Elephant & Castle Dental Clinic

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Inspection Report

32 New Kent Road
London
SE1 6TJ
Tel: 020 7703 2524
Website: NA

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Overall summary

We carried out an unannounced comprehensive inspection on 23 June 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 not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The Elephant & Castle Dental Clinic is located in the London Borough of Southwark. The premises are situated in a high-street location. There are four treatment rooms, a decontamination room, a reception room with waiting area, and a patient toilet across the ground, first and second floors of the building.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges.

The staff structure of the practice consists of a principal dentist, three associate dentists, a dental nurse, three trainee dental nurses, and two receptionists, who are also qualified dental nurses. There is also a part-time practice manager.

The practice opening hours are on Monday, Tuesday, Thursday and Friday from 9.00am to 5.30pm, and on Wednesday from 9.00am to 6.30pm. The practice is also open from 9.00am to 1.30pm on Saturdays.

The principal dentist is the registered manager. 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'.

Summary of findings

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 inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Three people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- The systems in place to reduce and minimise the risk and spread of infection were ineffective.
- The practice had a safeguarding policy in place. However, staff did not understand their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported accidents, but there were no other arrangements in place for reporting and learning from incidents.
- There were arrangements in place for managing medical emergencies. However, we found that some items of equipment and medicines required for the management of medical emergencies were not available.
- Equipment, such as the air compressor and X-ray equipment had been checked for effectiveness and had been serviced. However, other items, such as fire extinguishers and the ultrasonic bath, had not been well maintained or tested for effectiveness.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team. However, the systems for obtaining patient feedback, with a view to monitoring the quality of care, needed to be improved.
- The practice had not monitored staff training to ensure they maintained the necessary skills and competence to support the needs of patients.
- The practice had not effectively implemented procedures for managing comments, concerns or complaints.
- There were some governance arrangements in place for the smooth running of the practice. However, the practice did not have a structured plan in place to monitor quality and safety. The practice had not effectively monitored and mitigated the risks associated with carrying out the regulated activities.

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

- Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD).
- Ensure the practice's infection control procedures and protocols are suitable taking into account guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- 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. The practice should ensure that 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 systems are in place to assess, monitor and improve the quality of the service such as undertaking regular audits of various aspects of the service and ensuring that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure that the practice has appropriate procedures and implements relevant processes to safeguard people. Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated 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:

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.

Summary of findings

- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the security of prescription pads in the practice and ensure there are systems in place to monitor and track their use.
- Review staff awareness of, and training in relation to, Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities as it relates to their role.
- Review the practice's responsibilities as regards to the Control of Substances Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Review the practice's complaints handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by patients.
- Review the practice's responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.
- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Review the systems for checking and monitoring equipment to ensure that all equipment is well maintained.

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 had some policies and protocols related to the safe running of the service. However, staff were not always following these accurately. We found that the systems in place to reduce and minimise the risk of infection were inadequate. For example, cleaning protocols had not been effectively used or monitored to ensure that the practice remained visibly clean. Staff had not kept up to date with their annual infection control training. Staff did not follow the correct procedure for manually cleaning instruments and used personal protective equipment (PPE) inappropriately.

The practice had systems for the management of medical emergencies, but had not checked that all of the equipment stored for this purpose were in date, or up to date, with relevant guidance. We also found that the practice had not maintained all of the equipment, such as the ultrasonic bath or fire extinguishers, in line with current guidance.

Staff did not understand their responsibilities in terms of safeguarding patients from abuse. Not all staff had been appropriately trained in safeguarding at the time of the inspection.

Enforcement action

Are services effective?

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

The practice monitored patients' oral health and gave appropriate health promotion advice. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff had engaged in continuous professional development (CPD) but were not meeting all of the training requirements of the General Dental Council (GDC).

Staff did not demonstrate a good understood Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005.

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to manage the services provided at all times. We found four examples in the past year where it could not be confirmed that appropriate numbers of dental nurses were working with the dentists during dental treatments. Staff confirmed that dentists occasionally worked without dental nursing support.

Requirements notice

Summary of findings

Are services caring?

