Mazdak Eyrumlu and Azad Eyrumlu

Vicarage Lane Dental Care

Inspection Report

Vicarage Lane
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Overall summary

We carried out an unannounced comprehensive inspection on 14 November 2016 in response to concerns that were reported to CQC about the essential standards of quality and safety that were not being met. We asked 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

Vicarage Lane is a dental practice providing NHS and private treatment for both adults and children. The practice is located in a residential area in commercial premises in Surrey.

The practice is based at ground floor level and is accessible to wheelchair users, prams and patients with limited mobility. The practice has four dental treatment rooms and a separate decontamination room used for cleaning, sterilising and packing dental instruments.

The practice employs two dentists, one hygienist, two dental nurses of which one is a trainee, one receptionist and a practice manager. The practice manager was on maternity leave and therefore a temporary practice manager had been in post until recently. The temporary practice manager had left the practice within the last week.

The practice's opening hours are 8.45am to 1pm and 2pm to 5.45pm Monday, Tuesday and Thursday, 8.45am to 1pm and 2pm to 6.45pm on Wednesday, 8.45am to 1pm and 2pm to 5pm Friday and 8.45am and 1pm on Saturday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

The registered manager at the time of our inspection was the practice manager and was on maternity leave. A registered manager is a person who is registered with the

Summary of findings

Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We obtained the views of four patients on the day of our inspection. They spoke positively about their experience of the care they received at the practice. They commented that dental treatment was explained to them prior to any treatment being provided. They also mentioned that they had good access to appointments if they were in pain.

Our key findings were:

- Medicines and life-saving equipment was available in accordance with current guidelines but we found that two emergency medicines had passed their expiry date and the storage container of one emergency medicine had a broken seal potentially affecting their effectiveness.
- The practice appeared visibly clean and well maintained.
- Generally, there was appropriate equipment for staff to undertake their duties however staff reported that several items of equipment were broken. Although these issues were raised through the practice manager within the company, staff reported that these issues had not been addressed in a timely manner.
- Although Infection control procedures followed published guidance we found shortfalls in the maintenance of the validation test recording system of the sterilisers and ultrasonic cleaning baths used in the decontamination process.
- Staff we spoke to understood the issues around safeguarding adults and children living in vulnerable circumstances.
- Although documentation was in place for the reporting of untoward incidents in the practice, a recent needle stick injury had not been managed appropriately and we could not find any records pertaining to the injury or how learning from such an injury was shared with the rest of the practice staff.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- Patients could access treatment and urgent and emergency care when required.
- We saw records that showed staff received training appropriate to their roles in the practice.
- Recruitment records we saw did not contain written references prior to staff beginning with the company.
- Although staff we spoke with were committed to providing a quality service to their patients, staff did not feel supported by the various management structures within the company.
- Staff reported that there had been a rapid turnover of staff in the last twelve months including the recruitment of a temporary practice manager. We found that relationships between the temporary manager and staff were strained and this had contributed to the feeling by the staff we spoke with that the practice was not effectively managed.
- Due to the pressure of treating patients, dentists did not have sufficient time to complete clinical records in a contemporaneous manner. Clinical records tended to be completed by the clinicians at the end of the clinical day.
- We found that there were deficiencies in the operation of some clinical governance systems. This included shortfalls in the systems relating to whistleblowing and the monitoring of the expiry dates and condition of medicines used for dealing with medical emergencies in the practice.

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

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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.
- Ensure appropriate systems are in place to meet health and safety regulations with respect to incident and accident reporting and the monitoring of water quality.
- Ensure that dental equipment is properly maintained and repaired in a timely manner.
- Ensure that whistleblowing concerns are appropriately managed.

Summary of findings

- Ensure that dentists have sufficient time to enable them to carry out contemporaneous record keeping with respect to dental care records.
- Ensure the feedback from patients and staff is reviewed and improvements are implemented in response to poor feedback.

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

- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the availability of hearing loops for patients who are hard of hearing.
- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Consider the provision of an external name plate providing details of the dentists working at the practice including their General Dental Council (GDC) registration number in accordance with GDC guidance March 2012.
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely .
- Review the storage of dental materials and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is correctly monitored and recorded.
- Review the storage arrangements for local anaesthetic medicines.
- Review the frequency of audit of infection control procedures in line with current national guidelines HTM 01 05 (national guidance for infection prevention and control in dental practices).

