaint. Patients' we spoke to confirmed they did not know how to complain about the services and who to if the need arose.

There was a practice information leaflet available for patients which contained no information about how to complain. The leaflets were only for patients who had a private care plan in place.

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 Enforcement section at the end of this report).

Staff reported the registered provider was approachable, they were able to raise issues or concerns at any time and they felt supported in their roles. The culture within the practice was seen by staff as open and transparent.

The practice sought some feedback from patients in order to improve the quality of the service provided. No action plans were in place to review and discuss the feedback provided from patients.

The practice did not have any audits in place to monitor their performance and help improve the services offered, including patient dental care records, infection control and X-rays.

Summary of findings

The practice did not have structured staff meetings, any discussions were as and when required but there was no evidence of this within the practice. There was no evidence staff were supported to meet their professional standards and follow their code of conduct.

Patient dental care records were not stored securely within the reception area. Archived patient dental care records from another practice were stored upstairs in an office area, again not securely.

Alan Jones Dental Surgery

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 was carried out on the 10 November 2015 and was led by a CQC inspector and a dental specialist advisor.

We informed Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

The methods that were used to collect information at the inspection included interviewing staff, observations and review of documents also talking to people using the service.

During the inspection we spoke with the dentist, a dental nurse and the receptionist. We saw policies, procedures and other records relating to the management of the service. No Care Quality Commission comment cards had been completed prior to the inspection.

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 guidance for staff about how to report incidents and accidents. However, we saw no evidence that incidents or accidents had been documented, investigated and reflected upon by the dental practice. Significant events were not recorded and no evidence of a discussion was available. Patients would be given an apology and informed of any action taken as a result. The staff had a basic understanding of the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy, however this was not always carried out. We observed an accident book with no entries recorded. Information was shared during the inspection about one incident that had occurred and not been recorded.

The practice was aware of the national patient safety and medicines alerts from the Medicines and Healthcare products Regulatory Authority (MHRA) which related to the dental profession. We were told a record of the information received and actions taken by the registered provider was not documented. The registered provider said it was shared verbally within the practice.

Reliable safety systems and processes (including safeguarding)

We reviewed the practice's policy and procedures in place for child protection and safeguarding vulnerable adults who use the service. They included the contact details for the local authority safeguarding team, social services and other relevant agencies. There was no lead for safeguarding. This role includes providing support and advice to staff and overseeing the safeguarding procedures within the practice.

There was no evidence any safeguarding training in vulnerable adults and children had taken place. Staff could easily access the safeguarding policy, however staff were not sure of the reporting process and who they would report any concerns to. The policy had no date and staff did not know when the policy had last been updated. Staff demonstrated their awareness of the signs and symptoms of abuse and neglect. They were not aware of the procedures they needed to follow to address safeguarding concerns.

The practice did not have a sharps policy or procedure in place. This should include clear guidelines about responding to a sharps injury (needles and sharp instruments). However, staff were aware how to respond to a sharps injury and who to report it too.

The registered provider told us that they did not always use a rubber dam when providing root canal treatment to patients. A rubber dam is a small square sheet of latex (or other similar material if a patient is latex sensitive) used to isolate the tooth operating field to increase the efficacy of the treatment and protect the patient. We discussed the good practice guidelines with the registered provider for their use so that they could reflect on their approach. The dentist told us he would us a sponge to protect the patient's airway if rubber dam could not be placed.

Dental care records were stored on paper, these records were not securely stored and other archived records were not stored safely within the practice.

We observed some records that did not always contain certain elements of good practice in relation to clinical record keeping. For example, X-rays were not always justified, graded or reported, basic periodontal examination (BPE) – a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums were not always updated and evidence of a discussion of treatment needs with the patient was not routinely recorded. These deficiencies could be identified by the provider by carrying out regular audits of record keeping standards.

The practice had a whistleblowing policy which staff were aware of. Staff told us that they felt confident that they could raise concerns about colleagues without fear of recriminations.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency. Staff had not received training within the last 24 months in basic life support including the use of an Automated External Defibrillator. (An AED 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).

The practice did not have an AED on the premises or a risk assessment in place to identify where the nearest one was

situated. The dentist told us there was access to one at the local church. We noted the church opening times did not coincide with the dental practice. This was brought to the attention of the registered provider.