No action

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

The practice provided clear, written information for patients which supported them to make decisions about their care and treatment. The dental care records demonstrated that staff provided people with explanations about the risks and benefits of different treatments. This supported people to be involved in making their own choices and decisions about their dental care.

We received positive feedback from patients. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times.

We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

No action

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

The culture of the practice promoted equality of access through the use of an equality and diversity policy, which staff were following. Staff at the practice spoke a range of languages which supported some patients to access the service. However, the practice was not wheelchair accessible. The principal dentist told us they had explored the possibilities for increasing wheelchair access. However, there was no formal Disability Discrimination Act audit to identify what further reasonable adjustments could be made to the premises.

There was a complaints policy in place. However, the practice had not kept a log of complaints to monitor for trends and there was not a system in place to formally review complaints with a view to preventing recurrences. We viewed some records for complaints that were held in each patient's dental care record. However, not all the documents related to each complaint were available to view.

Are services well-led?

Enforcement action 

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 described an open and transparent culture where they were comfortable raising and discussing concerns with each other. The practice had some clinical governance and risk management structures in place.

However, a system of audits was not used to monitor and improve performance. For example, there had not been an audit of the dental care records or X-ray

Summary of findings

quality to identify areas for improvement. Risk assessments in relation to general health and safety, Control of Substances Hazardous to Health (COSHH), Legionella, fire safety and use of sharps were either not present, or, if they were present, they had not been fully implemented.

Some governance policies, such as those for the reporting and recording of incidents were missing.

A clear schedule to follow for the maintenance of equipment was lacking.

The system in place for seeking and acting on feedback from patients regarding the quality of the service had not been implemented effectively and the results of the feedback had not been reviewed or acted on.

Elephant & Castle 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.

We carried out an unannounced, comprehensive inspection on 23 June 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

During our inspection we reviewed policy documents and spoke with seven members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. Two of the dental nurses demonstrated how they carried out decontamination procedures of dental instruments.

Three people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an accidents reporting book with one accident recorded and investigated in the past year. Staff were aware of the process for accident reporting, and had heard of, but did not fully understand, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

There was no policy or other system in place for reporting and learning from incidents. We discussed this with the principal dentist who assured us that such a system would now be implemented. They sent us evidence, two days after the inspection, that an incidents reporting and reviewing policy had been drawn up.

The principal dentist and staff were not aware of the Duty of Candour requirements. [Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The principal dentist confirmed with us that they were committed to operating in an open and transparent manner. Patients would be told if they were affected by something that went wrong; they would now investigate any such incidents, offer an apology to patients, and inform them of any actions that were taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding policy which referred to national guidance, but did not include up-to-date information about the local authority contacts for safeguarding concerns. Not all staff were aware of their responsibilities in relation to safeguarding. For example, they could not describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect.

We asked the principal dentist and practice manager about staff training in safeguarding. They did not have a clear overview as regards to what training staff had completed on this topic. We checked five staff records and found that some staff had completed training in 2012 and 2013. The General Dental Council (GDC) recommend that safeguarding training is completed every three years. There was no evidence in other staff records that any further safeguarding training had been undertaken and completed.

The principal dentist subsequently sent us evidence, two days after the inspection, that all staff had now been asked to complete online safeguarding training (equivalent to Level 2 child protection) and a staff meeting had been held to review the topic.

The practice had implemented some policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. Following administration of a local anaesthetic to a patient, needles were not resheathed using the hands and a rubber needle guard was used instead, which was in line with current guidelines. The staff we spoke with demonstrated a clear understanding of the practice protocol with respect to handling sharps and needle stick injuries. There had been no sharps injuries recorded in the past year. However, the practice did not have a written risk assessment, and associated risk-reduction protocol, describing the rationale for recapping local anaesthetic syringes during patient treatment in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We checked whether the practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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. Rubber dam should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in patients' dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids, in line with the Resuscitation Council UK guidelines and the General Dental Council (GDC) standards for the dental team. (An

Are services safe?

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).

However, we noted that some items of equipment, such as portable suction and self-inflating bags, were not available.

The provider held the majority of emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that midazolam was not present. Adrenaline was available, but had gone past its use by date.

