

Ringway Dental Care Limited

Ringway Dental Care

Inspection Report

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Overall summary

We carried out this announced inspection on 18 December 2018 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 not 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

Ringway Dental Care is in Heald Green, Stockport, Cheshire and provides private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs. Some car parking spaces are available immediately outside the practice, with additional street parking near the practice.

The dental team includes a principal dentist, a visiting dental implantologist, two dental nurses and a receptionist. The practice has two treatment rooms.

Summary of findings

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Ringway Dental Care is the principal dentist.

On the day of inspection, we collected 12 CQC comment cards filled in by patients. All feedback was positive.

During the inspection we spoke with the principal dentist, two dental nurses and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday and Tuesday from 8.30am until 5.00pm, Wednesday 11am until 7.00pm, Thursday 8.30am until 6.30pm and on Friday 9.00am until 3.00pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance. However, staff were not following manufacturer instruction when using products to clean dental unit water lines.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available but some of this required separating from medicines and appliances that were out of date or redundant so not suitable for use.
- Systems to help manage risk to patients and staff required review, risk assessments for management of legionella, for management of radiation equipment and for conducting efficacy testing on dental instruments that had been through the decontamination process.
- The provider had suitable safeguarding processes and staff knew their responsibilities for safeguarding vulnerable adults and children. Training for some staff and policies required updating.
- The provider had staff recruitment procedures clearly outlined in their recruitment policy but these were not always followed.
- Other areas of recommended training for some staff required updating.
- 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.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided.
- The provider dealt with any complaints or concerns raised positively and efficiently.
- The provider had information governance arrangements in place but these required review.

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.

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

- Review the practice's protocols and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. This includes making the required declaration to the Health and Safety Executive, confirming that all equipment is being used safely and in accordance with the regulations.
- Review the practice's protocols for medicines management and ensure all medicines are stored, prescribed and dispensed of safely and securely. This includes disposing of safely, any medicines that are out of date, and the prescribing of medicines in accordance with latest recognised guidance.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

The practice had some systems and processes in place to provide safe care and treatment. Some of these required review, for example the local rules in respect of radiation and X-ray equipment, the radiation protection information available to staff using X-ray equipment and legionella risk assessments.

Staff used learning from incidents and complaints to help them improve.

Staff received training in safeguarding people and knew how to recognise the signs of abuse and how to report concerns. Training for some staff required updating, and the policies staff referred to required updating and customising for the practice.

Staff were qualified for their roles and the practice had completed some essential recruitment checks for most of the staff, for example Disclosure and Barring Service (DBS) checks were in place. However, references, proof of address and evidence of immunity to blood borne diseases, for example Hepatitis B, was not in place for all staff.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments. We noted that staff were not carrying out protein residue testing on instruments that had been cleaned, before placing in the autoclave. Staff were not following manufacturer's instructions when using products for the flushing of dental unit water lines.

The practice had suitable arrangements for dealing with medical and other emergencies.

There was no effective system in place to receive and share alerts and updates, for example, from the Medicines and Healthcare Products Regulatory Agency (MHRA), or from the National Institute for Health and Care Excellence (NICE).

Requirements notice



Are services effective?

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

No action



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 excellent, very good and personalised. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

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. Systems to help them monitor this could be improved.

Are services caring?

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 kind, patient and understanding if they were nervous about treatment.

They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that staff made them feel at ease, especially when they were anxious about visiting the dentist.

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

No action



Are services responsive to people's needs?

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. 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. The practice had access to telephone interpreter services if required.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

No action



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. There were areas where this could be improved.

Staff felt supported and appreciated.

Requirements notice



Summary of findings

Governance overall required improvement. We found the system in place to monitor staff training was not effective; several staff required refresher training in key areas, for example, safeguarding. Staff had not received Caldecott training, training on the Mental Capacity Act and Gillick competence.

There were no local rules in place for the X-ray equipment at the practice. There was no radiation protection file available for staff to refer to. The casing on one of the X-ray sets was damaged, although this surgery was not being used at the time we inspected.

The legionella risk assessment for the practice had been carried out, but none of the action points had been addressed. A new assessment was being undertaken due to changes to the facilities in the practice. This was not available to us at the time of our inspection. Overall, staff knowledge on the importance of flushing lesser used water outlets and temperature testing, in relation to management of legionella, could be improved.

