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# Reading Dental Sedation Clinic

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 30 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

We found that this practice was 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**

Reading Dental Sedation Clinic provides both a general dental service and a specialised sedation service for patients who require sedation to undergo dental treatments. The practice has been located in converted premises in Reading since the 1990's. In 2004 the current principal dentist took over the practice and introduced the specialist sedation service. The practice carries out NHS treatments for patients under the age of 18 and for non fee paying adults. All other treatments are carried out on a private fee paying basis.

The principal dentist employs a practice manager and three receptionist/administrators. There are two associate dentists who work sessions at the practice. Sedation clinics are supported by a specialist anaesthetist. There was also a visiting dental hygienist working one session a week.

# Summary of findings

Due to the specialist nature of some of the services offered the practice did not open all day on every weekday. On Monday the practice was open from 8am to 6pm. From Tuesday to Thursday from 8am to 5pm and on Friday from 8am to 2pm.

The principal dentist is registered as an individual with the CQC. The dentist is therefore, responsible for the management of the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We received feedback from 20 patients. Because we undertook our visit when one clinic was being held we were only able to speak with three patients who used the service. We also received 17 completed CQC comment cards. All 20 patients were complimentary and positive about the services they received from the practice. They all said how caring the dentists and staff were and how their fear of dental procedures was reduced by the staff.

Our inspection identified that the practice was not meeting the requirements of Regulation 17, Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The practice had failed to identify and take action on the risks posed by not complying with current guidance regarding reviewing processes to reduce the risk of cross infection at proscribed intervals and ensuring risk assessment for potentially hazardous materials are up to date. Full details of the regulation not being met are at the end of this report.

**Our key findings were:**

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had robust arrangements in place to deal with medical emergencies.
- Staff received training relevant to their roles and were supported in their continuing professional development.
- Patients' needs were assessed and care was planned and delivered in line with general professional and other published guidance.
- Patient feedback was consistently positive about the care and treatment received from the dentists.
- The arrangements in place to protect patients from the risks posed by exposure to X-rays were mostly operated in accordance with regulations.
- Dental sedation was carried out effectively and the practice had received accreditation for these procedures.
- Governance arrangements were in place but were sometimes operated inconsistently.

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

- Ensure audits of control of infection are carried out at six monthly intervals and actions identified from the audits are recorded.
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely and that COSHH assessments are up to date.
- Review the equipment used to clean the practice and the storage of the equipment to check that it is fit for purpose
- Review the flooring in the treatment rooms taking into account current design standards with non-porous flooring that reduces the risk of cross infection.
- Ensure monitoring of cleaning standards is consistently undertaken.

# 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 providing safe care in accordance with the relevant regulations.

There were systems in place to reduce the risk of cross infection. However these were monitored inconsistently. For example, infection control audits were not completed in accordance with the required timetable and monitoring of cleaning had not identified shortfalls in one area of the practice.

There were appropriate arrangements in place for the management of medical emergencies at the practice. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

There were sufficient numbers of staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

The practice operated appropriate systems to ensure patients were protected from the risks associated with X-rays.

**Are services effective?**

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

The dental care provided was evidence based and focussed on the needs of the patients. There was a strong focus on oral health and prevention of dental health problems. The practice used current national professional guidance to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council and were meeting the requirements of their professional registration.

The practice met the requirements of the Society for the Advancement of Anaesthetics in Dentistry (SAAD) who are the accrediting body for dental practices that offer dental sedation. They had passed their accreditation visit in October 2015.

**Are services caring?**

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

Our observations of the practice showed staff to be kind and compassionate in their interactions with patients. We received 17 CQC comment cards and spoke with three patients during the visit. All of the patients commented on the quality of care they received.

We also saw that patients took part in the friends and family recommendation test. In 2015 there had been 289 patients who completed the test and all of them said they were either very likely or likely to recommend the practice to others.

**Are services responsive to people's needs?**

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

The practice was aware of the needs of the population served. Opening hours reflected the needs of the number of patients registered for treatment and the specialist nature of the sedation service.