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?

No action

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

The practice had arrangements for essential areas such as infection control, clinical waste control, and dental radiography (X-rays). Medicines and life-saving equipment was available in accordance with current guidelines but we found that two emergency medicines had passed their expiry date and the storage container of one emergency medicine had a broken seal potentially affecting their effectiveness.

Although documentation was in place for the reporting of untoward incidents in the practice, a recent needle stick injury had not been managed appropriately and we could not find any records pertaining to the injury or how learning from such an injury was shared with the rest of the practice staff.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

The staff received professional training and development appropriate to their roles and learning needs.

Are services caring?

No action

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

We obtained the views of four patients on the day of our visit. These provided a positive view of the service the practice provided.

Are services responsive to people's needs?

No action

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in language they could understand and had access to

Summary of findings

telephone interpreter services when required. There were areas where the provider could assist with the needs of the more disabled members of society. Examples included the use of hearing loops for the hard of hearing and providing an emergency pull cord in the patient toilet.

Are services well-led?

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

Although the practice had clinical governance and risk management structures in place there were shortfalls in the system. This included the effective checking of expiry dates of emergency medicines, ensuring equipment is appropriately maintained, the monitoring of water temperatures as part of ensuring the quality of the water systems and ensuring that dentists had sufficient time to maintain contemporaneous clinical records in a timely way. We also found that certain pre-employment checks had not been carried out prior staff commencing employment with the company.

We noted that although there was effective clinical care provided by the clinicians we spoke with working in the practice, the practice would benefit from an empowered and well trained practice manager. This would ensure that the company's governance policies and procedures are effectively delivered.

In addition, the company should ensure that it addresses the concerns raised by patients and staff in an effective and timely manner. This would have the effect of improving staff morale and well-being.

Requirements notice ✖

Vicarage Lane Dental Care

Detailed findings

Background to this inspection

We carried out an unannounced, comprehensive inspection on 14 November 2016 in response to concerns that were reported to CQC about the essential standards of quality and safety that were not being met. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of six members of staff. We also spoke with a company compliance officer and an Area Business Manager.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of four patients on the day of our inspection.

Patients gave positive feedback about their experience 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?

This informed our view of the care provided and the management of the practice.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a policy and an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

A staff member we spoke with described that a recent needle stick injury they sustained had not been managed appropriately. We could not locate any records pertaining to the injury or how learning from such an injury was shared with the rest of the practice staff to avoid recurrences.

Although the company compliance officer told us that practices received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Agency (MHRA), there were no records kept in relation to recent alerts that were pertinent to dentistry that had been issued by MHRA. These included those relating to Automated External Defibrillators, emergency medicines used in dentistry and electrical socket covering devices. We also noted that there did not appear to be an effective system in place for sharing alerts with staff by practice managers such as using regular practice meetings.

Reliable safety systems and processes (including safeguarding)

The practice had a policy and protocol in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. The policy had been reviewed in January 2016. Recruitment records we saw showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice policy file that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.

The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles.

We asked both dentists on duty, how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice generally followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. Instances where this was not possible dentists protected the airway in other ways to prevent a patient inhaling or swallowing a root canal file. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Emergency medicines were available to treat medical emergencies in the dental chair. A laminated sheet containing the expiry dates of the emergency medicines was situated in the room containing the emergency medicines kit but this was not being checked in an effective way because we found that two emergency medicines had passed their expiry date and the storage container of one emergency medicine had a broken seal potentially affecting their effectiveness The company's compliance officer assured us that replacements were ordered on the day of our inspection and would be in place the following day.

The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

Staff recruitment

All staff where appropriate had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that detailed the checks required to be undertaken before a person

started work. For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover and immunisation status and references.

We looked at four staff recruitment files and records confirmed they were not recruited in accordance with the practice's recruitment policy. None of the staff records had evidence of references available for inspection. We were advised that company policy had recently been changed and were assured that under no circumstances would a person be employed without having a reference in place first going forward. However, this did not mitigate for those persons already employed, on the day of our inspection a new member of reception staff was starting their first day.

We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. This included a general practice health and safety risk assessment. A legionella risk assessment had been carried out in April 2015 and was due to be reviewed again in 2017. One of the recommendations from the report, that of regularly testing the water temperatures was not being carried out (Legionella is a term for particular bacteria which can contaminate water systems in buildings).

