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Broad Street Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 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

Broad Street Dental Practice is located in the town of Whittlesey in Cambridgeshire. It provides a private dentistry service to adults and an NHS dental and orthodontic service to children up to the age of 18 or up to the age of 19 if in full time education. The practice is led by a partnership of two principal dentists who employ two part time dentists, two dental hygienists, three dental nurses and three receptionists. The practice opens from 8.30am until 5pm three days a week, has extended hours until 7.30pm on Wednesdays and closes at 4pm on Fridays. It also opens on Saturday mornings twice a month.

A dental partner 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'. 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 47 patients either in person or through CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all very positive showing that

Summary of findings

patients valued the service they received. Patients said that staff were very welcoming, patient and helpful. They told us staff listened to them, involved them in decisions about their care and provided a service they valued.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had access to emergency equipment and this included an automated external defibrillator and medical oxygen. Emergency medicines were in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines and current legislation.
- Patients received clear explanations about their proposed treatment and its costs, benefits, and risks and were involved in making decisions about them.
- Patients were treated with dignity and respect and their confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Arrangements for staff training were in place although improvement was needed to identify their individual learning and development needs.
- An accident reporting process was in place although improvement was needed to the records made of any actions taken including any learning.
- A complaints process was in place and this was well managed. However, a process for identifying learning and any subsequent action was not in place.

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

- Ensure that action is taken to identify and manage any infection control risks. This must include regular infection control audits, the appropriate use of personal protective equipment, regular checks of the water temperatures and adequate control measures for any identified legionella risks.

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 arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the practice's system for recording, investigating and reviewing accidents, incidents or significant events with a view to preventing further occurrences, ensuring that improvements are made and sharing the learning appropriately.
- Review the actions taken following sharps handling injuries in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the systems used to record the checks completed of the emergency equipment and medicines.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review fire safety procedures at the premises and ensure that all staff are familiar with them.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.
- Review the checks used to validate the effectiveness of the ultra-sonic cleaning bath.
- Review and develop health and safety risk assessments and responsibilities in regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 so that information is clear and staff understand how to minimise any associated risks.
- Review the appraisal process for staff to include the identification of their learning and development needs and any on-going assessment.
- Review the practice's recruitment procedures to ensure that a written policy is in place and ready to use when new staff are recruited.
- Review the practice's audit protocols for radiography to help improve the quality of service. The practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.
- Review its complaint handling procedures to include a process to identify and act upon learning from complaints raised.

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 for the cleaning and decontamination of dental instruments. Regular quality monitoring checks of the decontamination procedures had not been established to encourage improvement and ensure that practice was always in line with national guidelines.

The practice did not have arrangements in place to receive patient safety alerts. An accident reporting system was in place although records of any actions taken or resulting improvements were not recorded. There was no process in place to identify incidents or significant events to promote learning and improvement. Other monitoring systems such as risk assessment and COSHH assessments (Control of Substances Hazardous to Health) required further development.

Emergency equipment and medicines were available for use although the regular checks were not recorded. Medicines were prescribed to patients appropriately. Equipment at the practice was well maintained. X-ray machines and other items of equipment had been serviced, maintained correctly and were operated by the appropriate staff. Some health and safety risks required a review, for example staff had not received fire training and hazardous solutions and cleaning materials were stored in an unlocked room.

The practice was visibly clean and there were safe systems in place to manage clinical waste and the disposal of sharp instruments.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs including taking a medical history. Explanations were given to patients in a way they understood. Risks, benefits, options and costs were explained. Staff were supported to complete core training although opportunities to identify personal learning and development were limited. Patients were referred to other services in a timely manner and staff followed appropriate guidelines for obtaining patient consent.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. Patients told us that staff were caring, helpful and put them at ease. Treatment was clearly explained and they were provided with treatment plans and costs. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

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

Summary of findings

Appointment times met the needs of patients and waiting times were kept to a minimum. Information about emergency treatment was made available to patients. A practice leaflet was available in reception to explain to patients about the services provided. The practice had made reasonable adjustments to accommodate patients with a disability. Patients who had difficulty understanding care and treatment options were supported. The practice had a complaints policy to deal with complaints in an open and transparent way and apologise when things went wrong.

Are services well-led?

