Mr. Declan Thompson

Mr Declan Thompson - Harley Street

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 November 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was 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

Mr Declan Thompson – Harley Street is a dental practice located in the London Borough of Westminster. The premises are situated on the first floor of a building where other health care providers are also situated. There is one treatment room, a dedicated decontamination room, an administrative office, and a patient toilet. There is also a shared waiting room with reception area on the ground floor.

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

The staff structure of the practice comprises a principal dentist (who is also the owner), a dental nurse and a part-time administrator.

The practice opening hours are from 9.00am to 6.00pm, Monday to Friday.

The Care Quality Commission (CQC) previously inspected the practice on 16 January 2014 and asked the provider to make improvements regarding infection control. We checked these areas as part of this comprehensive inspection and found they had been resolved.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

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

Eight 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:

- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Some equipment, such as the air compressor and autoclave (steriliser), had been checked for effectiveness and had been regularly serviced; although we noted that some records for other equipment, including the ultrasonic bath were not up to date.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- Staff understood the importance of obtaining informed consent prior to treatment, but did not regularly keep a record of when verbal or written consent had been obtained. Awareness of the needs of higher-risk groups, including young people and those with impaired decision-making capacity, as regards consent processes could be improved.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Staff recorded accidents, but there was no system for reporting or recording incidents or significant events.
- The practice had undertaken some relevant checks for the clinical staff at the time of employing them, but there was no formal recruitment policy, and staff did not have current job descriptions or contracts.
- The principal dentist had a vision for the practice and staff told us they were well supported, although staff had not received regular, formal appraisals.
- Governance arrangements were in place for the running of the practice; however the practice did not have a structured plan in place to assess various risks arising from undertaking the regulated activities and to effectively audit quality and safety.

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 the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff.
- Ensure dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Ensure audits of various aspects of the service, such as radiography, infection control and dental care records are undertaken at regular intervals 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.

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 recruitment arrangements to ensure they are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Establish a system for 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 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 protocols and procedures for use of X-ray equipment giving due regard to Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment.
- 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 staff awareness of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- Review the practice's arrangements 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).

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.

The practice had some policies and protocols related to the safe running of the service. Staff were aware of these and were following them. There were effective systems in place to reduce and minimise the risk of infection. 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, in line with current guidance.

Are services effective?

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

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) and were meeting all of the other training requirements of the General Dental Council (GDC).

Are services caring?

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

We received positive feedback from patients through comments cards, by speaking to patients on the day of the inspection, and by checking the results of the practice's collection of patient feedback letters. 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?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of people with disabilities had been considered and there was a lift providing access to the treatment room on the first floor.

There was a complaints policy in place and we saw that complaints received had been acted on in line with this policy. The principal dentist carried out relevant investigations and recorded the outcome of these. The practice disseminated the outcomes of these investigations at ad hoc staff meetings with a view to preventing a recurrence of any problems.

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 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

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audits was not used to monitor and improve performance. For example, there had not been an audit of the dental care records to identify areas for improvement. The dental care records shown to us demonstrated that they were not always legible and did not contain a full and complete record of all decisions and discussions. Systems for recording the obtaining of verbal or written consent were not robust.

Some governance policies, such as those for the reporting and recording of incidents or staff recruitment, were missing. A clear schedule to follow for the maintenance of equipment was lacking.

The principal dentist had not kept up to date with relevant guidance about evidence-based care for example, from the Department of Health, National Institute for Health and Care Excellence or Faculty of General Dental Practice There were no systems in place for receiving alerts from external agencies such as Medicines and Healthcare products Regulatory Agency (MHRA).

There was no system in place for carrying out formal appraisals with staff to discuss their role and identify additional training needs. Staff employed also did not have written job descriptions or contracts.

Mr Declan Thompson - Harley Street

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 announced, comprehensive inspection on 19 November 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with two members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Eight 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 no policy or other system in place for reporting and learning from incidents. We discussed this with the principal dentist and practice nurse. They described some minor incidents related to equipment failure, and the treatment of patients, which could have been recorded and investigated. They were able to describe the actions they took at the time to remedy the problems.

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). None of the accidents or incidents had required notification under the RIDDOR guidance.

The principal dentist and practice nurse told us that they were committed to operating in an open and transparent manner; they told us they would always inform patients if anything had gone wrong and offer an apology in relation to this.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance and included local authority telephone numbers for escalating concerns that might need to be investigated. This information was displayed in the administrative office. There was evidence in staff files showing that staff had been trained to an appropriate level in safeguarding adults and children.