The emergency medicines were stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

The oxygen was checked on a monthly basis, but other items such as the AED and medicines were not regularly checked.

We discussed these issues with the principal dentist; they subsequently confirmed via email that they had ordered both the medicines and required items of equipment for the emergency kit.

Staff recruitment

The staff structure of the practice consists of a principal dentist, three associate dentists, a dental nurse, three trainee dental nurses, and two receptionists who are also qualified dental nurses. There is also a part-time practice manager.

We reviewed the staff recruitment records. There was a formal recruitment policy for the practice to follow during any recruitment process.

However, some of the relevant checks to ensure that the person being recruited was suitable and competent for the role had not been carried out. This included evidence of relevant qualifications and references. The principal dentist told us that verbal references had been obtained for new members of staff, although notes for these references had not been kept.

We noted that the practice had obtained evidence of professional registration and insurance indemnity at the time of recruitment, but had not subsequently monitored these to assure themselves that their members of staff remained up to date.

We found that it was the practice's policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff. However, we found one example where a trainee dental nurse, who had worked at the practice for six months, did not have a DBS in place. The trainee dental nurse told us that a DBS application had been made, but had not yet been completed. There was no risk assessment in place for this member of staff for the period they had been working without a completed DBS.

In other cases, the provider had relied on DBS certificates supplied by new staff members in relation to employment at other services. The provider had not carried out new DBS checks at the time of their employment.

Monitoring health & safety and responding to risks

There were limited arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place.

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). These were handled by the practice manager and disseminated to staff via email, where relevant.

There were informal arrangements to refer patients to other practices in the same building, or on the same street, should the premises become unfit for use.

We noted that the premises had not been assessed in relation to fire risks. Fire equipment had not been serviced within the past year, and one fire extinguisher had not been serviced since 2013. The principal dentist arranged for this equipment to be serviced on the day after the inspection

The practice had considered some arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH policy. However, there was no associated file where risks to patients, staff and visitors associated with hazardous substances were identified along with the recommended actions to

minimise identified risks. We spoke with the practice manager on the day of the inspection. They told us that there was such a file, but it was not located during the inspection. The practice manager commented that the file may have been held with themselves, off site. Therefore it was not on the premises for staff to review. The staff we spoke with were unaware of the contents of any COSHH file.

Infection control

The systems in place to reduce the risk and spread of infection within the practice were not effective.

There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste.

The practice had carried out a practice-wide infection control audit in April 2016, but there was not any evidence that these audits had been carried out at six-monthly intervals prior to this, as recommended.

We asked two of the dental nurses to demonstrate to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had not followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

One of the dental nurses explained the decontamination of the general treatment room environment following the treatment of a patient. They described the decontamination of the working surfaces and the dental chair, as well as the treatment of the dental water lines. However, we observed that the systems had not been successful at keeping the practice clean.

Environmental cleaning was carried out by a cleaner. The cleaning equipment stored in a cupboard showed that there were colour-coded mops in accordance with the national colour coding scheme. However, there was only one bucket available rather than a separate, coloured bucket for each coloured mop.

The arrangements for cleaning the treatment rooms and practice areas had not been effective. The practice was visibly unclean. We observed that some surfaces, including window sills, floor coverings, and skirting boards revealed dirt present when wiped. We also noted that, for example, one of the foot rests on a dental chair was not clean, and the insides of the drawers in the treatment rooms had also either not been cleaned, or ineffectively cleaned.

The principal dentist sent us evidence, two days after the inspection, showing that there was a cleaning schedule in place, but noted that it had not been in use at the time of the inspection.

There was clear zoning which demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment rooms and toilets. Hand-washing protocols were also displayed appropriately in various areas of the practice. However, the decontamination room did not have a dedicated hand-washing sink.

We checked the contents of the drawers in the treatment rooms. We found that some single-use items, including matrix bands and burs had been reused. We also asked one of the associate dentists and dental nurses about the use of the '3 in 1' tips. They confirmed that the same tip was used throughout the morning's clinical session. It was wiped with alcohol between patients. The tips are designed for single patient use only.

