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Bearwood Dental Care

Inspection Report

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Overall summary

We carried out this announced inspection on 14 January 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

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

Bearwood Dental Care is in Smethwick and provides private treatment to adults and children.

There is ramped access for people who use wheelchairs and those with pushchairs. Two car parking spaces are available at the front of the practice and parking is also available on local side roads.

The dental team includes two dentists, three trainee dental nurses, one qualified dental nurse – (the practice manager) and one dental hygiene therapist. The practice has two treatment rooms.

Summary of findings

The practice is owned by an individual who no longer undertakes any clinical work at the practice. Providers who are individuals who will not be in day-to-day charge of carrying on the regulated activity must have a registered manager in respect of the regulated activities carried on at each location. At the time of inspection there was no registered manager in post as required as a condition of registration. A registered manager is legally responsible for the delivery of services for which the practice is registered

On the day of inspection, we received feedback from 12 patients.

During the inspection we spoke with two dentists, (including the principal dentist) two dental nurses, one dental hygiene therapist, and the practice manager. We looked at practice policies and procedures and other records about how the service is managed. The registered provider attended the practice at the start of the inspection to introduce themselves to the inspection team.

The practice is open: Monday and Tuesday 9.30am to 8pm, Wednesday to Friday 9.30am to 5pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance. Staff were not always working in accordance with these.
- Staff knew how to deal with emergencies. The majority of appropriate medicines and life-saving equipment were available. Missing items were purchased on the day of inspection.
- The practice had systems to help them manage risk to patients and staff although improvements were required.
- Improvements were required with the servicing and maintenance of X-ray equipment. The provider had not registered correctly with the Health and Safety Executive.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures. The practice did not have proof that two staff were adequality protected against the risk of hepatitis B and there was no risk assessment in place regarding this.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs. The practice provided extended opening hours two days per week and were accommodating to patients' needs at other times.
- Staff worked well as a team.
- The provider asked patients for feedback about the services they provided.
- The provider had systems in place to deal with complaints positively and efficiently.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulation the provider is not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review the providers registration conditions to ensure the regulated activities at Bearwood Dental Care are managed by an individual who is registered as a manager.
- Review the practice's systems for checking and monitoring equipment taking into account relevant guidance and ensure that all equipment is well maintained. In particular implement systems to monitor the practice's autoclave to ensure that it is working within the correct parameters. Implement systems to ensure that the practice's emergency lighting and equipment used to monitor blood pressure of patients who were undergoing sedation is subject to regular servicing and maintenance.

Summary of findings

- Review staff awareness of the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's current performance review systems and have an effective process established for the on-going assessment and supervision of all staff.
- Review the practice's protocols for completion of dental care records taking into account the guidance provided by the Faculty of General Dental Practice.

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.

Systems were in place to enable them to use learning from incidents and complaints to help them improve although we were told that there had been no incidents or significant events at the practice.

The practice completed essential recruitment checks although we noted that hepatitis B titre levels were not recorded for two members of staff.

Premises and equipment were clean and properly maintained, some improvements were required regarding maintenance of equipment. There was no evidence that emergency lighting had been serviced. We were told that staff were completing visual checks of portable electrical appliances but there was no evidence to demonstrate this.

We were not provided with evidence to demonstrate that X-ray equipment was appropriately serviced or maintained and the practice had not registered the correct address with the Health and Safety Executive regarding the use of X-ray equipment. Dispensing labels on medicines did not record the address of the practice.

The practice followed national guidance for cleaning, sterilising and storing dental instruments. Staff were using foaming disinfectant whilst scrubbing used dental instruments. Non-foaming solution was purchased immediately following this inspection. Waste was stored in an area that was cluttered and presented a trip hazard.

The practice had suitable arrangements for dealing with medical and other emergencies. Items missing from the medical emergency kit were purchased on the day of inspection. Staff had received training in basic and immediate life support on an annual basis.

There was no evidence that the trainee dental nurse who supported the dentist whilst placing dental implants had received any training regarding this. We were told that this staff member had completed in-house training but there was no evidence of this training on file. One member of staff was overdue to complete training regarding safeguarding. We were not shown evidence to demonstrate that the principal dentist had completed the required number of hours of continuous professional development regarding Ionising Radiation (Medical Exposure) Regulations (IRMER).

Are services effective?