The practice kept medicines and equipment for use in a medical emergency in the surgery although these adrenaline and glucagon was out of date were not all in date. We observed the practice did not have a portable suction device as part of their emergency equipment and the oro-pharyngeal airways were out of date as were the syringes and needles. . There was no evidence of the medical oxygen cylinder being serviced, replaced or expiry date. This was not in line with the 'Resuscitation Council UK' guidelines.

All staff knew where these items were kept. We saw the practice kept some logs which indicated the medical oxygen cylinder was checked monthly. This was not in place for the emergency medicines. Some emergency medicines were not in date including the Adrenaline and Glucagon. A planned replacement programme should be in place for disposable equipment items that have been used or that reach their expiry date. We discussed our findings with the registered provider and all equipment and medicines were ordered immediately.

Staff recruitment

The practice did not have a policy for the safe recruitment of staff which should include seeking references, proof of identity, checking relevant qualifications and professional registration. No staff files were available on the day of the inspection.

The practice had no evidence when the last Disclosure and Barring Service (DBS) checks for all staff had been carried out, the registered provider told us this was done in 2013. 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 whose circumstances may make them vulnerable.

All qualified clinical staff were registered with the General Dental Council (GDC). We saw copies of current registration certificates for the dentist but not for the dental nurse. The dentist had their own indemnity insurance cover and the dental nurse was covered by the registered provider's personal indemnity policy (insurance professionals are required to have in place to cover their working practice). In addition, there was employer's liability insurance which covered employees working at the practice.

Monitoring health & safety and responding to risks

The practice had no evidence of undertaking any risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice. The practice had a Health and Safety policy which included guidance on fire safety and manual handling of clinical waste. We saw the policy had not been reviewed recently.

On The day of the inspection the practice could not provide evidence of did not have a Control of Substances Hazardous to Health (COSHH) folder and no risk assessments had not been completed for any materials used on the premises. 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. We brought this to the attention of the provider during the inspection.

We observed the fire extinguishers had been checked annually to ensure that they were suitable for use if required. We noted the fire extinguishers had been checked in April 2015.

Infection control

The practice had a decontamination room that was set out in accordance to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices. All clinical staff were aware of the work flow in the decontamination room from the 'dirty' to the 'clean' zones.

No separate hand washing sink was available for staff and only one sink was in place for decontamination procedures. Bowls were available to soak and manual scrub instruments.

The procedure for cleaning, disinfecting and sterilising the instruments was clearly displayed on the wall to help staff. We discussed with staff the appropriate personal protective equipment (PPE) when working in the decontamination, this included disposable gloves, aprons and protective eye wear.

Are services safe?

We found that instruments were being cleaned and sterilised in line with published guidance (HTM01-05).The dental nurse we spoke with was knowledgeable about the decontamination process. For example, instruments were examined under illuminated magnification and sterilised in an autoclave. Sterilised instruments were correctly packaged, sealed, stored. For safety, instruments were transported between the surgeries and the decontamination area in lockable boxes.

The practice had some systems in place for daily quality testing of the decontamination equipment and we saw records which confirmed these had taken place. The practice did not undertake a daily automatic control test of the autoclaves. Test strips were not always used with sterilisation cycle to confirm the process was successful. This test ensures that the correct temperature and pressure is achieved during the sterilisation cycle. We informed the registered provider who told us that these tests would be done from now on.

There was no evidence available on the day of the inspection staff had received infection prevention and control training.

There were adequate supplies of liquid soap, paper hand towels in the surgery. A poster describing correct hand washing techniques was displayed above some of the hand washing sinks. Paper hand towels and liquid soap was also available in the toilets.

We observed the sharps bin was being used correctly and located appropriately in the surgery.

Clinical waste was not always stored securely for collection. This was generally taken straight from the surgery weekly and there was not a need to store any excess. On the day of the inspection there was an open clinical waste bag situated in a store room with no locks. The registered provider had a contract with an authorised contractor for the collection and safe disposal of clinical waste. The risk assessment was due for review in 2012. This had not been completed. The practice organised a new contract and audit to be completed as soon as possible.

Staff records of immunisation were not available on the day of the inspection.

The practice had not carried out the self- assessment audit relating to the Department of Health's guidance on decontamination in dental services (HTM01-05). This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment.

The practice did not have a legionella risk assessment in place. This was brought to the attention of the registered provider. We were told this would be completed as soon as was possible.

Equipment and medicines

Prescriptions were pre-written and stamped before they were issued. We brought this to the attention of the registered provider to only stamp at the point of issue to maintain their safe use. The practice did not keep a log of all prescriptions given. There was no evidence of audits to monitor prescriptions given by the dentist to ensure that they were in line with current guidelines.