Staff did not used personal protective equipment, such as gloves, aprons, and visors appropriately. The dental nurses we observed did not wear aprons or visors to protect themselves during the cleaning of instruments. Staff wore gloves inappropriately around the practice, increasing the risk of cross-infection. The inspection team could not be assured that gloves were changed or disposed in between each contact with a patient, or that staff were not contaminating surfaces by wearing gloves, which had been in use during treatment, as they walked around the practice.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used, which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in 2016. The practice

was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record kept of the outcome of these checks on a monthly basis.

However, we noted that the record did not specify the temperatures reached, but instead relied on a tick box activity. We asked the member of staff responsible for checking temperatures to demonstrate that the water was within the correct temperature range. They provided us with a thermometer that could not be used to test water temperature. The principal dentist assured us, after the inspection, that the correct thermometer had now been purchased and would be in use.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised.

We observed two of the dental nurses caring out the cleaning process. Both of the dental nurses manually cleaned the dental instruments. However, they did not check the temperature of the water and they cleaned instruments above the water, thus increasing the risk of aerosol spray.

One of the dental nurses also used an ultrasonic bath prior to placing instruments in an autoclave (steriliser). The other dental nurse placed items directly into the autoclaves after manual cleaning. When instruments had been sterilized, they were stored in lidded boxes, until required. We were told that instruments were resterilised at the start of each day.

We saw that there were systems in place to ensure that the autoclaves were working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date. However, there was no evidence that the ultrasonic bath had been tested, maintained or serviced. The principal dentist confirmed with us via email, after the inspection, that the ultrasonic bath was no longer in use.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location outside the practice prior to collection by the contractor. Waste consignment notices were available for inspection. However, we noticed that one of the sharps bins was situated on the floor of one of the treatment rooms. This had been identified as a risk in the infection control audit from April 2016, but had not been moved as a result.

Staff files did not hold records indicating that staff regularly attended training courses in infection control, and at least on an annual basis. The principal dentist told us that all staff had been reminded of the correct protocols for infection control at a meeting held after the inspection.

Clinical staff had produced evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

Equipment and medicines

We found that the majority of equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) had been completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

However, we also found that the fire equipment and ultrasonic bath had not been maintained appropriately. The principal dentist sent us evidence, two days after the inspection, confirming these issues had been resolved.

The practice stored small numbers of prescriptions pads for NHS treatment and each dentist correctly wrote out private prescriptions. However, we noted that there was no system for tracking the NHS prescription numbers at the practice, for enhanced security.

The use by dates of medicines, oxygen cylinder and equipment had not been regularly monitored using daily, weekly and monthly check sheets to enable staff to replace out-of-date drugs and equipment promptly.

Radiography (X-rays)

Are services safe?

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules. The provider sent us evidence after the inspection demonstrating that staff had completed radiography and radiation protection training.

However, we found that audits on X-ray quality had not been undertaken at regular intervals. We saw evidence that an audit had been carried out in the past, and this was confirmed by the principal dentist via email, after the inspection. However, such an audit, for each operator, had not been carried out in the past year in line with IR(ME)R recommendations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. Three of the dentists described to us how they carried out their assessments. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately.

We saw details of the condition of the gums were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The dentists told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. They were aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). They told us they held discussions with their patients, where appropriate, around smoking cessation, sensible alcohol use and dietary advice. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials available in the treatment rooms. The dentists also used models and diagrams to support patients' understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked staff records. We found that these did not contain evidence in relation to all of the mandatory requirements for registration issued by the General Dental Council. For example, although the practice could demonstrate that all staff were trained in responding to emergencies and relevant staff had radiography and radiation protection training, they could not show that staff were up to date with infection control and safeguarding training. The principal dentist sent us evidence, after the inspection, showing that staff had completed safeguarding training.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us that they were well supervised and that the practice supported their career development and aspirations. Longer-standing members of staff had been engaged in an appraisal process within the past year.

We reviewed the process for ensuring that there were sufficient numbers of staff working at the practice to ensure risks to patients were mitigated. We reviewed the staff rota, appointments book, dental nursing time sheets and locum dental nursing agency invoices.