No action

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

Summary of findings

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as professional. We were told that the dentists discussed treatment with patients so they could give informed consent. Patients dental care records that we saw did not record that verbal consent was obtained on each occasion.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The provider supported staff to complete training relevant to their roles and had systems to help them monitor this. A compliance system in place at the practice recorded staff training and was used as a tool to help ensure staff training was kept up to date.

Are services caring?

No action

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

We received feedback about the practice from 12 people. Patients were positive about all aspects of the service the practice provided. They told us staff were pleasant, approachable and caring.

They said that they were given detailed, helpful, explanations about dental treatment and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist. The practice offered sedation for those patients who were extremely anxious about receiving treatment at a dental practice.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

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 practice's appointment system took account of patients' needs. Extended opening hours were provided two days per week. Staff told us that the practice was flexible and staff would stay later than the advertised opening hours to accommodate patient's needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for patients with a disability and families with children. Step free access was provided to the practice and one of the treatment rooms was located on the ground floor. The practice had access to telephone and face to face interpreter services but had not used these recently. Staff were aware of patient's individual communication needs and felt that these were met. The practice did not have a hearing loop but currently staff felt that this was not required.

Summary of findings

The practice took patients views seriously. They valued compliments from patients and had systems in place to respond to concerns and complaints quickly and constructively.

Are services well-led?

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

The practice had some arrangements to ensure the smooth running of the service although these were not always effective. For example, the practice kept a log of all emergency medical equipment; we identified that some items of equipment were missing, the checklist was therefore not effective. The practice was not operating systems to ensure that all equipment was in good working order; staff were not downloading information from the autoclave data logger. A new data logger was to be fitted and staff were to be trained in its use. Blood pressure monitoring equipment was not subject to routine servicing. Emergency lighting was not being serviced.

The practice manager held the majority of lead roles and was responsible for all out of hours contact with patients who required an urgent appointment. The registered provider did not work at the practice and there was no registered manager responsible for the day to day running of the practice.

The practice team kept patient dental care records which were, clearly written or typed and stored securely. Information regarding treatment options and the risks and benefits of the treatment were not always recorded. Evidence that verbal consent had been obtained was not always recorded in patient dental care records.

The principal dentist monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients. Not all of the audits seen contained action plans or evidence of resulting improvements. The infection prevention and control audit was not being completed on a six-monthly basis and the practice had not completed and audit regarding sedation.

Requirements notice ✖

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse of adults or children. This also included information for staff regarding adults that were in other vulnerable situation such as those who have experienced modern-day slavery or female genital mutilation. The practice manager had also completed training regarding this. We saw evidence that staff received safeguarding training. The practice manager was the lead for safeguarding and had completed higher level training. One member of staff was overdue to complete safeguarding training according to the practice's training matrix. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC. A safeguarding flow chart for reporting suspicions of abuse was available in the patient information folder in the waiting area. A copy of this was also available in various other places throughout the practice for staff to review as necessary.

The practice had a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy. Staff could report concerns to an external organisation if they did not wish to speak to someone connected with the practice. Contact details for this organisation were detailed in the whistle blowing policy. Staff did not always feel confident they could raise concerns without fear of recrimination.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. The practice did not have a supply of non-latex dental dam kits. The practice manager told us that these would be purchased immediately. Following this inspection, we were sent evidence that these had been purchased.

The practice had a recruitment policy, a separate advice sheet was available regarding pre-employment checks to be completed. Information recorded was in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These helped the practice employ suitable staff. We looked at three staff recruitment records. These showed the practice followed their recruitment procedure.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice had some systems to ensure that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, although some improvements were required.

A fire risk assessment had been completed by an external company in February 2018. Records showed that fire detection equipment, such as smoke detectors, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced.

We were shown evidence to demonstrate that staff had completed fire safety training. Fire drills had been completed in October 2017 and February 2018. We were not shown records of any fire drills since that date. There were no records available to demonstrate that emergency lighting was subject to routine maintenance and testing. Although records were available to demonstrate that daily, monthly, six monthly and annual checks were completed of fire safety systems. A fire safety audit check sheet had been completed in April 2018 to review fire safety systems in place.

We saw evidence that electrical wiring had been checked in 2016 as part of a five-year fixed wiring check and that gas safety checks had been completed in January 2019. The practice was awaiting a copy of the gas safety certificate. We were not sent a copy of this certificate following this inspection.

Records were available to demonstrate that an external professional had completed annual checks of portable electrical appliances until 2017. The practice had

introduced a new system whereby staff visually checked portable electrical appliances annually, and an external professional completed checks every three years. We were told that records were not kept demonstrating the completion of visual checks, however the practice risk assessment recorded that these checks were to be completed. The practice manager confirmed that they would record details of the checks completed on the practice risk assessment which was reviewed on an annual basis. A list of all equipment to be checked was to be kept with the risk assessment.