The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. We noted the environmental cleaning products had not been included.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice that were in line with HTM 01 05 (national guidance for infection prevention and control in dental practices) The practice had in place an infection control policy that was regularly reviewed. We saw records that auditing the quality of infection control procedures was carried out in June 2016. The previous audit was carried out in May 2015. Current guidance recommends audit of infection control procedures should be carried out every six months.

We saw that the four dental treatment rooms in use, waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of all treatment rooms in use were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria they described the method they used which was in line with current HTM 01 05 guidelines.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging of processed instruments. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of manual scrubbing and ultra-sonic cleaning baths for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for

sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

Although there were systems in place to ensure that the autoclaves and ultrasonic cleaning baths used in the decontamination process were working effectively, the recording of the validation tests stopped in October 2016. We pointed this out to the company compliance officer who arranged for new data recording books to be reinstated on the day of our visit.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in two separate yellow bins adjacent to the practice prior to collection by the waste contractor. We did note that one of the yellow bins was not locked although it was in a secure area next to the practice. We did point this out to a member of staff. Waste consignment notices were available for inspection.

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. We did note that a storage cupboard for cleaning equipment and materials including bleach was not secure from unauthorised access by the general public. The company compliance officer informed us that this would be addressed as soon as possible.

Equipment and medicines

Equipment was serviced regularly, for example, the autoclaves and compressor had been serviced and calibrated in 2016 and the practice's X-ray machines had been serviced and calibrated as specified under current national regulations in December 2015. Staff reported that breakdowns of certain equipment such as a faulty X-ray set, ultrasonic scaler and problems with the practice computer system had not been dealt with by the company in a timely manner, after repeated reporting by staff. We also found that the temperature of the fridge used to store various dental materials and one of the emergency medicines was not being maintained within the 2-8-degree Celsius range, the normal parameter for stored materials and medicines.

We noted that batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. We found that these items were not always stored securely. We noted that a box containing packs of anaesthetic was stored in an open room that could be accessed by members of the general public. We informed the company compliance officer who arranged for their removal.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a radiation protection file that contained documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We saw records that showed that auditing of the quality of X-rays taken by dentists working at the practice had been carried out. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for people using best practice

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. Both dentists we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown to us by the dentists demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care.

Both dentists explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

Dental care records we observed demonstrated that the dentists had given appropriate oral health advice to patients.

Staffing

All clinical staff had current registration with their professional body, the General Dental Council.

The dental hygienist did not work with chairside support. We pointed this out to the company's compliance officer and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team' specifically standard 6.2.2 working with other members of the dental team.

Although we saw evidence of an induction and training programme for staff to follow which ensured they were skilled and competent in delivering safe and effective care and support to patients, staff had told us they had not received such a formal induction when they started work.

Working with other services

Dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

Both dentists we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then

Are services effective?

(for example, treatment is effective)

documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options.

The dentists went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed.

They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were not always closed when patients were with one dentist. This meant that a patient's dignity and privacy could not always be preserved. We pointed this out to the dentist concerned.

Patients' clinical records were stored on paper and on computer. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; with paper records stored in an area of the practice not accessible to unauthorised members of the general public.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area.

Both dentists we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on standard private treatment planning forms for dentistry.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

During our inspection, we looked at examples of information available to patients. A practice information leaflet was available but this was on display and freely available to patients in the waiting area. The leaflet explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint.

The practice website was generic and did not provide opening hours and out of hour's information or information about the dental team.

We observed that the appointment diaries provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. We did note that although dentists decided how long a patient's appointment needed to be to take into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment there were some issues. Due to the pressure of time taken to treat patients, dentists did not have sufficient time to complete clinical records in a contemporaneous manner. Clinical records tended to be completed by the clinicians at the end of the clinical day.

Tackling inequity and promoting equality

We asked staff how they would support patients that had difficulty with hearing or vision. They explained how they would face the patient and speak slowly and clearly especially for someone who had hearing difficulties to allow the patient to lip read. Staff told us they would assist a blind patient or any patient who had difficulty with mobility by physically guiding and holding their arm if needed.

The practice had made some adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services. This included a grab rail in the patient's toilet but improvements could be made. The practice did not provide a hearing loop for patients who used a hearing aid but undertook to purchase one. The practice had made provision for patients using wheelchairs. There were parking spaces available in the drive for people using wheelchairs or those with limited mobility. The treatment rooms were all located on the ground floor giving level access.