We found four examples in the past year where we could not confirm that each dentist working on that day had been suitably supported by a dental nurse, who was providing chairside support. The reception staff stated that dentists occasionally worked without a dental nurse present. This was not in line with GDC guidance. For

Are services effective?

(for example, treatment is effective)

example, there was no risk assessment to demonstrate that the dentists understood the risks involved of working without chairside support, and to demonstrate what steps had been taken to mitigate the risk. The dentists were working routinely on Saturday mornings and providing a range of treatments. Therefore, the work taking place could not be considered as occurring under exceptional circumstances.

The principal dentist subsequently confirmed, via email, that they did not anticipate ever again being in a position where the dentists would be working without assistance from a dental nurse.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The dentists we spoke with explained how they worked with other services, when required. They were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, there was a system in place for referring patients to hospital consultants using a fast track process for suspected cases of oral cancer.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for care and treatment. We spoke to three of the dentists about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

However, not all of the staff we spoke with were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). Staff also did not have a working understanding in relation to the rights of young people, under the age of 16 years, to receive treatment, in line with the Gillick competence test.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff told us they were mindful about treating patients in a respectful and caring way. We observed staff speaking with patients in the waiting area and noted that staff were welcoming and treated patients respectfully. We collected feedback from three patients. They also described a positive view of the service and confirmed that they were treated by a caring staff team.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and the staff told us that the doors were closed at all times when patients were having treatment. We observed this to be the case throughout the day of the inspection.

Staff understood the importance of data protection and confidentiality and there was a relevant policy in place for information governance. Patients' dental care records were stored in a paper format. All records were kept in locked filing cabinets behind the reception desk or in the staff room.

Involvement in decisions about care and treatment

The practice displayed information in the waiting are which gave details of the NHS dental charges. The reception staff held information at the reception desk, which was available on request, in relation to the private dental fees.

We spoke with a range of staff on the day of our inspection including dentists and dental nurses. They told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the dental care records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentists. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and guides to different types of dental treatments. Staff also had access to information that could be used to support patient understanding in the treatment rooms. The dentists used models and diagrams to illustrate their proposed treatment plans.

Tackling inequity and promoting equality

Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. There was an equality and diversity policy which staff were following.

Staff spoke a range of languages which supported some patients to access the service. However, the practice did not have access to a telephone interpreter service for those languages not spoken at the practice.

Staff were also able to provide large print, written information for people who were hard of hearing or visually impaired, but did not have access to other technological support, such as a hearing loop.

The practice was not wheelchair accessible with access to the treatment rooms up a flight of steps to the first floor. The practice had not carried out a Disability Discrimination Act audit to determine what reasonable adjustments could be made to the premises to support people to access the service. The principal dentist told us that they had, in the past, explored the possibility of installing a lift or chair lift to support access. They reported that they had been told the premises were not suitable for this type of engineering work.

Access to the service

The practice opening hours are on Monday, Tuesday, Thursday and Friday from 9.00am to 5.30pm, and on Wednesday from 9.00am to 6.30pm. The practice is also open from 9.00am to 1.30pm on Saturdays.

We asked the reception staff about access to the service in an emergency or outside of normal opening hours. They told us that there was an answerphone message which directed patients to other local out of hours services.

Staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. We observed someone arriving at the practice on the day of the inspection to request an emergency appointment because they were experiencing some dental pain. We noted that the reception staff were able to book an appointment for this patient on the same day.

Concerns & complaints

We viewed a copy of the complaints policy and saw that it described how the practice handled formal and informal complaints from patients. The principal dentist was the complaints manager. We asked the principal dentist for a summary of complaints that had been received in the past year. They were not able to provide us with such a summary and were not aware of the number of complaints received in the past year.

We were able to review the documents in relation to the response for two complaints. Documents related to complaints were held in each person's dental care record. However, the documents available did not represent a complete audit trail; some documents were missing, for example, either in relation to the content of the original complaint, or all of the subsequent interactions produced by the practice. There was no evidence to indicate that staff discussed the handling of complaints, for example, at staff meetings, with a view to identifying action points and sharing learning to prevent recurrences.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements and a management structure. There were relevant policies and procedures in place. Staff were aware of these policies and procedures, but had not always acted in line with them. For example, staff were not accurately following the infection control policies and protocols.