The practice did not have suitable arrangements to ensure the safety of the X-ray equipment. Copies of the local rules kept in the radiation protection file had not been fully completed and those seen on display in dental treatment rooms were also not fully completed.

There was no documentary evidence to demonstrate that the practice was carrying out simple in-house function checks on X-ray equipment. There was no evidence of three yearly assessments being completed for the intra-oral X-ray machines.

X-ray equipment was not fitted with a rectangular collimator. Rectangular collimation is good practice as it reduces the radiation dose to the patient.

We saw that the practice had registered with the Health and Safety Executive (HSE) regarding the use of ionising radiation. The address details given to the HSE were incorrect and therefore their certificate incorrect.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation.

We did not see evidence to demonstrate that the principal dentist had completed a sufficient number of hours of continuing professional development (CPD) in respect of Ionising Radiation (Medical Exposure) Regulations (IRMER).

Risks to patients

There were systems to assess, monitor and manage risks to patient safety although these were not effective.

The practice's health and safety policies, procedures and risk assessments were reviewed regularly to help manage potential risk. We saw a sample of risk assessments in place. For example, risk assessments were available regarding display screen equipment, pregnant mothers, dental nurses and the dental surgeon.

The practice had current employer's liability insurance dated April 2018.

We looked at the practice's arrangements for safe dental care and treatment. The staff did not always follow relevant safety regulation when using needles and other sharp dental items. Staff were not using safer sharps and there was no re-sheathing device available at the practice. A sharps risk assessment had been undertaken and was updated annually. This did not record details of all sharps equipment in use at the practice. Following this inspection, we were sent information to demonstrate that the practice had purchased an appropriate device for the re-sheathing of used needles for each treatment room.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. The practice did not have proof that two staff were adequality protected against the risk of hepatitis B. There was no risk assessment regarding non-immunised or non-responder staff for these two members of staff.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. Immediate Life Support training for sedation was also completed by all staff at the practice.

The majority of emergency equipment and medicines were available as described in recognised guidance. We found that the practice did not have a size one oropharyngeal airway and there were no clear face masks for self-inflating bags. We were told that the missing items would be ordered immediately. Following this inspection, we were sent evidence that these items had been ordered. The systems in place to monitor and record checks of these to make sure these were available, within their expiry date, and in working order was ineffective as not all required medical emergency equipment was recorded on the checklist.

Are services safe?

We discussed sepsis management and identified that sepsis management had not been discussed at a clinical meeting. There was no system in place to enable assessment of patients with presumed sepsis in line with National institute of Health and Care Excellence guidance.

A dental nurse worked with the dentists and the dental hygiene therapist when they treated patients in line with GDC Standards for the Dental Team.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. A file was available recording details of all hazardous substances in use at the practice with supporting risk assessments. Product safety data sheets were not available and we were told that these were not available. The practice manager confirmed that this information would be obtained immediately. Following this inspection, we were sent evidence to demonstrate that product safety data sheets had been obtained.

The practice had an infection prevention and control policy and procedures although some improvements were required to ensure they followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care. Infection prevention and control training had recently been provided by an external professional. We were told that staff also received in-house updates and completed on-line training as required.

Some minor improvements were required to the practice's arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. For example, we saw that the practice was using a foaming solution when initially scrubbing instruments during the decontamination process. Following this inspection, we were sent evidence to demonstrate that the practice had purchased non-foaming cleaning solution.

The practice were using metal three in one tips which were difficult to clean due to the narrow lumen. HTM01-05 states that where instruments are difficult to clean, consideration should be given to replacing them with single-use instruments where possible. Following this inspection, we were sent evidence to demonstrate that new disposable three in one tips had been purchased.

The records showed equipment used by staff for cleaning and sterilising instruments was maintained in line with the manufacturers' guidance. Staff were not downloading information from the autoclave's data logger. Staff were using time, steam, temperature (TST) strips during the first cycle of use of the autoclave but not thereafter. Without information provided by the data logger or TST strips the practice were not able to demonstrate that the autoclave was working in accordance with the manufacturers requirements on all occasions. Following this inspection, we were sent evidence to demonstrate that a new data logger had been purchased and was to be fitted on 18 January 2019. Staff were to be trained on its use at this time.

The practice had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management were in place.