Review of antibiotic usage showed some prescribing that appeared to be outside of recognised guidance. There was no audit of X-rays undertaken.

There was no system in place within the practice to routinely receive, share and discuss alerts from the Medicines and Healthcare Regulatory Agency, or updates on guidance from National Institute of Health and Care Excellence. Staff had not made checks to see if the battery in the practice defibrillator, was affected by a recent manufacturer recall. The practice provided assurances following inspection, that the battery in the defibrillator was not included in a batch that was subject to manufacturer recall.

Some essential recruitment checks were not in place for all staff. For example, we saw that for some staff there was no references, proof of address and evidence of immunity to blood borne diseases, for example Hepatitis B.

The practice team kept complete patient dental care records which were clearly typed and stored securely.

The provider asked for and listened to the views of patients and staff.

Are services safe?

Our findings

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

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. We saw evidence that staff received safeguarding training but for some staff this required updating. The lead on safeguarding was the principal dentist, whose training for this was in 2011 and had not been refreshed since then. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

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 felt confident they could raise concerns without fear of reprimand.

The dentists used dental dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record and a risk assessment completed.

The provider had a business continuity plan describing how they would deal with events that could disrupt the normal running of the practice.

The practice had a recruitment policy and procedure to help them employ suitable staff and had checks in place for any agency and locum staff. We looked at four staff recruitment records. These showed the practice did not always follow their recruitment procedure. We found there were no checks on proof of address for staff and for two staff members there was no evidence of references being sought.

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

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice had some arrangements to ensure the safety of the X-ray equipment. However, there was no radiation protection file in place for equipment in either of the two surgeries. There were no local rules in place for each of the two X-ray sets. We did see evidence of servicing and testing, which was performed annually. The equipment had been critically examined at the site it was at previously, but there was no evidence of this having been done when it was moved to the new practice premises.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice had not carried out radiography audits, in line with current guidance and legislation.

Clinical staff had completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

The practice's health and safety policies, procedures and risk assessments were reviewed to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated.

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, and that the effectiveness of the vaccination was checked.

Are services safe?

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. We saw evidence of the dentist having attended this training. We were told that staff had attended at the same time as the dentist but evidence of this was not present at the time of our inspection.

Emergency equipment and medicines were available. We found redundant equipment that made essential items of emergency kit less accessible. We found out-of-date medicines, for example adrenaline pens used for the treatment of anaphylaxis, antihistamines, used for treatment of allergic reactions and diazepam, a sedative. We found the automatic external defibrillator was a make and model that was subject to a recent recall. Staff had not made checks to see if the serial number of the battery in this device was affected. Following inspection the practice provided confirmation that the battery in the defibrillator was not included in a batch that was subject to a manufacturers product recall.

A dental nurse worked with the dentists 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.

The practice had an infection prevention and control policy and procedures. 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. Staff had completed infection prevention and control training but updates to this training were not being provided as required, for example, at least every five years.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated and maintained in line with the manufacturers' guidance. We saw that staff were not following manufacturer's instructions on products used for the flushing of dental unit water lines. Weekly protein residue tests were not being performed on instruments cleaned, to check that equipment used was functioning correctly.

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 commissioned a risk assessment which detailed procedures to reduce the possibility of legionella or other bacteria developing in the water systems. We saw that recommendations had not been actioned. Records of water testing and dental unit water line management were in place, but products used for the flushing of dental unit water lines were not being used in line with manufacturer instructions. Due to further development of facilities available at the practice, shortly before our inspection a new legionella risk assessment had been completed but was not available for us to review. This would take account of the first-floor facilities, which provided a shower room for a visiting clinician. This shower room was used infrequently and had not been part of the previous legionella assessment. No flushing of the shower taps was in place at the time of our inspection.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice carried out infection prevention and control audits, but not at the expected frequency of every six months, in line with recognised guidance. Audits we were shown were from 2017. Any shortcomings identified from these audits had been addressed. Some of the issues we had identified on inspection had not been picked up by these audits, for example, the lack of protein residue tests being performed on dental instruments, and flushing of lesser used outlets on the first floor of the practice. The lack of knowledge of staff on the required frequency of infection control audit, of management of legionella, of required tests within the decontamination process confirmed the need for upated infection control training for all staff at the practice.