Staff told us that Portable Appliance Testing (PAT) took place annually however no certification was available on the day of the inspection. (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

We reviewed equipment maintenance records such as autoclaves that showed they were serviced in accordance with the manufacturers' guidance. The regular maintenance ensured that the equipment remained fit for purpose. There was no evidence available on the day regarding the X-ray equipment maintenance and no inventory was present, there was also no evidence of a critical examination having taken place.

Other than emergency medicines the practice held a selection of antibiotics and pain killers. These were not stored safely or securely and no logs were in place to know what stock had been used. The dentist had a system if a patient came and asked for a prescription and there was no dentist on the premises the dentist would be contacted by telephone. The dental nurse or reception staff would dispense antibiotics and pain relief without a consultation. This was brought to the attention of the dentist medicines should only be dispensed by himself after a consultation.

Radiography (X-rays)

We reviewed the practice's radiation protection information. The local rules stated how the X-ray machine

Are services safe?

needed to be operated safely. The local rules were displayed on the wall of the surgery. The local rules also contained the name and contact details of the Radiation Protection Advisor.

There was no evidence available on the day regarding the radiography equipment last service. There was no evidence that the dentist was up to date with continuing professional development training in respect of dental radiography. The dentist told us that no X-ray audits had been completed.

The practice used chemical processing of films but a quality control test film was not taken and used regularly. Yearly tests for the dark room and light penetration test were not recorded. These tests could prevent the need to retake an X-ray.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients attending the practice were not always asked to complete a medical history form which includes their health conditions, current medication and allergies prior to their consultation and examination of their oral health with the dentist. The practice did not always record the medical history information within patient dental care records. However, staff told us this was done verbally. In addition, the dentist told us that they discussed patients' social lifestyle and behaviour such a smoking and drinking and where appropriate offered them health promotion advice. This again was not always recorded in the patient's records.

We looked at ten patient dental care records on the day of the inspection. The records showed that dental examination appointments included soft tissue and oral cancer checks had taken place.

The patient records had not been audited; this would ensure they complied with the guidance provided by the FGDP. We explained to the registered provider the patient records we reviewed were not always accurate and complete.

The dentist told us they always discussed the diagnosis with their patients and, where appropriate, offered them any options available for treatment and explained the costs. The dentist did not always include an assessment of the patients gum health and did not include details of discussions with regards to treatment options being discussed. There was no record of patients being informed of a diagnosis of gum disease. We also noted that there was no record of oral hygiene advice, dietary advice or smoking cessation advice.

Patients' oral health was monitored through follow-up appointments. These were not always scheduled in line with the NICE recommendations. We saw from the records the dentist was not following the NICE guidelines on recalling patients for check-ups.

The practice did not always follow current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the dentist did not always follow the guidance from IR(ME)R with regards to taking X-rays to ensure that disease processes could be monitored or treatment could be provided effectively. Justification for the taking of an X-ray was not recorded in the patient's dental care record.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentist we spoke with told us patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. However, this was not always recorded in the patients' dental care records.

The dentist advised us they offered patients oral health advice and provided treatment. The dentist told us this was not based on the Department of Health's policy the 'Delivering Better Oral Health' toolkit. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

We saw all relevant staff were currently registered with their professional bodies. Staff were encouraged to maintain their continuing professional development (CPD) to maintain, update and enhance their skill levels although evidence of this was not available. Completing a prescribed number of hours of CPD training is a compulsory requirement of registration for a general dental professional, however no evidence of CPD was available on the day of the inspection.

Staff training was not monitored or recorded by the registered provider. They were unaware of any short falls in staff training requirements. Records we reviewed showed all staff had received training in basic life support in 2013. There was no evidence infection prevention and control training was available to staff. Details of staff attending safeguarding training for children and vulnerable adults was recorded.

Staff we spoke to said they did not have annual appraisals. We discussed this with the registered provider.

Working with other services

The dentist explained they would refer patients to other dental specialists when necessary. They would refer patients for sedation, minor oral surgery and orthodontic treatment when required. The referrals were based on the

Are services effective?

(for example, treatment is effective)

patients' clinical need. In addition, the practice followed a two week referral process to refer patient for screening for cancer. Referral letters and proformas were filled in with adequate patient details.