The practice had carried out some risk assessments and 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. The practice followed a protocol to minimise needle stick injuries whereby needles were not resheathed by hand following administration of a local anaesthetic to a patient. It was the dentist's responsibility to handle the syringes. Staff demonstrated a clear understanding of the protocol with respect to needle stick injuries.

We checked whether the practice followed national guidelines on patient safety. For example, we checked how the practice treated the use of instruments which were used during root canal treatment. A rubber dam is recommended for use in root canal treatment in line with the guidance supplied by 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.] The principal dentist told us that a rubber dam was used in some, but not in all root canal treatments.

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 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, including syringes and plastic airways tubing were out of date and needed replacing. We were informed by the practice, after the inspection, that these items had been replaced.

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 presentalthough an alternative (diazepam) was. We discussed this with the principal dentist; they subsequently confirmed via email that they had ordered midazolam for the emergency kit. The emergency medicines were all in date and 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.

Staff recruitment

Are services safe?

The practice staffing consisted of the principal dentist, a dental nurse, and a part-time administrator.

We reviewed the staff recruitment records and noted that the last member of staff who had been recruited was the practice nurse in 2010. There was no 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 been carried out. This included evidence of relevant qualifications and a check of registration with the General Dental Council. The principal dentist also told us that a verbal reference had been obtained for the dental nurse, although notes from this reference had not been kept.

Other checks and relevant documents had not been recorded. For example, the practice did not hold records demonstrating proof of identity, a review of employment history, and information about physical or mental health. However, the principal dentist told us that they had requested and reviewed this information during the recruitment process.

We found that it was the practice's policy to carry out a Disclosure and Barring Service (DBS) check for both members of the clinical staff, with the last having been carried out in 2011.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The freeholder was responsible for assessing the premises for risk of fire, and fire extinguishers were placed throughout the building. Staff told us they were regularly engaged in fire drills.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted that a review of COSHH substances in use at the practice had not been carried out for over a year.

The practice did not have 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).

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. However, not all emergency arrangements had been considered. For example, the practice relied on a paper appointments book with no other back up. There was also no plan with key contacts, for example, for the servicing of electrics or plumbing, which could be referred to in the event of service failures.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The principal dentist was the infection control lead. 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.

We asked the dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had 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)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. They ensured that the working surfaces, dental unit and dental chair were cleaned down. This included the flushing of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme.

We checked the contents of the drawers in the treatment room. These were well stocked, clean and ordered. There were appropriate supplies of personal protective equipment, such as gloves and aprons, available for staff and patient use. Instruments were pouched. It was obvious which items were for single use and these items were clearly new. We noted one exception. This was in relation to the use of hand files for root canal treatments which were

stored in an open tray in a drawer within the treatment zone. We discussed this with the principal dentist who assured us that these items would now be individually pouched.

Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and towels in the treatment room, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of 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 2015. A number of recommendations were detailed in the report; this included regular testing of the water temperatures. We saw evidence that these checks were being carried out. A record had been kept of the outcome of these checks on a daily basis.

The practice used a decontamination room for cleaning and decontaminating used dental instruments. 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. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Items were cleaned in an ultrasonic bath. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. Instruments were pouched after sterilisation and a date stamp was used to indicate when the sterilisation became ineffective.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. The ultrasonic bath was checked for effectiveness through the use of a weekly protein test – as recommended in HTM01-05.

The practice had carried out a practice-wide infection control audit in January 2014, although we noted they had not repeated the process on a six-monthly basis before or since that time, in line with HTM01-05 guidance.

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 within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff told us that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. The sent us documentary evidence in relation to this on the day after the inspection.

Equipment and medicines

We found that the majority of equipment used at the practice had been regularly serviced and well maintained. For example, we saw documents showing that the air compressor and X-ray equipment had been inspected and serviced. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in September 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

However, the ultrasonic bath had not been serviced since 2012. We discussed this with the practice nurse on the day after the inspection. They confirmed that a service for the ultrasonic cleaner had been booked and that a system of manual cleaning, in line with HTM01-05, would be implemented until the service for this equipment was completed.

Some medicines were being stored appropriately in a fridge; there was a record of daily temperature checks for the fridge to ensure that medicines were being stored within the correct temperature range.

Radiography (X-rays)

There was a 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

Are services safe?

and the Radiation Protection Supervisor. There was also a copy of the three-yearly maintenance log showing that the next service was due in 2017. A copy of the local rules was displayed in the treatment room.