We saw cleaning schedules for the premises. Practice staff were responsible for cleaning all areas used by the dental practice including corridors, waiting area and toilets. The practice was visibly clean when we inspected. Patients reported that the practice was visibly clean.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance although staff were not working in accordance with these on each occasion. We saw that the area used to store clinical waste was cluttered with items such as ladders and chairs and presented a trip hazard. The principal dentist confirmed that this area would be cleared immediately.

We were shown copies of the infection prevention and control audits for March 2018 and January 2019. There was no evidence that the practice carried out infection prevention and control audits twice a year. The latest audit showed the practice achieved a score of 88.2%. We were not shown any evidence of the resulting improvements.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Are services safe?

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required

Some improvements were required to the practice's systems for appropriate and safe handling of medicines. For example, not all antibiotics dispensed from the practice were in original manufacturer's packaging. Patient information leaflets were therefore not always available. Appropriate dispensing information was not recorded on dispensing labels. Following this inspection, we were sent a copy of a newly developed label. This did not record sufficient information as the address of the practice was not recorded. We saw evidence that antibiotics had been purchased in sufficient amount to enable dispensing in original packaging. The dentist we spoke with was not aware of the current guidance on antibiotic prescribing.

Track record on safety and Lessons learned and improvements

The practice had developed some risk assessments in relation to safety issues. Systems were in place to monitor and review incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

There were adequate systems for reviewing and investigating when things went wrong. Incident log forms were available for use as required. In the previous 12 months there had been no safety incidents.

There was a system for receiving and acting on safety alerts. These were received at the practice via the practice's compliance system. The practice manager also received these alerts and printed off copies of alerts to be discussed with staff as appropriate. The practice learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep dental practitioners up to date with current evidence-based practice. We saw that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice offered dental implants. These were placed by the principal dentist who had undergone appropriate post-graduate training in this speciality. The provision of dental implants was in accordance with national guidance. A trainee dental nurse assisted the dentist during implant procedures. We were told that this nurse had completed in-house training, there was no documentary evidence on file to demonstrate this.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. Staff told us that they had a focus on providing preventative care for patients.

The dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children and adults based on an assessment of the risk of tooth decay.

The dentists and dental hygiene therapist where applicable, discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health. We were told that information was also given to patients verbally and models were used to demonstrate oral hygiene techniques. Advice was available on the practice's website about tooth discolouration, gum disease, enamel erosion amongst other things.

The practice was aware of national oral health campaigns and local schemes in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary. The dental hygiene therapist had visited a local school and children's club to provide a presentation to the children regarding oral health and hygiene. The practice was introducing a patient's noticeboard which would provide information regarding oral health and hygiene.

The dentist and dental hygiene therapist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition

Patients with more severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

We were told that the practice obtained consent to care and treatment in line with legislation and guidance. The practice team understood the importance of obtaining and recording patients' consent to treatment. Patient dental care records that we saw did not always record that verbal consent had been obtained. Evidence that dentists gave patients information about treatment options and the risks and benefits of these was not always recorded in patient dental care records. Without this information it would be difficult for patients to make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment. We were told that patients were always given a copy of their treatment plan.

We saw that most staff had completed training regarding the Mental Capacity Act. However, not all staff showed a thorough understanding of the Mental Capacity Act and Gillick competence guidelines, and how they might impact on treatment decisions. The practice manager confirmed that this would be discussed at a practice meeting to update

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed

Are services effective?

(for example, treatment is effective)

patients' treatment needs in line with recognised guidance. Information about treatment options and the risks and benefits of the treatment were not always recorded in patient dental care records.

We saw the practice audited patients' dental care records to check that the dentists/clinicians recorded the necessary information. There was no action plan or evidence of progress to address issues identified.

The practice carried out conscious sedation for patients who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The staff assessed patients appropriately for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history, blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines.

The records showed that staff recorded important checks at regular intervals. These included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. We were not shown evidence to demonstrate that the blood pressure monitor had been subject to routine servicing.

The operator-sedationist was supported by a trained second individual. The name of this individual was recorded in the patients' dental care record.

Effective staffing

Staff new to the practice had a period of induction based on a structured programme. Staff told us that their induction training included an orientation to the practice, reading policies and procedures, shadowing senior staff and observations of their working practice by senior staff. An employee handbook was made available to staff during their induction and staff sign to confirm that they had read this. Clinical staff confirmed that they completed the continuing professional development required for their registration with the General Dental Council.