Information to deliver safe care and treatment

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

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

Are services safe?

findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements. Staff had not received training on Caldecott principles and there was no appointed Caldecott guardian at the practice. Staff were unable to explain their responsibilities in line with Caldecott principles, and how only information relevant to a specific request, or information required to provide specific treatment, should be released about a patient when making any referral.

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

The provider had reliable systems for appropriate and safe handling of medicines.

There was a stock control system for medicines which were held on site. However, this had not prompted staff to dispose of medicines that had passed their expiry date.

The practice kept records of prescriptions issued within patient records. This did not facilitate the auditing of prescribing, for example, antibiotics. The dentist was aware

of current guidance with regards to prescribing medicines. When we reviewed records, we found recent examples of prescribing of antibiotics. These did not appear to be in line with current guidelines.

Antimicrobial prescribing audits were not being carried out annually.

Track record on safety and Lessons learned and improvements

There were risk assessments in relation to other safety issues. The practice monitored and reviewed any incidents. This helped it to understand risks led to safety improvements.

In the previous 12 months there had been no safety incidents.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and acted to improve safety in the practice.

There was no clear system in place for receiving and acting on safety alerts or updates to clinical practice. Nurses were unaware of current safety alerts, for example, in relation to batteries in a defibrillator, and whether their defibrillator was affected by this product recall. In the examples of minutes of meetings, we were shown, there was no mention in any of the minutes of discussion of safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The principal dental practitioner told us they kept themselves up to date with current evidence-based practice. When we spoke with dental nurses and reviewed the brief records of practice meetings, we saw updates were not discussed with other clinical staff to ensure information was shared across the practice. We were happy that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance supported by clinical pathways and protocols.

The practice offered dental implants. These were placed by a visiting implantologist who had undergone appropriate post-graduate training in this speciality. The provision of dental implants was in accordance with national guidance.

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.

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

The dentist, 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.

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 dentist 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

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. The dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice had a consent policy included information about the. When we asked questions of the dental team, they demonstrated limited understanding of their responsibilities under the Mental Capacity Act 2005 when treating adults who may not be able to make informed decisions. Staff had not received training on the Mental Capacity Act. Staff had not received training on Gillick competence but could demonstrate an awareness of the need to consider this when treating young people under 16 years of age.

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 detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

We saw the practice audited patients' dental care records to check that the dentist and visiting implantologist recorded the necessary information.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. We found several areas of training for some of the dental nurses required updating. A member of staff new to the practice had not undergone a period of induction based on a structured programme and had not received some highly recommended training, for example in the safeguarding of children and vulnerable adults. We confirmed clinical staff had access to on-line training and to external training courses, to enable them to complete continuing professional development required for their registration with the General Dental Council.

Are services effective?

(for example, treatment is effective)

Staff discussed their training needs at annual appraisals and at practice meetings. We saw evidence of completed appraisals for the dental nurses.

Co-ordinating care and treatment

Staff worked together and with other health 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 had systems to identify, manage, follow up and where required refer patients for specialist care when presenting with dental infections.

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.

The practice was a referral clinic for dental implants and staff monitored referrals and ensured the dentist was aware of all incoming referrals daily.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were kind, helpful and professional. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate, understanding and told us staff were kind and helpful when they were in pain, distress or discomfort.

Information folders and thank-you cards were available for patients to read.

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. 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.

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. Staff ensured that all information they provided to patients, could be understood and interpreted correctly.

- Patients were also told about multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way that they could understand and communication aids and easy read materials were available.
- Staff helped patients and their carers find further information if required. They helped them ask questions about their care and treatment.
- Staff were aware of how they could access translation services, to provide reading material in different languages.

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.

The practice's website provided patients with information about the range of treatments available at the practice.

The dentist 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.

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

Patients with dental phobia, those with health conditions and those with caring responsibilities were offered appointments where they would not be kept waiting in the reception area.

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

The practice could accommodate patients for whom they needed to make adjustments to enable them to receive treatment, for example, there was parking immediately outside the practice for any patient with limited mobility.

The practice had made reasonable adjustments for patients with disabilities. This included step free access and an accessible toilet with hand rails and a call bell.