However, not all of the necessary documentation pertaining to the X-ray equipment was held in the file. For example, the notification to the Health and Safety Executive (HSE), as well as the critical examination and acceptance test report were not available. There was also no record of an initial risk assessment or schematic for the X-ray unit, and no annual, general maintenance log carried out by the practice. We were informed by the practice on the day after the inspection that the HSE had been notified.

The administrator had kept a record of quality for each X-ray taken to demonstrate that the dental X-rays were graded and quality assured every time. However, there was no radiological audit, for example, of image quality, which systematically analysed the quality of X-rays and identified areas for improvement. Neither the dental care records that we checked, nor the record of X-ray quality, contained a written justification for why X-rays were being taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The principal dentist described to us how they carried out the dental assessments. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. 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 medical history was updated at yearly intervals and signed by the patient.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A letter was subsequently sent to the patient which described the consultation and proposed treatment plan, as well as 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 with the principal dentist to confirm the findings. The records were handwritten and not always legible. We therefore discussed the notes with the principal dentist. We found that the findings of the assessment and details of the treatment carried out were not always recorded appropriately. For example, the principal dentist told us that the condition of the gums were checked using the basic periodontal examination (BPE) scores. (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). However, the outcomes of these examinations were not recorded, and there was no consistent use of the BPE scores to prompt further investigation or onward referral, for example, to a hygienist (although this did happen on occasion).

Overall we found that the good practice guidelines in clinical examination and record keeping produced by the Faculty of General Dental Practice (FGDP; 2009) had not been followed. For example, recording of consent or social history, such as current smoking or alcohol consumption had not been completed. The principal dentist assured us that these processes formed part of the assessment, although the recording did not reflect this full process. There had also been no audit of record keeping to systematically identify and redress any below standard recording issues.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The principal dentist told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice, although these discussions did not appear in the dental care records that we checked. The principal dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist also carried out examinations to check for the early signs of oral cancer.

Staffing

Staff told us they received appropriate professional development and training. We checked both of the clinical staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

However, there was no systematic induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. The dental nurse did not have a written job description or formal contract. They had not been engaged in an appraisal process which reviewed their performance and identified their training and development needs.

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. Referrals were made to other dental specialists when required.

The principal dentist and dental nurse explained how they worked with other services, when required. Dentists 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, the practice referred patients to a hygienist who was working in another practice located in the same building. They also had systems in

Are services effective?

(for example, treatment is effective)

place for referring patients with complex surgical needs to secondary care, as well as accessing emergency care for cases of suspected oral cancer. Copies of referral letters were kept with the patient's dental care records.

Consent to care and treatment

We spoke to the principal dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. If they assessed that the patient needed a complex treatment plan then a follow up letter was written to the patient so that they could consider their decision prior to commencing treatment. We saw that these letters contained a detailed explanation of the proposed treatment, risk and benefits and costs. Therefore, implied consent was obtained when the patient made an appointment to attend for the treatment.

However, we also found that patients were not asked to sign to indicate they had understood their treatment plans and formal, written consent forms were not completed for specific treatments. We also noted that verbal consent was not recorded in the dental care records and there was no recording of the options discussed in the dental care records.

Staff were aware of the Mental Capacity Act 2005, but had not received any formal training in relation to their responsibilities under this act. They could explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. However, staff were not aware of the Gillick competency and the requirement possibly to treat young people below the age of 16 years, without parental permission, following an assessment of their capacity to provide informed consent. 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. We were informed by the practice, after the inspection, that action had been taken to engage staff in relevant training around this topic.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from eight patients. They described a positive view of the service. The practice had also received some written feedback over the past three years. These sources of information indicated a high level of satisfaction with care.

Staff were mindful about treating patients in a respectful and caring way. For example, the principal dentist described strategies for working with patients who were nervous. They offered to reschedule appointments, or put in place a system of multiple appointments where small amounts of work were carried out, so that they could work at a pace which a nervous patient could manage. This strategy served to increase the patient's confidence in the team by developing a good working relationship over time.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment room was situated on the floor above the waiting room. This meant that conversations between patients and the principal dentist could not be overheard by other people, and thus protected patients' privacy.

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 a locked filing cabinet in the administrative office.

Involvement in decisions about care and treatment

The practice did not publicly display information about the private charges or fees. However, the principal dentist held this information in a printed format which could be shown to patients, on request. Details of fees were also described in letters written to patients prior to complex treatment plans being implemented.