The practice worked with another local dental practice to cover any holidays or periods of illness. Joint training for staff on some core subjects had happened previously. There was no evidence of any sessions taking place in the last year.

Consent to care and treatment

Staff we spoke with demonstrated awareness and its relevance to their role of the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentist demonstrated how they would obtain consent from patients who they thought would experience difficulty in providing consent. This was consistent with the provisions of the MCA.

Staff ensured patients gave their consent before treatment began. The dentist informed us verbal consent was always given prior to any treatment. In addition, the advantages and disadvantages of the treatment options were discussed before treatment commenced. We noted this was not always recorded. Patients were given time to consider and make informed decisions about which option they preferred. Staff were aware consent could be removed at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. If a patient needed to speak to a receptionist confidentially they would speak to them in the surgery or in a private room.

Staff we spoke with understood the need to maintain patients' confidentiality. The registered provider had not undertaken any training in information governance, this would provide a responsibility to ensure patient confidentiality was maintained and patient information was stored securely. We saw that patient records were not held securely.

Comments from the patients we spoke to on the day included statements saying the staff were caring, very friendly, respectful and professional.

Involvement in decisions about care and treatment

Comments made by patients confirmed that patients were involved in their care and treatment.

When treating children the dentist told us that to gain their trust and consent they explained the reasons for the treatment and what to expect. For patients with disabilities or in need of extra support staff told us that they would be given as much time as was needed to provide the treatment required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There was minimal information within the patient waiting area, for example the complaints policy was not available. Staff told us patients were seen as soon as possible for emergency care and this was normally within 24 hours. The practice also had a sit and wait service for emergency patients where the emergency slots had been taken for that day.

Patients confirmed they had good access to routine and urgent appointments. Patients were sent letters to remind them of appointments and also if they were due for a routine check-up.

The practice was open:

Monday - Wednesday 08:30 - 17:30

Thursday 09:00 - 16:30

Friday 08:30 - 14:00,

Tackling inequity and promoting equality

The surgery was located on the ground floor of the building with access via a ramp for patients with mobility issues. We saw no evidence staff had received equality and diversity training. Staff told us patients were offered treatment on the basis of clinical need and they did not discriminate when offering their services.

There was a patient toilet available on the ground floor with enough access for a wheelchair.

Access to the service

Patients could access the service in a timely way by making their appointment either in person or over the telephone. When treatment was urgent, patients would be seen on the same day. For patients in need of urgent care out of the practice's normal working hours the answer phone message directed them to the out of hours service who would then provide information about where to attend.

Concerns & complaints

The practice had a policy and processes to deal with complaints. However, this was not practice specific and these were not accessible to patients. The policy did not clearly provide any information about who to complain to or how long the process would take. This was not in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The practice had not received any complaints in the last year.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place such as various policies and procedures for monitoring and improving the services provided for patients. For example, there was an infection prevention and control policy. Staff we spoke with were aware of their roles and the registered provider was in charge of the day to day running of the service. We saw they had patient surveys in place to monitor the quality of the service; however, these systems were not always followed through.

There was no evidence of processes to identify where quality of treatment was being compromised. The practice had not conducted an audit of clinical records or of prescriptions, cross infection audits and X-ray audits had not been completed.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff were aware of whom to raise any issues with and told us that the registered provider was approachable to their concerns and acted appropriately. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos.

Learning and improvement

The practice did not maintain full records of staff training so it was difficult to see if staff were up to date with their training. Evidence of the last CPR training was available however this was done in November 2013.

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

The registered provider explained that the practice had a good longstanding relationship with their patients. Patent satisfaction survey were available for patients to feed back any information to the practice. No review of the information was in place and there were no systems in place to share this information with patients.

We understood the practice held informal practice meetings which were not minuted. This platform allowed sufficient opportunity to share information and discuss any concerns or issues which had not already been addressed during their daily interactions.

This section is primarily information for the provider

Enforcement actions

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 (RA) Regulations 2014 Safe care and treatment **The registered provider failed to assess the risks to the health and safety of service users of receiving the care or treatment.** **The registered provider failed, where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.** **The registered provider failed to maintain the proper and safe management of medicines.** Regulation 12 (1)(2)(a)(g)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.** Regulation 16 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The registered provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The registered provider failed to assess, monitor and mitigate the risks relating to 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.

The registered provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

The registered provider failed to maintain accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided (including justification and results of diagnostic tests).

Regulation 17 (1)(2)(a)(f)(g)