

Arggen 1 Limited

Dentcare1 Boston

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 February 2016 and 19 February 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

Dentcare1 is a private dental surgery located in the town of Boston in Lincolnshire. The building had been occupied as a dentist since the 1950's. The practice has a large and spacious reception area with chairs and sofas throughout the waiting area. The practice is on two floors however all treatment is provided on the ground floor with offices, staff room and staff toilet on the first floor. There were also three treatment rooms that were not in use on the first floor. These were not decommissioned as the practice said that they may use them if they expanded in the future. There is pay and display parking available nearby. The main entrance to the practice is at the rear of the building. There is a separate entrance that patients with wheelchairs and limited mobility can use which enables access to the treatment rooms however this would be accessed after checking in at the reception area. The practice provides general dentistry, sedation and implants.

There are two dentists, one that works part time at this practice two days per week and one that is full time. There are also three trainee dental nurses and one dental nurse that is also the registered manager and practice manager. The trainee dental nurses have a dual role and also cover reception.

The practice provides private dental treatment to adults and to children. The practice is open Monday to Friday from 9am to 5pm.

Summary of findings

The practice manager 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.

The provider has two other practices and the registered manager works across all three sites with one day per week spent at this practice. One of the trainee dental nurses is also the team leader and is involved in the day to day running of the practice in the absence of the registered manager.

We received feedback from five patients about the services provided. The feedback reflected positive comments about the staff and the services provided. Patients commented that the practice was clean and tidy. They said that they found the staff offered a caring service and that staff were friendly. Patients said that explanations about their treatment were clear and that treatment was always discussed.

Our key findings were:

- There were sufficient numbers of suitably qualified staff to meet the needs of patients at present.
- Infection control procedures were in place and staff had access to personal protective equipment.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum where possible.
- Conscious sedation was delivered safely in accordance with current guidelines.
- The practice did not open any late nights or weekends.
- Not all staff had been trained to deal with medical emergencies.
- Appropriate medicines and life-saving equipment were readily available and accessible.
- Policies and procedures were in place however these were not all practice specific.
- Not all staff had not received safeguarding training or knew the processes to follow to raise any concerns.
- The safeguarding lead was unaware that they were the lead and had not completed any safeguarding training.

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

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.
- Ensure that all staff have completed mandatory training including safeguarding and basic life support.
- Ensure there is an effective approach for identifying where quality and/or safety is being compromised and steps are taken in response to issues.

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

- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded..
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's infection control procedures and protocols giving due regard to 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'
- Review the practices' current Legionella risk assessment and implement the required actions giving due regard to 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'
- Review the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.
- Review its audit protocols to ensure audits including of dental care records are undertaken at regular intervals

Summary of findings

to help improve the quality of service. Practice should also ensure, that where appropriate audits have documented learning points and the resulting improvements can be demonstrated.

- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 care which was safe in accordance with the relevant regulations.

The practice had some systems and processes in place to ensure all care and treatment was carried out safely. The practice had procedures in place for accidents and significant events however staff we spoke with did not know how to report incidents including near misses and therefore there was no learning or preventing reoccurrence of these.

Not all staff had not received training in safeguarding vulnerable adults and children and the lead for the practice was not aware that they were the lead and had received no training in safeguarding.

Patients' medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. However, some staff had a limited knowledge of how to deal with medical emergencies.

Infection control procedures were in place; followed published national guidance and staff had been trained to use the equipment in the decontamination process. The practice was operating an effective decontamination pathway, with some checks in place to ensure sterilisation of the instruments.

Are services effective?

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

Patients' dental care records provided some information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and provided treatment as appropriate.

The practice generally followed current guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE).

The dentists were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application, fissure sealants and oral hygiene advice.

When providing conscious sedation the practice followed a robust procedure which included a thorough pre-sedation assessment and effective monitoring before, during and after the procedure.

Patients receiving dental implants were assessed prior to treatment. However, not all of these assessments were documented.

Referrals were made to secondary care services if the treatment required was not provided by the practice.

Staff had not received formal training in the Mental Capacity Act (MCA) 2005 however the dentist that we spoke with were able to explain to us how the MCA principles applied to their role. The trainee dental nurses had little knowledge of the MCA principles.

Are services caring?

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

Summary of findings

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients provided positive feedback about the dental care they received, and had confidence in the staff to meet their needs.

Patients said they felt involved in their care. Patients told us that explanations and advice relating to treatments were explained to them.

Are services responsive to people's needs?

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

The practice was well equipped. The waiting room was spacious and comfortable. The practice had been adapted for people that used a wheelchair with a ramp entrance available with took patients straight to the treatment rooms. However this was not signposted and patients needed to attend the main reception area initially and then go back outside.