A disability access audit had been completed and an action plan formulated to continually improve access for patients. Staff telephoned some patients on the morning of their appointment to make sure they could get 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 in their information leaflet and 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. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

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. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took any complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a policy providing guidance to staff on how to handle a complaint. The practice website explained how to make a complaint. The principal dentist was responsible for dealing with these. Staff would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The principal dentist aimed to settle any 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 looked at comments, compliments and thank you cards received by the practice in the past 12 months. No complaints had been received by the practice during this time.

Are services well-led?

Our findings

Leadership capacity and capability

We found the principal dentist had the capacity and skills to deliver high-quality, sustainable care, but that overall governance, systems and processes required improvement.

The principal dentist and dental nurses were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

The principal dentist was open and available to staff at all times. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Culture

The practice had a culture of quality, sustainable care. Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients. Openness, honesty and transparency were demonstrated when responding to any incidents and concerns. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour. Staff could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability outlined in a range of policies, designed to support good governance and management.

The principal dentist had overall responsibility for the management and clinical leadership of the practice, and was responsible for the day to day running of the service. Staff understood the management arrangements and their roles and responsibilities.

The practice had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff. These policies were generic and had not been adapted for the practice. Staff were not fully familiar with the content of these policies and we found they were not embedded in the daily work of the practice. For example, in relation to safeguarding,

recruitment and documents required as part of the recruitment process. The lack of robust systems in place to receive and manage MHRA alerts and updates to clinical guidance, meant staff were unaware of notices which may affect them.

A radiography audit had not been completed. Also, highly recommended audits, for example on prescribing of antibiotics, were not in place; clinicians had no plans to introduce this audit. Cross infection and control audits were not completed six monthly with the last infection control audit being completed in 2017. This had not identified the shortfalls highlighted on the inspection day.

Appropriate and accurate information

The practice acted on 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. However, staff had not received Caldecott training and could not define what the principals of Caldecott guardianship were.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used all patient feedback and views about the service, to inform improvements. We saw examples of suggestions from patients the practice had acted on.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

The practice had quality assurance processes to encourage learning and improvement. These included audits of dental care records and infection prevention and control.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. Some of the

Are services well-led?

training was more than five years old and had not been refreshed or updated. All staff required updated safeguarding training. Staff also had not completed training on current topics such as Sepsis awareness. Training records were not organised in a way that allowed managerial oversight, to enable the scheduling of training for staff who needed it.

The dental nurses had annual appraisals. They discussed learning needs, general well-being and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

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 Regulation 12 Safe care and treatment. The registered person 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: 1. The registered provider had failed to ensure that staff are up to date with highly recommended training, for example, in infection control and safeguarding of children and vulnerable adults. 2. Staff recruitment was not in line with the practice policy. All checks required under Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, had not been applied when recruiting staff. 3. There had been no radiation protection information or production of new local rules, following the re-siting of X-ray equipment at the new premises. There was no critical examination certificate for the X-ray equipment. There was no schematic drawing of either of the sets in each surgery. 4. Out of date medicines were being held at the surgery, rather than being destroyed securely, for example, diazepam, loratadine and adrenaline. 5. Staff were not fully aware of their responsibility to manage legionella within the practice. The points for action within a legionella risk assessment had not been addressed. Flushing of lesser used outlets was not routinely in place. Staff were not following manufacturer instructions on materials used for the flushing of dental unit water lines. Regulation 12(1)

Requirement notices

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 Good governance

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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. In particular:

1. The registered provider failed to ensure a system was in place to receive MHRA alerts and updates into the practice, and for these to be actioned and shared with all staff.
2. Recruitment records were incomplete and did not reflect the requirements of the practice recruitment policy, or of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
3. Systems for checks of emergency equipment and medicines had not prompted staff to removed out of date items and medicines.
4. There was no effective system in place to allow oversight of staff training,

Staff training records were held in different locations by individual staff members, meaning the registered person did not have oversight of these.

5. Infection control audits had not identified that protein residue tests were not being carried out within the decontamination process. Infection control audits were not being carried out every six months as indicated in recognised guidance.

This section is primarily information for the provider

Requirement notices

6. The registered provider had failed to carry out a radiography audit.

7. Practice policies required updating and making practice specific.

Regulation 17(1)(2)