Patients feedback informed us that patients could access appointments when they needed them. The practice provided patients with written information about how to prevent dental problems.

# Summary of findings

A dental treatment room and sedation recovery area were on the ground floor enabling ease of access for patients with mobility difficulties and families with prams and pushchairs.

Special attention was paid to the needs of patients who were nervous about receiving dental treatment.

**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 and the details of the Requirement Notice can be found at the end of this report.

The principal dentist was visible in the practice and staff told us they were approachable. Staff were supported with appropriate training and appraisal. There was an open management style and all staff felt able to contribute to the running of the practice.

The practice was not operating consistent monitoring systems. For example, audit of control of infection processes and the practice environment had not identified inconsistent standards of cleaning and poor maintenance of cleaning equipment. They had also failed to identify that records relating to keeping potentially hazardous substances on the premises had not been checked and updated for two years.

# Reading Dental Sedation Clinic

**Detailed findings**

## Background to this inspection

Care Quality Commission (CQC) carried out a comprehensive inspection of Reading Dental Sedation Clinic Dental Practice on 30 March 2016. The inspection was undertaken by a CQC lead inspector and a dental specialist advisor.

We informed the NHS England area team that we were inspecting the practice. They confirmed that the practice was meeting their contractual commitment for NHS treatments. They also provided us with evidence that the practice had passed their accreditation with the professional body to provide sedation services.

During the inspection we:

- Spoke with the principal dentist, the practice manager, two dental nurses and two members of the reception staff.
- Also spoke with three patients.
- Undertook a review of records relevant to the management of the service.
- Carried out observations around the service.
- Asked the specialist dental adviser to look at a number of anonymised patient records to corroborate that the dentist carried out their consultations, assessments and treatment in line with general professional guidelines.

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 a system in place for the reporting and recording of significant events and near misses. We noted that there had not been any incidents reported during the last two years. Staff we spoke with were aware of the practice procedure and told us they would not hesitate to report any incidents that had placed, or could have placed patients at risk.

We were told that if an incident was reported it would be investigated and that learning from the incident would be shared via staff meetings to ensure that all staff were aware of the measures that should be taken to avoid similar occurrences in the future.

The practice manager took responsibility for receipt and action arising from national patient safety and medicines alerts received by the practice. We saw that alerts received had been recorded as either not relevant to the practice or detailed the action taken arising from the alert.

### Reliable safety systems and processes (including safeguarding)

We spoke with the principal dentist, two dental nurses, the practice manager and two members of reception staff during the inspection. All the staff we spoke with were able to describe the types of abuse they might witness or suspect during the course of their duties. Staff records and minutes of meetings showed us that appropriate training in safeguarding; both children and vulnerable adults, had been undertaken by all staff. The practice had a safeguarding protocol in place and the principal dentist was the safeguarding lead for the practice.

Details of a local safeguarding agency was held by the practice manager and was displayed in the staff beverage area. However, we noted that this information was out of date and not wholly relevant to the Reading area. When we discussed this with the practice manager they took immediate steps to obtain the most up-to-date details for the Reading area. We were reassured from our discussions with staff that they would report any safeguarding concerns in line with the practice protocol.

We found, from our discussions with dentists and practice staff, and review of dental care records, that a rubber dam was used in all cases of root canal treatment. (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).

Staff were able to describe the action they would take if they suffered a needlestick injury. The dentists took personal responsibility for dealing with used needles used to deliver the sedation agent.

The dentist told us, and records we saw confirmed, that a specialist anaesthetist was present to administer the sedation agent for patients requiring sedation. In addition the practice employed a specialist recovery nurse to support patients coming round from their sedation.

### Medical emergencies

The practice had 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]. We checked this during the inspection and found that both child and adult pads were available and were in date. Medical oxygen was held at the practice and we found that the cylinder was full with oxygen. There were adult and child masks available and these were within their expiry date. Both the AED and medical oxygen were checked on a regular basis.

The practice held emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. One of the dental nurses was responsible for checking emergency medicines. We saw records to show that the drugs were checked monthly. All the emergency medicines were within their expiry date.