The principal dentist told us that there were staff meetings that were called to discuss governance concerns. These were arranged, when needed, but were not always minuted. We saw one example of minutes from a meeting within the past year where some governance concerns, for example, in relation to infection control, had been discussed.

However, overall we found there were limited arrangements for identifying, recording and managing risks through the use of risk assessments, audits, and monitoring tools.

In terms of risk assessment, the practice had not properly addressed risks across a range of topics, including, but not limited to, general health and safety, Control of Substances Hazardous to Health (COSHH), Legionella, fire safety and use of sharps. All of these documents and assessments relate to minimising risk with a view to keeping patients and staff safe.

Furthermore, there was no clear schedule for testing and monitoring all of the equipment used on the premises. For example, the ultrasonic bath had not been serviced in a timely manner and relevant protein-residue testing had not been carried out and recorded on a regular basis. Fire equipment had also not been inspected in a timely manner and there were items of equipment and medicines missing from the medical emergency kit.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff told us they were comfortable about raising concerns with the dentist. They felt they were listened to and responded to when they did so. They told us they enjoyed their work and were well supported by the principal dentist. We found staff to be hard working, caring towards the patients and committed to the work they did. Longer-standing members of staff had received a formal appraisal to review their performance.

However, we noted some concerns with the leadership at this practice. For example, although there was a practice manager in place, staff did not understand the role of the manager. The principal dentist's reports on the operation of the practice contradicted what other members of staff told us, for example, in relation to the obtaining and monitoring of patient feedback and in relation to the provision of appropriate dental nursing support for dentists during treatment.

Learning and improvement

Staff had engaged in some continuing professional development (CPD), in line with standards set by the General Dental Council (GDC). However, we found that the practice did not have a system in place to monitor staff training. We identified gaps in training at the time of the inspection. For example, not all staff had completed or renewed safeguarding and infection control training at the time of the inspection.

The practice did not have a structured plan in place to audit quality. For example, there had been no radiography or dental care record audit within the past year. An audit for infection control, which had been completed within the past six months, had not been followed up in terms of rectifying identified concerns, for example, in relation to placement of sharps bins. The audit had failed to identify concerns observed by the inspection team.

There was no internal system for reporting and recording significant events or incidents with a view to sharing learning and preventing further occurrences.

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

There was an opportunity for staff to provide feedback during the appraisal process and at staff meetings. However, the practice had not established and operated effective systems for seeking and acting on feedback from patients regarding the quality of the service provided.

The principal dentist told us that feedback was acquired through the use of the NHS 'Friends and Family Test' comments cards which were on display in the reception area. We found that these cards were not on display. We

Are services well-led?

asked reception staff about the test. They commented that the survey cards had not been collected for some time. They located some completed cards in a cupboard with a stack of blank cards.

The practice manager told us they were not in charge of making the monthly NHS submissions in relation to this test. There was no other system in place for monitoring or responding to the feedback collated through the test. The practice did not have any other alternative protocols for systematically collecting patient information.

The principal dentist stated, in an email after the inspection, that they had reviewed the systems for receiving patient feedback. They would now be managing the Friends and Family test appropriately and would additionally provide a comments book in the reception area.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider had not established and operated effectively systems and processes to prevent abuse of service users and investigate any allegations or evidence of such abuse. **Regulation 13 (1) (2) (3)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to manage the services provided at all times. The provider did not always ensure all staff members received appropriate support, training and supervision necessary for them to carry out their duties. **Regulation 18(1) (2)**

Regulated activity	Regulation
	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider did not have an effective recruitment procedure in place to assess the suitability of staff for their role. Not all the specified information (Schedule 3) relating to persons employed at the practice was obtained.

Regulation 19 (1) (3)

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 How the regulation was not being met: The provider had not assessed the risk of preventing, detecting and controlling the spread of infections. **Regulation 12(1)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have systems to enable them to continually monitor risks, and to take appropriate action to mitigate risks, relating to the health, safety and welfare of patients and staff. The provider had also not ensured that their audit and governance systems were effective. **Regulation 17 (1)**