We spoke with the principal dentist and the dental nurse on the day of our visit. They told us they worked towards providing clear explanations about treatment and prevention strategies. The letters written to patients contained explanations about the proposed treatment plans, and included a description of the risks and benefits of any proposed treatments.

The patient feedback we received via comments cards, and through speaking to one of the patients on the day of the inspection, 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' needs. The principal dentist could decide on the length of time needed for their patient's consultation and treatment. They told us they always had enough time available to prepare for each patient. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

There was a practice website which held information about opening hours, the types of services available and the ethos of the practice. The principal dentist told us that new patients were invited to hold preliminary discussions about the services available over the phone, or face to face, prior to commencing with any consultation.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. 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. This had been reviewed on a yearly basis.

The principal dentist told us the service provision was predominantly to an English-speaking population. However, some patients had attended with their own translators, and they could offer to arrange for translation services, if necessary. They were also able to provide large print, written information for people who were hard of hearing or visually impaired. The practice was wheelchair accessible with a lift from the ground floor providing access to the treatment room on the first floor. The principal dentist had also trained in the use of portable ramps and these could be positioned at the entrance to enable wheelchair access, when necessary.

Access to the service

The practice opening hours were from 9.00am to 6.00pm, Monday to Friday.

Staff told us that there were always appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could get an appointment when they needed one. The principal dentist told us that they aimed to respond to their patients' needs in terms of timings of appointments and would arrange to see patients at a time suitable for them.

The principal dentist told us they always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case. The appointment schedules showed that patients were given adequate time slots for appointments of varying complexity of treatment.

Concerns & complaints

There was a notice in the treatment room informing patients that the complaints policy was available for review, on request. We checked the complaints policy. This described how the practice handled formal and informal complaints from patients. There had not been any complaints recorded in the past year. We noted that the policy stated that a record would be kept of what had occurred and actions taken at the time to address the problem; a timeline for responding to complaints was also provided. We reviewed an example of a complaint that had been received three years ago. We noted the practice had responded in line with the policy. Staff told us they discussed complaints as they arose with a view to learning and preventing further occurrences.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements and a management structure. There were also relevant policies and procedures in place. Staff were aware of these policies and procedures and acted in line with them.

However, there were limited arrangements for identifying, recording and managing risks through the use of risk assessments, audits, and monitoring tools. For example, there had been no infection control audit within the past year. Typically infection control audits are completed every six months in order to monitor the effectiveness of infection control protocols with a view to keeping staff and patients safe.

There had also not been an X-ray audit or an audit of the dental care records. This meant that systems for identifying potential problems and concerns were not robust. For example, our check of the dental care records found that recording of the outcomes of assessments, explanations and consent processes were not in line with current good practice guidance.

There was a COSHH file at the time of the inspection, but this had not been kept up to date meaning that the actions needed to minimise the risks associated with hazardous substances had not been disseminated effectively amongst staff. There was also no written recruitment policy. These documents and assessments relate to minimising risk with a view to keeping patients 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. The documents relating to the operation and use of the X-ray equipment had not been kept.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty.

The dental nurse 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 spoke with the principal dentist who outlined the practice's ethos for providing good care for patients. They had a clear ethos about providing high quality and patient-centred care. The dental nurse shared and understood this philosophy.

However, there was no system of staff appraisals to identify career goals and aspirations. The dental nurse also did not have a formal job description or contract to refer to in relation to her employment status.

Learning and improvement

Staff engaged in continuing professional development (CPD), in line with standards set by the General Dental Council (GDC). However, we found that there were not effective systems for improving the quality and safety of the service through a process of reviewing current, relevant good practice guidance or other published safety information. For example, the staff had not kept up to date with guidance issued by National Institute for Health and Care Excellence (NICE) such as those issued in relation to antibiotic prescribing or wisdom tooth extraction.

We also found that there was no 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).

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

The practice gathered feedback from patients in an ad hoc manner both verbally and through letters they had received. The majority of feedback had been positive and did not require further action. Staff feedback was also obtained on an ad hoc basis at daily meetings. A more formal staff meeting with written minutes had also been

Are services well-led?

held in November 2015. This provided staff with an opportunity to review the practice's performance and suggest improvements to the smooth running of the practice.

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 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 not ensured that they had maintained an accurate, complete and contemporaneous record of the care and treatment provided to patients and of the decisions taken in relation to their care and treatment. The provider had also not ensured that their audit and governance systems were effective. Regulation 17 (1) (2) (a) (c) (f)

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 did not provide appropriate appraisal for staff as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)