### Staff recruitment

We reviewed the recruitment files of five staff and found that appropriate pre-employment recruitment checks had been undertaken in most cases. The practice used a specialist dental employment agency to source new staff. We found that the agency had passed on relevant details for staff to the practice but the practice had not kept copies of CV's for two members of staff employed. The practice was able to demonstrate that they held proof of identity and references for all staff. Copies of Disclosure and Barring Service (DBS) checks for clinical staff were held. Risk assessments had been undertaken for reception and administration staff and these identified that DBS checks were not required for this group of employees.

# Are services safe?

**Monitoring health & safety and responding to risks**

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. There were a number of risk assessments that had been completed. For example, fire safety, radiation, general health and safety issues affecting a dental practice. However, the risk assessments for control of substances hazardous to health (COSHH) had not been updated since 2014. The practice could not demonstrate that these were up-to-date.

The practice had a record of staff immunisation status in respect of Hepatitis B, a serious illness that is transmitted by bodily fluids including blood.

The practice had a business continuity or disaster recovery plan in place. Staff were aware of this plan and knew what to do if they arrived at the practice and found they could not deliver the services to patients due to an emergency situation.

## Infection control

The practice was mostly clean and tidy but some improvement must be made. Dental surgery rooms were generally clutter free and the system for disposal of clinical waste from these rooms, including sharps bins, was appropriate. However, we found one treatment room where thank you cards were displayed on a wall divider. When we moved these cards dust fell onto the surface of one of the worktops in the main treatment area. Accumulation of dust poses a risk of contamination in treatment rooms.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean colour coded instruments between the treatment rooms and decontamination room. The practice used a system of manual scrubbing for the initial cleaning process, followed by a visual inspection with an illuminated magnifier before placing the instruments into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated in accordance with current guidelines. The decontamination room was appropriately identified with an area for clean instruments separated from dirty instruments. Identifiable separation of the decontamination room helps to ensure dirty instruments are kept away from clean and sterile instruments and reduces the risk of cross contamination.

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

Cleaning of the general areas of the practice was undertaken by a contract cleaning company against a cleaning specification. Monitoring of the cleaning was recorded by the cleaners. However, the cleaning equipment used was not stored appropriately and some of the equipment was dirty.

Our checks of the dental treatment rooms identified that the wipe clean flooring surface in one room had worn away. This had exposed a porous area of floor where dirt and dust could collect. The flooring in this area did not conform to current guidance for the design of dental treatment rooms. The hand washing sinks in the patient toilets did not have a hot water supply and hand washing guidance was not displayed for patients to follow.

The practice held personal protective equipment (PPE) for staff to use during treatments or when cleaning the treatment rooms after each patient. This included disposable gloves, disposable aprons and eye protection for staff and patient use. The treatment rooms had designated hand wash basins for hand hygiene and liquid soaps and paper towels. There was a hand hygiene poster displayed above all hand wash basins.

We saw that audits of the processes and procedures to reduce the risk of cross infection had been undertaken. However, these had not been completed at the frequency required by current guidance. They had been undertaken on a yearly basis and should have been carried out every six months.

The practice had a legionella risk assessment in place. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We reviewed records that showed actions required from the risk assessment had been completed.

## Equipment and medicines

We saw that the practice was well equipped to deal with a wide range of dental treatments. The maintenance records we reviewed showed that servicing of the medical equipment in use was undertaken in accordance with manufacturers' recommendations.

# Are services safe?

The practice held stocks of sedation agents required for dental procedures. This was held securely and stock recorded. When sedation was administered the batch number was recorded in the patient's dental record.

If a patient required a medicine this was prescribed by the dentist and the prescription was taken by the patient to a pharmacy of their choice. We found that stock prescription pads were held securely in a safe. However, prescription pads in use were held by the dentists in their treatment rooms in unlocked drawers and these were already identified with a practice stamp. These were therefore at risk of being taken by unauthorised people. When we discussed this with the dentist and practice manager they made immediate arrangements to remove the pads from the treatment rooms and secure them.