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

The systems used to monitor the overall quality of the service required improvement. Some policies and procedures were in use at the practice although these were not always robust and were not always kept up to date. For example the complaints policy had not been reviewed and the appraisal process was unclear and did not help to promote staff development. Regular practice meetings took place although records did not demonstrate that any actions were raised and taken forward. There was limited evidence that learning from incidents or accidents, clinical audits and complaints was shared with the staff.

Staff were clear about leadership responsibilities within the practice although we found leadership arrangements for infection control and decontamination procedures were not clear and could account for areas of infection control that had not been identified by the practice for improvement.

Staff told us that they worked well as a team. All staff knew how to raise any issues or concerns and were confident that action would be taken by the partners without fear of discrimination. Core training was in place for staff. However, the appraisal system required a review so that personal development plans could be identified to support continual skills development of staff.

Clinical audits were taking place at the practice but these required improvement in areas of infection control and radiology so that quality improvements could be made.

Broad Street Dental Practice

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.

This inspection took place on 8 March 2016 and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information for review although we did not receive this.

We informed NHS England area team that we were inspecting the practice; however, we did not receive any information of concern from them.

During the inspection we spoke with the principal dentists, the dental nurses, dental hygiene therapist and reception

staff. We reviewed policies, procedures and other documents. We also obtained the views of four patients on the day of the inspection and received 44 comment cards that we had provided for patients to complete during the two weeks leading up to the inspection.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The registered manager described a good awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). The practice had an accident reporting book in place to use in the event of an injury to a patient or to any staff members. This was last used in 2014 to report a sharps injury to a member of staff. We found that appropriate action was taken to deal with the injury but there was no record that the member of staff had been referred for a medical assessment and follow up in accordance with guidelines in the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. This was confirmed by the registered manager. We also found the practice had not followed its own policy which stated an occupational health referral should be made in such circumstances. There was no record of any learning or actions that may have taken place.

There was no other process or policy in place to identify, report and investigate incidents in the practice. The practice had not received any national patient safety alerts such as those related to the safety of medicines and medical devices for some time as they were not registered to receive these by email. The practice had a policy detailing the duty of candour, when and how to notify CQC of incidents which cause harm.

Reliable safety systems and processes (including safeguarding)

Staff had received appropriate training for safeguarding children and vulnerable adults. When we spoke with staff they were able to describe potential safeguarding concerns and told us they would discuss their concerns with the named lead for safeguarding. They were aware of the safeguarding reporting policy and procedures and knew where to locate this guidance.

We found that a rubber dam was not used in all root canal treatments. A rubber dam is a thin rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. We spoke with two dentists and found that a rubber dam was not routinely used in all root canal treatments in line with guidance issued by the British Endodontic Society in relation to the use of the rubber dam. The dentists we

spoke with described what alternative precautions were taken when it was not possible to use rubber dam. This should be recorded in the patient's 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 at the practice. There was an automated external defibrillator (AED), which is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment and completed a monthly check of the AED to ensure that it was in working order although this was not recorded.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The expiry dates of medicines were checked by staff on a regular basis although they did not record the checks. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

The practice team had completed appropriate medical emergencies training. We found they did not test their skills and procedures through practicing medical emergency scenarios.

Staff recruitment

The practice had not recruited any new staff for a number of years. We found there was no recruitment policy in place to guide this process if the situation may change in the future. It was the dental practice's policy to request a Disclosure and Barring Services (DBS) check for all staff and records we reviewed showed this had been completed. These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The arrangements in place to monitor health and safety and deal with foreseeable risks required some improvement. We found that a fire inspection visit had

Are services safe?

taken place in January 2016 and the fire safety equipment had been serviced. However staff had not received fire training, there were no designated fire marshals and fire drills had not been conducted.

The practice had a health and safety risk assessment in place that was last completed in January 2015. This covered risks such as sharps injuries, risk of slips/trips and electric shocks. While these helped to address and mitigate the risks identified, further assessment of the environmental risks had not been addressed. For example, we found that potentially hazardous solutions and cleaning materials were stored in an unlocked room. The arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations required improvement. Although the practice had identified some hazardous substances, the assessments did not detail sufficient control measures. The assessments did not include a number of hazardous solutions that were used within the practice such as cleaning products for cleansing instruments and disinfectants.