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

The practice did not open late nights or weekends however there were no suggestions that this was required by the patients.

Are services well-led?

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

Staff were involved in leading the practice to deliver satisfactory care. Staff were receiving annual appraisals. The practice was carrying out audits of clinical areas to assess the safety and effectiveness of the services provided. However, the clinical record audit could be improved.

The practice had systems in place to involve, seek and act upon feedback from patients using the service.

Staff that we spoke with had different understanding of the management structure in the practice. There were no clear lines of responsibility for the registered manager and the nominated individual.

Staff told us that training and development was in place however mandatory training such as safeguarding and basic life support had not taken place for three staff members.

The practice had systems in place to involve, seek and act upon feedback from patients using the service.

Dentcare1 Boston

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 10 February 2016 and was conducted by a CQC inspector and a second CQC inspector. A CQC inspector re-visited on the 19 February 2016 to speak with staff who had not been available at our initial visit.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with a number of staff working on the day. We reviewed policies, procedures and other documents. We viewed five Care Quality Commission (CQC) comment

cards that had been completed by patients, about the services provided at the practice. We also viewed comments that had been left in the patient comment book on the reception desk at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have procedures in place to investigate, respond to and learn from incidents and complaints.

Accidents could be recorded in an accident book and staff we spoke with were aware of this. Staff told us of incidents that had occurred in the practice such as a patient falling on the stairs, staff member minor accidents and near misses. These had not been reported and staff were unaware of how to report them or the reason for doing so. Staff told us that anything that happened they would telephone the registered manager and inform them.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for recognising and responding to concerns about the safety and welfare of patients. Staff we spoke with were aware of these policies and were able to explain who they would contact and how to refer to agencies outside of the practice should they need to raise concerns. Not all staff were able to demonstrate that they understood the different forms of abuse. The practice had information at reception in a folder of who to contact if they had any concerns in relation to safeguarding of children or adults. From records viewed we saw that staff at the practice had not completed safeguarding training in safeguarding adults and children. The management said that all staff had read the safeguarding policy. The team leader was the lead for safeguarding to provide support and advice to staff and to oversee safeguarding procedures within the practice however the team leader was unaware that they were the lead and had not had any safeguarding training. Staff members gave us differing answers to who was the lead however the only person that was trained to level two was not one of those given. No safeguarding concerns had been raised by the practice.

Rubber dam (this is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth) was not used by all dentists when providing root canal treatment. However, we were told that root canal instruments were secured with dental floss when being used.

The practice had a whistleblowing policy although staff we spoke with did not understand what whistleblowing was and when it was asked where would they go if they needed to raise concerns outside the practice staff were unclear. However staff that we spoke with on the day of the inspection told us that they felt confident that they could raise concerns without fear of recriminations.

The practice had an up to date employer's liability insurance certificate which was due for renewal December 2016. Employers' liability insurance is a requirement under the Employers' Liability (Compulsory Insurance) Act 1969.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency. The emergency resuscitation kits, oxygen and emergency medicines were stored in one of the ground floor surgeries. Most staff knew where the emergency kits were kept however one member of staff was unsure. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Records showed weekly checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full, the AED was fully charged and the emergency medicines were in date.

Only the dentists had received basic life support training including the use of the AED. Staff we spoke with were unable to describe how they would deal with a number of medical emergencies including anaphylaxis (severe allergic reaction) and cardiac arrest.

Staff recruitment

The practice had a recruitment policy which described the process when employing new staff. This included obtaining proof of their identity, checking their skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service check was necessary. We saw that all staff had received a Disclosure and Barring Service check. Three recruitment files checked did not contain references nor did they have interview records which was part of their recruitment policy. Out of the three files we found one

Are services safe?

reference for one staff member. When we spoke with the registered manager we were told that some references had been taken verbally but this had not been recorded in the recruitment file.

The practice had a formal induction system for new staff which was documented within the recruitment files that we checked, part of this induction included the staff reading practice's policies and also the manager reading the policies to staff for example safeguarding and whistleblowing.

There were sufficient numbers of qualified staff working at the practice however these were not all suitably trained.

Monitoring health & safety and responding to risks

A health and safety policy was in place at the practice which had been read and reviewed annually and signed as understood by all staff. There was a comprehensive risk assessment that had been completed in January 2016 covering risks such as autoclave burns, biological agents, fire and manual handling. There were also risk assessments for trainee dental nurses, pregnant women and nursing mothers. Where appropriate the risks had been identified and control measures put in place to reduce them.