During our inspection we found a number of dental cements and other materials that were out of date kept in drawers in dental treatment rooms. Whilst we were assured that these materials were no longer used there was a risk that they could be used by mistake and place patients at risk. All the items we found were removed from use immediately and set aside for disposal.

The medicines used for sedation were held in the treatment rooms and recovery room. However, they were kept in unlocked drawers and were at risk of being taken by unauthorised people. We advised the dentist of our findings and they told us they would make arrangements to secure these medicines.

### Radiography (X-rays)

The practice had the majority of the appropriate arrangements in place that were in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The practice had records that contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. However, the local rules governing the use of X-ray equipment had not been updated since 2014. We discussed this with the dentist and they assured us they would update the rules and get them signed by staff within two days of our inspection.

The principal dentist acted as the Radiation Protection Supervisor. We saw the critical

examination packs for each X-ray set along with the three yearly maintenance logs. The maintenance logs were within the current recommended interval of three years.

Dental care records we saw showed when dental X-rays were taken they were justified and, reported upon. A quality assurance process was in place to document the quality of each X-ray taken by the dentists. The practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

Patients requiring general dental care completed a full medical history and were asked if there were any changes to medical conditions or medicines taken before any course of treatment was undertaken. The dental care records we reviewed showed medical history had been checked. The three patients we spoke with all told us that the dentists asked them about their state of health and any medicines they were taking prior to commencing treatment.

When patients were referred for, or required, treatment under sedation their suitability to receive this was fully assessed at a pre-treatment appointment. The dentists collected information at this time to ensure patients were both fit for a procedure involving sedation and understood the processes involved. Pre-treatment assessment also included giving the patient advice about preparing for sedation. For example, not eating or drinking for four hours prior to the procedure. The advice was also contained in written information that was handed to the patient and also on the practice website.

Patients undergoing treatment under sedation were also told to ensure they had a responsible adult with them who could drive them home after the treatment. This advice was also included in the written information handed to patients and contained on the practice website. The three patients we spoke with all confirmed they had been given information they understood about undergoing sedation and the need for an escort to accompany them.

The practice met the requirements of the Society for the Advancement of Anaesthetics in Dentistry (SAAD) who are the accrediting body for dental practices that offer dental sedation. They had passed their accreditation visit in October 2015. This meant that the accrediting body had observed the procedures used in sedation and found them to meet current standards.

The practice used current guidelines when making decisions on treatment and clinical risk. For example the requirement to take X-rays and the frequency of recall was based upon a full oral examination. Each time the patient received a dental check their records were updated and decisions about their future treatment and check-up regime were noted.

### Health promotion & prevention

The dental care records we reviewed and feedback from patients showed us that oral health and preventative measures were discussed with patients. Appointments with the dental hygienist were offered when appropriate and patients were given the option of taking up the offer. There were health promotion leaflets available in the practice to support patients to look after their oral health. These included information about good oral hygiene.

The dentists working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. We spoke with the principal dentist on the day of our visit. They described to us how they carried out their assessments. The assessments began with the patient updating a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

### Staffing

There were enough support staff to support the dentists during patient treatment. It was apparent by talking with staff that they were supported to receive appropriate training and development.

This included training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and other specific dental topics. Training certificates we saw also evidenced that staff attended off site training when this was appropriate. This demonstrated that the provider was supporting the staff to deliver care and treatment safely to an appropriate standard.

We spoke with members of staff who confirmed they had their learning needs identified through both informal discussions and their annual appraisal and they were encouraged to maintain their professional expertise by attendance at training courses.

We saw evidence of medical indemnity cover for the dentists, hygienist, the specialist in anaesthesia and nurses who were registered with the General Dental Council.

# Are services effective?

## (for example, treatment is effective)

### Working with other services

We discussed with the dentist how they referred patients to other services. Referral letters and responses were held in the patients' dental care records. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. Systems had been put into place by local commissioners of services and secondary care providers whereby referring practitioners would use bespoke designed referral forms. This helped ensure the patient was seen in the right place at the right time.