Infection control

The practice did not have effective systems in place to reduce the risk and spread of infection within the practice in line with the essential quality requirements for infection control set out in HTM 01 05 (national guidance for infection prevention control in dental practices). Infection control audits had been completed in August 2014 and again in January 2016. This was not sufficient to monitor and secure safe decontamination procedures. Following the audits, there was no summary of findings or an action plan to help improve standards.

There was a comprehensive infection control policy in place that was last reviewed in September 2015 and one of the partners was the dedicated decontamination lead. The practice did not have a dedicated decontamination room and completed the decontamination process in each of the three surgeries. A dental nurse demonstrated the process from taking the dirty instruments through the cleaning process and ready for use again. The practice used a system of manual scrubbing and an ultra-sonic cleaning bath for the initial cleaning process. Then, following an inspection of the instruments with an illuminated magnifier, they were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilised, most items were pouched, dated with an expiry date and stored until required. When

we completed a visual inspection of the equipment in the surgeries, we found some loose dental instruments in drawers. Staff informed us these items were used frequently and were always reprocessed within 24 hours. However they were not stored in suitable lidded containers away from areas where they may become contaminated from sprays. This was not in line with current HTM 01 05 guidelines.

We were shown the systems in place to ensure that the autoclaves used in the decontamination process were 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. Although monthly foil tests of the ultra-sonic cleaning bath were completed, the weekly protein residue test that's forms part of the validation of the ultra-sonic cleaning bath were not completed.

We found that staff were not using appropriate personal protective equipment such as aprons, visors and heavy duty gloves to complete the manual cleaning of used dental instruments. This is not in line with HTM 01-05 and places staff at risk of exposure to infection.

The dental water lines were flushed regularly to prevent the growth and spread of legionella bacteria. Legionella is a term for particular bacteria which can contaminate water systems in buildings. Staff described the method they used which was in line with current HTM 01 05 guidelines. We found that dip slide tests were completed on a monthly rotational basis although water temperature checks were not completed and recorded. A legionella risk assessment had been carried out at the practice by a competent person in 2012 and some remedial work was completed at the time. However, the report made several recommendations and the practice could not provide evidence to demonstrate that they had taken any action.

There were cleaning schedules in place for cleaning the premises and cleaning records were maintained by the cleaner who was directly employed by the practice. Equipment used for cleaning the premises was in line with NHS guidelines.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that staff used sharps containers, clinical waste bags and municipal waste in accordance with current guidelines although some sharps bins were not

Are services safe?

signed and dated at first use. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location outside the practice prior to collection by the waste contractor. Waste consignment notices were available.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturers' recommendations. For example, the autoclaves had been serviced and calibrated in February 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in March 2015 and the compressor in August 2015. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a secure cabinet to prevent loss due to theft.

Radiography (X-rays)

We reviewed the radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation

Medical Exposure Regulations 2000 (IRMER). This file 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. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

A radiological audit was last completed in April 2015 which looked at X-ray grading (a system used to determine if the X-ray is of diagnostic value). This did not include a sample of the original X-rays, for each clinician to verify the original grading before then recording results. The dentists we spoke with were able to describe appropriate protocols for the justification for taking X-rays, interpreting the findings and actions taken as a result. This was in accordance with national radiological guidelines and showed that patients and staff were protected from unnecessary exposure to radiation. Training records showed all staff that took X-rays, had received radiological training updates in line with IRMER 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with both of the dental partners about the care and treatments they offered to patients. Dental assessments and treatments were carried out in line with recognised general professional guidelines. Patients completed a questionnaire about their medical history, current health, medication and any known allergies before the dentists commenced their own assessment. The information was reviewed at each visit to ensure that any potential health issues were considered as part of their dental assessment and treatment plan. Dentists then completed an assessment that included 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 any recommended treatments options.

The dentists followed best practice principles for taking dental X-rays but not with reference to the Faculty of General Dental Practice guidelines. The patient records were updated with the details of the proposed treatment following discussion about treatment options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with National Institute for Health and Care Excellence (NICE) recommendations. Staff demonstrated their knowledge of NICE guidelines for dentistry practice during our discussions with them.