There were policies and procedures in place to manage risks at the practice. Policies had been reviewed annually and at the time of our inspection this review had been completed therefore the current date of the policies was January 2015. We were told that staff had read the policies on the induction. These included infection prevention and control, legionella policy and sharps policy.

The practice had a business continuity plan to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service. The staff within the practice were unaware of this but said that there was a diary at reception if they needed to contact anyone. The business continuity plan did not include any contact details for staff or other relevant personnel such as tradesmen and suppliers.

Infection control

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place, which clearly described how cleaning was to be undertaken at the premises including the treatment rooms and the general areas of the practice. The practice staff were responsible for cleaning the practice and for cleaning and infection control

in the treatment room and there were schedules in place for what should be done and the frequency. The staff told us that they had 15 minutes at the beginning and 15 minutes at the end of the day to complete the cleaning. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into a clinical waste bin for disposal by a registered waste carrier and appropriate documentation retained. However, we noted that the lock on this bin was broken and therefore could not be considered secure.

We found that there were adequate supplies of liquid soaps and paper hand towels in dispensers throughout the premises. Posters describing proper hand washing techniques were displayed in the dental treatment room and the decontamination room.

Recruitment files reflected staff Hepatitis B status. 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.

An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

Decontamination procedures were carried out in a dedicated decontamination room in accordance with HTM 01-05 guidance. However, we noted that there was only one sink in the decontamination room. This was the dedicated hand washing sink. We were told that as part of the practice's refurbishment plan a new decontamination room was to be installed which would have the appropriate number of sinks.

The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process and these included heavy duty gloves, aprons and protective eye wear.

Staff showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice routinely manually cleaned and used an ultrasonic bath to decontaminate the used instruments. We noted that the water used in the scrubbing bowl was dispensed from a hot water heater as the tap did not dispense hot water. This water was very hot and we were told that they would add cold water to reduce

Are services safe?

the temperature. However, no temperature checks were done on this water to ensure it was below 45°C. HTM 01-05 states that the temperature of the water used when manually scrubbing instruments needs to be below 45°C to ensure that proteins are not coagulated which may inhibit their removal. After manually scrubbing the used instruments they were placed in the ultrasonic bath for further decontamination. We noted that there was an illuminated magnifying glass in the decontamination room and staff told us that this was used to examine the instruments after being decontaminated. However, the light was not working. Instruments were then sterilised in an autoclave. We saw that after sterilisation in the autoclave that the instruments were correctly bagged and dated to ensure their sterility.

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in February 2016 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05). This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment.

Records showed a risk assessment process for Legionella had been carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients and monitoring cold and hot water temperatures each month. The practice were also about to start using a water conditioning agent in the dental unit water lines. However, we noted that the Legionella risk assessment had made some recommendations. When we asked if these recommendations had been followed up they were unsure if these had been done.

Equipment and medicines

Records we viewed showed that equipment in use at the practice was regularly maintained and serviced in line with manufacturer's guidelines. Portable appliance testing had taken place the day before the inspection. Fire extinguishers had been checked and serviced by an external company in May 2015. Staff had not been trained in the use of firefighting equipment and evacuation procedures. The practice log showed that a fire drill had taken place the day before the inspection. The registered manager confirmed this and said that it was only staff and that no patients were in the practice despite the outcome of the drill saying all staff and patients were safely evacuated. We spoke with the staff members that had been present for the drill and they were unaware that there had been one. Staff told us that they would not feel confident in using the fire extinguishers.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray currently in use. On the day of inspection we noted that an engineer was carrying out the three-yearly critical examination of the X-ray machines. We asked to see previous copies of this, however, these could not be produced.

A Radiation Protection Supervisor (RPS) had been appointed, however, there was no Radiation Protection Advisor (RPA) documented in the radiation protection folder or the local rules. We later saw evidence that an RPA had been appointed after the inspection.

Local rules were available in all surgeries and within the radiation protection folder for staff to reference if needed. However, we noted that the local rules in the radiation protection folder was for a sister practice. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

We saw an X-ray audit had been carried out. This included assessing the quality of the X-rays which had been taken. The results of the most recent audit undertaken confirmed they were compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Feedback we received from five patients showed that they were satisfied with the service including the assessments, explanations, the quality of the dentistry and outcomes.

The practice kept up to date electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. The risk factors which the dentist took into account were dental decay, gum disease and tooth wear. These risk factors were documented and also discussed with the patient.

During the course of our inspection we discussed general patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary.