Staff discussed their training needs at annual appraisals. We saw evidence of completed appraisals these did not record how the practice addressed the training requirements of staff. Appraisal documentation had not been signed by the appraisee.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice also had systems for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Staff said that they took their time, listened to patients and always chatted to them to make them feel at ease.

Staff were aware of their responsibility to respect people's diversity and human rights. Patients commented positively that staff were professional, approachable and caring. We saw that staff treated patients respectfully and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. Comments received from one patient was that the treatment was professional and diminished their nerves about going to the dentist. Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

A patient information folder and thank you cards were available in the waiting area for patients to read.

Staff made follow up telephone calls to patients the day following any complex treatment.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided limited privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff would take them into another room. There was a television in the waiting room for patients to watch whilst waiting to see the dentist and radios played music in each treatment room. Staff said that they would offer to make a drink for a patient if the dentist was delayed for any reason. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

All consultations were carried out in the privacy of the treatment room and we noted that doors were closed during procedures to protect patients' privacy.

Closed circuit television (CCTV) cameras were in place to help monitor security at the practice. A sign was on display advising patients that CCTV was in use at the practice.

Involving people in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and were aware of the requirements under the Equality Act:

- Interpretation services were available for patients who did not speak or understand English this could be over the phone or face to face if arranged in advance. Some staff at the practice were multi-lingual and able to speak Russian, Polish, Punjabi and Hindi.

Staff communicated with patients in a way that they could understand. Information could be made available in larger print for those patients with sight impairment and could be printed off in languages other than English if requested. The practice did not have a hearing induction loop but staff were able to communicate by writing information down or patients could bring an interpreter with them.

The practice gave patients clear information to help them make informed choices about their treatment. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. Patient dental care records that we saw did not always record treatment options or the risks and benefits of treatment. Reception staff confirmed that they always checked to ensure that patients understood their treatment options and referred them back to the dentist if they raised any queries.

The practice's website provided patients with information about the range of treatments available at the practice. Information leaflets and posters were also available in the practice waiting room.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example photographs, models, videos and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences. There was a ground floor treatment room for patients who were unable to use the stairs. Extended opening hours were available two days per week until 8pm for patients who found it difficult to attend the practice during normal working hours. Staff said that they were flexible and would always try to fit a patient in for an appointment often staying open later than advertised to accommodate patient's needs.

Staff were clear on the importance of emotional support needed by patients when delivering care.

A note was put on the records of patients who were anxious to alert the dentist. Staff said they chatted to anxious patients to try and calm their nerves. We were told that longer appointments could be given to these patients if required. Patients could bring a friend or relative with them to their appointment. Reception staff said that anxious patients who found it unsettling to wait in the waiting room before an appointment could be given an appointment at less busy times of the day. For example, first thing in the morning or the first appointment after lunch. Patients who were extremely anxious were offered sedation.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had made reasonable adjustments for patients with disabilities. This included step free access, a ground floor treatment room and a ground floor toilet, although this toilet did not have hand rails or a call bell.

We were told that there was no hearing loop or magnifying glass but staff could communicate with patients by writing down information or patients were able to bring an interpreter with them. Information could be made available in large print. The practice had a clinipad for recording medical history and consent. Staff assisted patients to complete this information if required.

The practice offered patients private payment plans to help spread the cost of dental treatment. Costs of treatment were on display in the waiting room and were available on the website.

The front door to the practice was locked as a security measure. A buzzer alerted staff that someone required entry to the practice.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it on their website.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients had enough time during their appointment and did not feel rushed. Patients could book appointments via the practice website and those who had consented received a text message reminder of their appointment. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The staff took part in an emergency on-call arrangement with dentists working at the practice.

The practice's website and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. The practice manager was the out of hours contact for patients who requested an emergency appointment when the practice was closed. We were told they would triage the call and make the decision when an appointment was required. Patients would either receive an immediate appointment or would be seen at the practice the following morning dependent upon the severity of their symptoms. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment. The practice asked patients for feedback about access to the service. Responses seen were positive.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and had systems in place to respond to them appropriately to improve the quality of care. Staff had completed complaint handling training.

The practice had a policy providing guidance to staff on how to handle a complaint. A copy of the complaint policy was accessible to patients in the patient information folder kept in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

The practice manager was responsible for dealing with complaints. Staff would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice manager aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We were told that the practice had not received any complaints within the last 12 months.

We saw that complaints were a standard agenda item for discussion at practice meetings. This would include discussions regarding any complaints received and policies and procedures.