When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring. There was a system in place to ensure the information received from other services was entered in the dental care records to ensure the dentist saw this when they next treated the patient.

We saw that when other dental practices referred patients requiring sedation that the practice required a detailed set of information to support the referral. This included:

- Complete patient details
- Patient contact details
- Full medical history
- A full treatment plan
- Relevant X-rays
- Referral form

This information was used to inform the dentists before they undertook a pre-treatment consultation to assess whether sedation was appropriate and formed the basis of pre-treatment advice for the patient.

### Consent to care and treatment

All the patients who provided feedback said the dentists involved them in decisions about their care and treatment. The dentist we spoke with had a clear understanding of consent issues. They stressed the importance of ensuring care and treatment was explained to patients in a way and language patients could understand. The dentist we spoke with explained how they would take consent from a patient who suffered with any mental impairment, which may mean they might be unable to fully understand the implications of their treatment. The dentist explained if there was any doubt about the patient's ability to understand or consent to the treatment, then treatment would be postponed. They explained they would involve relatives and carers to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

When a procedure involved sedation of the patient written consent was required.

# Are services caring?

## Our findings

### Respect, dignity, compassion & empathy

We saw that staff made significant effort to maintain the confidentiality of patient information. For example, reception staff avoided repeating patient names when taking telephone calls to avoid other patients in the waiting room overhearing. The dentists or dental nurses came to greet patients in the waiting room and take them to the dental treatment rooms for their treatment.

The treatment rooms were situated so that conversations between patients and dentists could not be overheard by others in the waiting room. The computers in the practice were password protected and those at reception were positioned so that patients could not see the information on the screens.

The 20 patients who provided feedback were all positive about the dentists and staff treating them with care and concern. All of the patients said the dentist allaying their fears about dental treatment and in being sympathetic to those who required sedation to undergo their treatments.

### Involvement in decisions about care and treatment

Information to enable patients to make decisions about their treatment was available in written formats. However, we were told by the dentist, and patients confirmed, that the emphasis was on verbally advising patients of the treatment proposed or options available. We saw that treatment plans were used to confirm the treatments proposed and that these were signed by patients. Dental care records we reviewed showed us that options were documented.

The 20 patients that provided feedback told us that they felt they had sufficient time with the dentists and that the dentists took time to ensure treatment was fully explained along with oral health advice to help avoid future dental problems.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

Information on the range of treatments at the practice was available at reception, in the main waiting room and on the practice website. The treatments costs for private treatment were displayed and there was a leaflet explaining the monthly payment plan operated by the practice. The opening times of the practice were not displayed at the entrance but were detailed on the practice website.

The practice provided continuity of care to their patients by ensuring they saw the same dentist each time they attended. When this was not possible they were able to see one of the other dentists.

Patients new to the practice were required to complete a patient questionnaire so that the dentists could conduct an initial assessment and respond to their needs. This included a medical history form. The dentists undertook a full examination when patients attended for their first appointment and this was documented in the patient record. Decisions relating to the frequency of recall and the need for X-rays were based upon the findings of the initial assessment and then documented in the patient's records.

### Tackling inequity and promoting equality

The practice was accessible to patients in wheelchairs and those with walking difficulties. The practice provided a car park with a designated bay for disabled parking close to the entrance. There was a system in place to alert reception staff to patients arriving who had mobility difficulties. Reception staff would assist patients who arrived requesting help to access the reception area and treatment rooms.

There was lowered entrance to the reception desk where a patient using a wheelchair could locate themselves to speak with the reception staff. The main waiting room had sufficient space for a wheelchair or for pushchairs and prams. Dental surgery rooms were located on both ground and first floors. The dentists were able to use the ground floor room to treat patients who had difficulty getting up and down stairs.

We were told that the few patients who required assistance with translation were able to bring a relative or friend to support them.

Carers who accompanied patients were able to enter the treatment rooms with the patient to support them during their examinations and treatments unless the patient was undergoing sedation.

### Access to the service

The practice was open between 8am and 6pm on a Monday. From Tuesday to Thursday opening hours were 8am to 5pm and on Friday the practice closed at 2pm. The opening hours reflected the nature of the service with many patients having booked appointments for treatment requiring sedation.