We saw that the practice had a robust process for the provision of conscious sedation and this was in line with those set out in the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD). We saw that patients' anxiety was assessed prior to undertaking conscious sedation. This

involved the patient completing an anxiety questionnaire which would indicate to the dentist how nervous the patient was. The patient would be made aware that other forms of anxiety control were also available. If the patient wished to go ahead with conscious sedation then a pre-sedation assessment would take place which involved assessing their medical suitability for conscious sedation. The patient's American Society of Anaesthesiologists (ASA) physical status was assessed and documented and if it was one or two then the dentist felt this was appropriate to treat the patient in the surgery. If the ASA was above two then the patient would be referred to secondary care. The patient would also be given an intravenous sedation leaflet which included information about what to do on the day of the appointment and what to expect. This leaflet was very detailed and provided the patient with a great deal of information about the process. Prior to the induction of conscious sedation the dentist would re-check the patient's medical history to ensure nothing had changed since the pre-assessment. There was also a conscious sedation surgery checklist which was completed by one of the assisting staff to ensure that all the necessary equipment and arrangements were in place before commencing the surgery. The dentist would then record the patient's blood oxygen saturation, blood pressure and heart rate (vital signs). Throughout the procedure these vital signs were regularly checked and documented in the sedation record. We saw that the dose of sedative medicines were titrated to effect to ensure that the patient was not over-sedated. These doses were documented in the sedation records. We saw that a reversal agent to the sedative medicines was readily available if needed. However, we were told that this had never been needed. After the procedure the patient's escort would be suitably briefed with regards to post-operative care. We felt that the processes and procedures involved in the provision of conscious sedation ensured that it was provided safely and effectively.

The practice provided dental implants. We were told that patients underwent a full assessment prior to undertaking implant treatment. This included using study models and X-rays. The X-rays were used to assess the quality and volume of the bone and whether there were any important structures close to where the implant was being placed. We saw evidence that these X-rays were analysed to ensure the implant work was undertaken effectively. We were also told that the patients gum health was checked prior to

Are services effective?

(for example, treatment is effective)

undertaking implant treatment. However, this was not documented in the dental care records. This was brought to the attention of the dentist and we were told that these checks would now be documented.

Health promotion & prevention

The waiting room and reception area at the practice contained literature that explained the services offered at the practice.

The dentists were aware of the importance of preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, fluoride varnish was applied to children who attended for an examination and also fissure sealants to those who were at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

Staff told us that they advised patients on how to maintain good oral hygiene both for children and adults. Staff also advised patients on the impact of tobacco and alcohol consumption on oral health. Referrals were made for smoking cessation. Patients were advised of the importance of having regular dental check-ups as part of maintaining good oral health. Patients were given free samples of toothpaste when available.

Staffing

Staff training for the members that had started within the last 12 months had been based on the registered manager reading them the policy folder. The practice employed a management company that also provided a training session that covered topics such as safeguarding, infection control, data protection and handy hygiene. However at the time of the inspection only the dentist and the registered manager had completed this training although we were told that it was due to be run in March 2016 for the other staff. Following the inspection we were told that the practice would be closing for a day to enable a full training session for all staff in the key areas. Training had not been conducted in relation to basic life support for all staff and the staff that we spoke with were unsure how they would act in an emergency situation. Dental staff we spoke with told us that they were supported in their learning and development and to maintain their professional registration.

The practice had procedures in place for appraising staff performance. We saw that staff had annual appraisals completed. Staff confirmed that appraisals had taken place and they felt supported and involved in discussions about their personal development. They told us that the management team and dentists were supportive and approachable and always available by telephone for advice and guidance.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including oral surgery and paediatric dentistry. The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records. The dentist kept a log of when referral letters had been written and when they had been posted. The staff member who posted the letter signed the log book when the referral had been sent. This enabled the practice to have an audit trail for referrals.

Consent to care and treatment

We discussed the practice's policy on consent to care and treatment with staff. We saw evidence that patients were presented with treatment options, and consent forms which were signed by the patient. The dentist we spoke with was also aware of and understood the assessment of Gillick competency in young patients. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We saw in documents that the practice was aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Staff had not received formal Mental Capacity Act 2005 (MCA) training but the dentist that we spoke with understood their responsibilities and were able to demonstrate a basic knowledge. MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity and respect, and maintained their privacy. The main reception area was open plan and large but the seating area was away from the reception desk and staff told us for personal discussions a separate room could be used to maintain confidentiality. Staff members told us that they never asked patients questions related to personal information at reception if there were other patients.

A data protection and confidentiality policy was in place. This policy covered disclosure of, and the secure handling of, patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. Staff were aware of locking computers and the importance of not disclosing information to anyone other than the patient.