Are services well-led?

Our findings

Leadership capacity and capability

The provider who was registered with the Care Quality Commission owned the premises but did not work or provide dental treatment at this practice. The providers Statement of Purpose recorded that they would spend 30% of their time at this dental practice. We were told that the provider rarely attended the dental practice. Providers who are individuals who will not be in day-to-day charge of carrying on the regulated activity must have a registered manager in respect of the regulated activities carried on at each location. The principal dentist was in day to day charge of the practice with support provided by the practice manager. There was no registered manager in post.

Staff told us that the practice manager was approachable and supportive.

Culture

The practice had a culture of high-quality care. Staff stated they worked hard and focused on the needs of patients. We were told that the needs of patients were always the top priority and staff would work late to accommodate patients, often working outside of the advertised opening hours. Staff said that they worked well as a team.

The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Formal practice meetings were held monthly. The practice manager devised an agenda and staff could add items for discussion. Staff could speak out during these meetings or raise concerns with the practice manager at any time.

Governance and management

A compliance system had been purchased and was recently introduced at the practice. This supported the system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. Staff were converting all previous information from old policies to the new system and getting used to the new system.

Improvements were required to governance arrangements as risks were not being effectively identified or addressed. For example, the sharps risk assessment did not include information on all sharps objects in use at the practice. Rectangular collimators were not available on X-ray machinery; there was no evidence of appropriate servicing or maintenance of X-ray machinery, the practice had not appropriately registered for the use of X-ray equipment with the Health and Safety Executive. Emergency lighting was not being serviced. Product safety data sheets were not available for all hazardous substances in use at the practice, these were provided following this inspection. Infection prevention and control audits were not being completed on a six-monthly basis. There was no audit regarding sedation. There was no evidence in the radiography and dental care records audits of improvement actions taken following these audits.

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. Most staff had completed information governance training.

Engagement with patients, the public, staff and external partners

The practice involved patients to support high-quality sustainable services.

The practice used patient surveys and verbal comments to obtain staff and patients' views about the service. Patients were also asked if they would leave reviews and testimonials on the practice website and via social media. We saw that positive feedback had been recorded in patient surveys and in testimonials on the practice website.

The practice gathered feedback from staff through meetings and informal discussions. Formal practice meetings were held approximately once per month. Separate nurses' meetings were held to discuss issues specific to dental nursing. Informal meetings were held daily to discuss the day ahead and any information that should be bought immediately to the attention of staff. We were told that the minutes of any formal meetings were circulated to all staff.

Continuous improvement and innovation

Are services well-led?

The practice had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. Infection prevention and control audits were not being completed on a six-monthly basis. All the audits seen had clear records of the results, but some did not have action plans and we were not shown evidence to demonstrate that the required improvement actions had been implemented. The practice had not completed a clinical audit regarding sedation.

The whole staff team had annual appraisals. Some improvements were required to the system in place. We were shown a single page document which recorded grades that the appraisee and appraiser had completed. There was no additional information or comments recorded and the document had not been signed by the appraisee or appraiser. We saw another appraisal document which recorded more information and had been signed by the person completing the appraisal but not by the appraisee. The practice manager agreed that this documentation required review and confirmed that this would be amended as soon as possible.

Staff completed most of the 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. We were not shown evidence to demonstrate that the trainee nurse who assisted the dentist whilst implants were placed had received any specific training. We were told that in-house training had been completed. We were not shown evidence to demonstrate that the principal dentist had completed the required amount of continuous professional development regarding the Ionising Radiation (Medical Exposure) Regulations (IRMER).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: There was no evidence of three yearly assessments of X-ray machinery. Local rules had not been fully completed. The blood pressure monitor had not been subject to routine servicing. Appropriate dispensing information was not recorded on dispensing labels. Not all staff were aware of the current guidance on antibiotic prescribing. There was no system in place to enable assessment of patients with presumed sepsis in line with National institute of Health and Care Excellence guidance. Sepsis management had not been discussed at a clinical meeting. Regulation 12(1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk

The provider's sharps risk assessment did not include details of all sharp instruments in use at the practice.

Infection prevention and control audits were not completed on a six-monthly basis. The practice had not completed an audit regarding sedation. Some of the audits dental records and radiography audits seen contained action plans but there was no evidence that actions had been taken to address issues identified.

There was additional evidence of poor governance. In particular:

The provider did not have assurances that all clinical staff had immunity against vaccine preventable infectious diseases.

Regulation 17(1)