Patients who required specialised treatment such as conscious sedation were referred to other dental specialists. Their treatment was monitored after being referred back to the practice once it had taken place, to ensure they received a satisfactory outcome and all necessary post procedure care.

Patients we spoke with and comments received on CQC comment cards reflected that patients were satisfied with their assessments, the information they received and the quality of their dental care.

Health promotion & prevention

The practice promoted the maintenance of good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention'

when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. Where relevant, preventative dental information such as smoking cessation advice, alcohol consumption guidance, dietary advice and general dental hygiene procedures were provided.

Adults and children were provided with advice on the steps to take to maintain healthy teeth and correct tooth brushing techniques. Patients could be referred to the dental hygienist based at the practice if required. The waiting room and reception area contained leaflets that explained the services offered at the practice. A range of dental hygiene products to maintain healthy teeth and gums were available for sale in the reception area.

Staffing

The practice was led by two partners who employed two part time dentists, two dental hygienists, three dental nurses and three receptionists. All of the patients we asked on the day of our visit said they had confidence and trust in the dentists and staff. This was also reflected in the CQC comment cards we received.

We observed a friendly and welcoming atmosphere at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service and they felt the team worked well together. Agency staff were not used as team members covered for one another as far as possible.

One of the partners was responsible for arranging and monitoring regular training for staff. We found they had completed training for medical emergencies, safeguarding, information governance and infection control. However fire safety training was not in place. Staff confirmed they received an annual appraisal which gave the opportunity to share feedback with their employer. However, we found the process was not used to help identify any personal learning and development needs to benefit individual members of staff, as well as the practice.

Regular staff meetings were held on a rotational basis so that part time staff had the opportunity to attend in person from time to time. Staff told us the meetings included updates on any changes to the service, training or briefings on dental standards and provided staff with the opportunity to share any issues. Records of the meetings were very brief, did not reflect staff discussion, any learning points or delegated actions.

Are services effective?

(for example, treatment is effective)

Working with other services

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. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. Staff were able to demonstrate that the referral process was robust and this ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with the two dentists and the dental hygienist about how they implemented the principles of informed consent. They all had a clear understanding of consent issues and explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They recognised the importance of clear communication skills

when explaining care and treatment to patients to help ensure they had an understanding of their treatment options and tailoring the information to suit individual patient's needs.

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. The dentists had recently completed training in the MCA and could demonstrate an understanding of how this applied when considering whether or not patients had the capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. Not all staff we spoke with were familiar with the Gillick principles to help them judge when children and young people were able to make their own decisions about their treatment. Staff told us that children under the age of 16 required an adult with them to sign for their treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored in paper form in lockable cabinets. The records were also held within paper wallets to help protect information when passed from the reception desk to the treatment rooms. Minimal patient information was held on a database which was used for generating patient recalls only. Computers were password protected and regularly backed up to secure storage. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection we sent Care Quality Commission (CQC) comment cards to the practice for patients to tell us about their experience of the practice. We collected 44 completed CQC patient comment cards and obtained the views of two patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of

care was very good, their treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were always helpful and efficient. During the inspection, we observed staff in the busy reception area who were polite and helpful towards patients. The general atmosphere at the practice was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing private treatment costs was displayed in the waiting area and on the practice website. NHS treatments were only available to children and any treatment information or details of entitlements in relation to NHS costs were not made available in the practice. The practice's website informed the public that NHS treatments were free to children up to the age of 18 (or 19 if in full time education). The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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 the practice patient information leaflet. This explained opening hours, how to access emergency care outside of normal working hours and what to do if patients need to raise a concern or complaint about their care or treatment. The practice web site also contained useful information to patients such as how to book appointments on-line and how to provide feedback on the services provided.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent appointments allocated for each dentist. Patients were also invited to come and sit and wait if these appointments had already been allocated. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, or had a disability and the level and complexity of their required treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to prevent inequity for disadvantaged groups in society. The practice were able to access a translation service for any patients who had difficulty in understanding information about their treatment due to limited English language skills. Staff explained they would also help patients on an individual basis if they were partially sighted or hard of hearing to complete NHS and other forms. There was an accessible

toilet and a baby change facility. In addition, the ground floor treatment rooms had level access, there were double handrails on the staircase and raised chairs provided in the waiting room.