Patients told us that they felt that practice staff were friendly and caring and that they were treated with dignity and respect.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. This included discussions about risks, benefits and any associated costs. Feedback from patients included comments about how they were given good explanations and advice relating to treatments and any questions they had were answered.

Patients were also informed of the range of treatments available (including the option of joining the practice's monthly payment scheme) on notices in the waiting area. The practice's website also provides a great deal of information about the different treatments which are available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice information displayed in the waiting area described the range of services offered to patients and the complaints procedure.

The practice had an appointment system which patients said met their needs. Where treatment was urgent, patients would be seen the same day.

Appointment times and availability met the needs of patients. The practice opened Monday to Friday from 9am to 5pm. Out of hours was provided by NHS 111 and there were signs in the practice to tell patients this.

Tackling inequity and promoting equality

The practice had a range of policies around anti-discrimination and promoting equality and diversity. Staff we spoke with were aware of these policies. They had also considered the needs of patients who might have difficulty accessing services due to limited mobility or other physical issues. A disability access audit had taken place at the practice. The practice was aware of patients with limited mobility or wheelchair users. These patients could access the practice reception and when needed to go for treatment there was another entrance with a ramp that would take them straight to the treatment rooms. There was a toilet but this was not accessible to patients with a wheelchair and did not have a pull cord that sounded an alarm.

The practice was able to use an interpreting service, both via the telephone and by booking interpreters in advance if necessary for any non-English speaking patients. The practice had also had leaflets and information in other languages such as Polish and Lithuanian.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen on the day. Out of hours the patients could telephone the 111 service for advice and assistance.

Staff we spoke with told us that patients could access appointments when they wanted them. Patients' feedback confirmed that they were happy with the availability of routine and emergency appointments.

Concerns & complaints

The practice had a complaint procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. It also included the details of external organisations such as the dental complaints service that a patient could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly. Details of how to raise complaints were accessible in the reception area and in the practice leaflet. Staff we spoke with were aware of the procedure to follow if they received a complaint.

The practice manager told us that there had been two complaints made within the last 12 months. The complaint process that the practice had stated that patient's complaints would be acknowledged within two working days. Both complaints did not show that this had occurred and one of the complaints received in December 2015 still appeared to be outstanding with no record that this had been acknowledged. We spoke with the practice manager about this and they were unsure as to why this had happened and what stage they were at.

CQC comment cards reflected that patients were satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The practice had arrangements in place for monitoring and improving the services provided for patients. There were governance arrangements in place. Staff we spoke with were generally aware of their roles and responsibilities within the practice. However, the safeguarding policy stated that the practice lead was the safeguarding lead and the practice lead were not aware of this.

There was a full range of policies and procedures at the practice. We saw that policies and procedures were reviewed regularly and that staff read the policies on induction. However we saw that processes and procedures that were in place were not followed in practice. Staff spoken with were not able to discuss the policies such as whistleblowing and safeguarding which indicated that they had not read and understood them.

Leadership, openness and transparency

Staff told us that they could speak with one of the management team or dentists if they had any concerns. Staff we spoke with told us that there were not clear lines of responsibility and accountability within the practice and different staff gave us different members of management that they would speak with.

All staff were aware to raise any issue and told us that they would telephone the registered manager or the nominated individual.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records and X-rays. However, when we looked at the most recent dental care record audit it showed limited evidence that it followed the FGDP guidance. The audit stated “Check patient notes” and the outcome was “All seemed OK”.

Practice meetings were held regularly and were minuted. Some meetings were themed and had included subjects such as staff involvement and development, child safeguarding and patient and environmental safety. The practice meeting in December 2015 had included discussion of the two complaints that had been received.

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

Staff told us that patients could give feedback at any time they visited. The practice had completed a survey annually. The survey in 2015 had good results. The results of this survey also gave suggestions and improvements such as refreshments required for patients and also a comment in relation to appointments running on time. This had prompted discussions with the dentist to look into this further.

The practice had systems in place to review the feedback from patients including those who had cause to complain. Any complaints or feedback received would be discussed at the monthly practice meeting.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Staff were not trained to deal with emergency situations and were not able to explain how they would deal with an emergency situation.</p> <p>The lead for safeguarding had not had any training in safeguarding nor were they aware that they were the lead.</p> <p>Regulation 12 (1)(2)(c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider did not ensure staff had completed mandatory training.</p> <p>The provider did not ensure there is an effective approach for identifying where quality and/or safety is being compromised and steps are taken in response to issues.</p> <p>Regulation 17 (1)(2)(a)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p>