None of the patient comment cards or the patients we spoke with expressed any concerns about accessing appointments.

### Concerns & complaints

The practice had a complaints procedure. The practice manager was responsible for investigating and responding to any complaints the practice received. The complaints procedure was displayed in the waiting room. Staff we spoke with were clear in their understanding of the practice procedure and how they would support a patient who wished to lodge a complaint. The practice had not received any complaints in the last 12 months. We reviewed the NHS choices website for the practice. There had been seven patients offering feedback via this route. Five were wholly positive but two made complaints about their experience of sedation. We noted that the practice had not taken the opportunity to respond to patient comments on NHS choices.

# Are services well-led?

## Our findings

### Governance arrangements

The principal dentist was responsible for the day-to-day management of clinical matters and was supported by the practice manager to deal with the administrative functions of the practice.

The practice had an appropriate range of policies and procedures in place to govern the practice. For example, control of infection, health and safety and training and development. However, some of the policies relating to safety had not been updated. For example, safeguarding and control of substances hazardous to health.

Most policies were kept under review and had been updated in the last year. Staff were aware of where policies and procedures were held and we saw that these were accessible if the principal dentist and practice manager were absent from the practice. The front sheet of the governance file had been signed off by staff to confirm that they had read and understood the policies and procedures in place. However, we noted that the COSHH assessments had not been checked or updated for two years.

Monitoring of the premises and cleaning standards had not identified that one of the treatment rooms was not clutter free and that an area of flooring was damaged to the point where it had become porous and difficult to clean. The practice had also failed to identify that cleaning equipment was not stored appropriately or maintained in a way that it was fit for purpose.

### Leadership, openness and transparency

The practice had a statement of purpose. There was a strong ethos of providing safe, personal treatment and we saw that staff were committed to the ethos. Communication in the team was underpinned by team meetings which covered a wide range of topics. Records were kept of the meetings. Staff we spoke with told us they were encouraged to put forward ideas and they told us they were well supported to carry out their roles and responsibilities. Staff had job descriptions and were clear on the duties that were expected of them.

Staff we spoke with told us the practice had an open culture and that they would have no hesitation in bringing any errors or issues of concern to the attention of the dentist or practice manager. None of the staff we spoke with recalled any instances of poor practice that they had needed to report.

### Learning and improvement

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Training was completed through a variety of media and sources. Staff were given time to attend local training seminars and sourced other training opportunities online or through professional journals.

We found there were a number of clinical and non-clinical audits taking place at the practice. These included clinical record keeping and X-ray quality. Completion of some audits was however, intermittent. For example, audits of infection control measures were required to be completed on a six-monthly cycle but had only been completed annually.

The practice was subject to accreditation by SAAD for carrying out dental procedures under sedation.

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

The practice carried out patient satisfaction surveys to gain patient feedback on the services provided. These included a survey every 18 to 24 months of patients who attended for general dental treatment. There was also a 2015 survey specifically for patients who had undergone a treatment requiring sedation. Both of the most recent surveys showed patients were positive about the care and treatment they received from the practice. The practice also reviewed the feedback from the friends and family test. However, we were told that the results were not fed back to patients or the practice team.

The practice had not taken the opportunity to respond to comments posted by patients on NHS choices in the last year.

Staff told us they were able to contribute to the running of the practice. For example, reception staff told us that when they suggested changes to the appointment system they were encouraged to trial the system before implementation.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.<br>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—<br>(a) 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);<br>(b) 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;<br>(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).<br>How the regulation was not being met:<br>• COSHH data sheets had not been reviewed since 2014 and the practice could not demonstrate those held were relevant.<br>• Monitoring of the treatment rooms had not identified that they were not all clutter free.<br>• Audits of control of infection processes and the environment were not conducted at appropriate intervals. They had also not identified that flooring in one of the treatment rooms did not comply with current guidance.<br>• Monitoring of cleaning standards had not identified that cleaning equipment was not kept in a fit state for use. |