Access to the service

The practice was open from 8.30am until 5pm three days a week, offered extended hours appointments until 7.30pm on Wednesdays and closed at 4pm on Fridays. It opened on Saturday mornings twice a month. The practice used the NHS 111 service to give advice to NHS patients in case of a dental emergency when the practice was closed. This information was detailed on the telephone answering machine when the practice was closed. The answer phone message also advised private patients on how to access emergency care.

Concerns & complaints

The practice had a complaints handling policy in place that was due to be reviewed in February 2012. There was no evidence that this had taken place. The procedure set out how complaints would be addressed and the timeframes for responding. The lead receptionist was responsible for non-clinical complaints and a named dentist took the lead for clinical complaints. The practice's information leaflet and information on the practice's website directed patients to discuss concerns or complaints with staff in the first instance and to access a copy of the complaint process from staff.

The last complaint was received 18 months ago. Records demonstrated the practice had followed their complaints process in a timely manner, apologised to the patient and provided them with a written explanation. However, there was no record to demonstrate any learning identified or subsequent actions taken to improve the service as a result of the complaint.

Are services well-led?

Our findings

Governance arrangements

Overall responsibility for governance and monitoring the quality of the service was shared between the partners. We found they were not aware of some of the issues we identified during the inspection. Some policies and procedures were in use at the practice although these were not always robust and were not always kept up to date. For example the complaints policy had not been reviewed for four years, infection control audits were infrequent and not followed up and the appraisal process did not help to promote staff development.

Regular practice meetings took place although records demonstrated that they did not follow a regular governance agenda. Actions points were not raised or followed through to the next meeting and there was limited evidence that learning from incidents or accidents, clinical audits and complaints was shared with the staff.

Systems were in place to ensure that equipment such as machinery used in the decontamination process and fire safety equipment were regularly checked and serviced. Other monitoring systems such as risk assessment and COSHH assessments required further development.

Leadership, openness and transparency

The partners shared overall responsibility for managing the practice. Delegated responsibility for lead roles were in place and staff seemed to be clear about most team members' responsibilities. However not all areas were clear for example there was a lead dental nurse who had responsibility for infection control and checking emergency equipment. We were also informed that one of the dentists led on decontamination procedures. Areas of infection control that had required improvement had not been identified by either member of staff with these lead responsibilities.

Staff we spoke with told us that they worked well as a team and they were supported to raise any issues about the safety and quality of the service. We were told that there was a no blame culture at the practice and a policy was in place to support this. Through our discussions with the dentists and nurses we found that staff adopted a holistic approach to patient care with an emphasis on the

prevention of dental problems. We found staff were hard working, caring and committed to the work they did. All staff knew how to raise any issues or concerns and were confident that action would be taken by the partners without fear of discrimination.

Learning and improvement

Systems were in place to identify core training the practice required staff to complete although this did not include fire safety training. Regular practice meetings had been established and were often used to provide training sessions for staff. There was annual appraisal system in place for staff although this did not lead to a personal development plan to support their ongoing development.

Dentists and dental nurses at the practice were registered with the GDC. The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom.

We found that some clinical audits were taking place at the practice but these required improvement in some areas. Audits of clinical records were comprehensive and had been shared with staff. However infection control audits were too infrequent and did not drive quality improvements. X-ray audits required further development to reflect best practice guidelines. Audit outcomes were not shared with the wider staff team.

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

The practice used the NHS friends and family test to monitor patient satisfaction and address any comments or concerns. The monthly results were monitored and the feedback was displayed in the waiting room. These showed that 100% of patients who completed the test in January 2016 were extremely likely to recommend the practice. In February this dropped slightly to 95.3%.

The practice had completed a patient survey during three months of 2015. They received 30 replies giving the practice some very positive feedback. The practice had considered some suggestions and this included the addition of another hand rail on the staircase.

Staff we spoke with told us their views were sought informally and during staff meetings. They felt their contributions were valued by the partners.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • Systems used to assess, monitor and improve the quality and safety of infection control procedures were not robust. • The provider did not assess, monitor or mitigate the risks for staff who manually clean dental instruments without using personal protective clothing. Regulation 12 (1) (2) (a) (b) (h)