We asked staff to explain how they communicated with people who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. Staff told us if they were unable to communicate fully with a patient due to a language barrier they could encourage a relative or friend to attend who could translate.

Access to the service

The practice's opening hours are 8.45am to 1pm and 2pm to 5.45pm Monday, Tuesday and Thursday, 8.45am to 1pm and 2pm to 6.45pm on Wednesday, 8.45am to 1pm and 2pm to 5pm Friday and 8.45am and 1pm on Saturday.

We asked staff how patients were able to access care in an emergency or outside of normal opening hours. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed.

Each day the practice was open, emergency treatment slots were made available for people with urgent dental needs. Staff told us patients requiring emergency care during practice opening hours were seen the same day. Patients we spoke to commented that the practice was flexible with arranging appointments.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was a system in place which ensured a timely response.

Are services well-led?

Our findings

Governance arrangements

Although the practice had clinical governance and risk management structures in place there were shortfalls in the system. This included maintaining accurate records and responding to incidents appropriately, the effective checking of expiry dates of emergency medicines, ensuring equipment is appropriately maintained, the monitoring of water temperatures as part of ensuring the quality of the water systems and ensuring that dentists had sufficient time to maintain contemporaneous clinical records in a timely way. We also found that pre-employment checks such as references had not been carried out prior to staff commencing employment with the company.

Leadership, openness and transparency

Staff reported that there had been a rapid turnover of staff in the last twelve months including the recruitment of a temporary practice manager. We found that relationships between management and staff were strained and this had contributed to the feeling by the staff we spoke with that the practice was not effectively managed. These factors had contributed to the failings we observed in the governance systems operated by the practice.

We noted that although there was generally effective clinical care provided by the clinicians we spoke with; the practice would benefit from an empowered and well trained management structure. This would ensure that the company's governance policies and procedures are effectively delivered.

In addition, the company should ensure that it addresses the concerns raised by staff in a more effective and timely manner. This would have the outcome of improving staff morale and well-being.

Learning and improvement

We saw evidence of systems to identify staff learning needs; this included an appraisal system and several clinical audits. With respect to clinical audit, we saw results of audits in relation to clinical record keeping and the quality of X-rays which demonstrated that good standards were being maintained. These contained an analysis of the findings by the Clinical Support Manager. They would then provide useful hints and tips as to how the dentists could improve their standards. Each dentist was also given a red, amber or green rating of their records. The system in place ensured that any dentist rated red would be invited to discuss the findings with the company Clinical Director who would then arrange for further training or support.

Staff working at the practice were responsible for maintaining their continuing professional development as required by the General Dental Council.

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

The practice gathered feedback from patients on an ongoing basis through patient questionnaires left in the waiting area. We reviewed some of the comments left. Patients had commented that they waited passed their appointment times and staff did not apologise. Patients had commented that staff were sometimes abrupt in the way they spoke to patients.

The practice was listed on NHS Choices website and patient feedback was mixed with positive and negative comments. The practice had responded to the feedback. They were unable to explain where improvements had been made in response.

Staff we spoke to told us that due to dental equipment issues appointments were sometimes being cancelled at short notice. This was causing a strain on the appointment books and as result patients were complaining.

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 in place to:** • Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). **For example; a recent needle stick injury had not been managed appropriately and we could not find any records pertaining to the injury or how learning from such an injury was shared with the rest of the practice staff.** • Assess, monitor and mitigate the risks relating to the health, safety and welfare of staff and patients who may be at risk which arise from the carrying on of the regulated activity. **For example; two emergency medicines had passed their expiry date and the storage container of one emergency medicine had a broken seal potentially affecting their effectiveness, the temperature of the fridge used to store dental materials and one of the emergency medicines was not being maintained within the 2-8-degree Celsius range, the recruitment processes for staff also need to include reference checks and the recommendations from the Legionella risk assessment report, that of regularly testing the water temperatures was not being carried out.**

This section is primarily information for the provider

Requirement notices

- Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

For example; staff reported that issues around faulty equipment that had been reported to management had not been addressed in a timely manner and complaints reported by staff under the whistle blowing policy were not being followed up as per the company policy.

Regulation 17 (1) (2) (a)(b)(d (i)(e)(f))