Dr Vian Ansari

Hillcrest Dental Surgery

Inspection Report

142 Penn Road
Wolverhampton
West Midlands
WV3 0DZ
Tel: 01902 341991
Website:

Date of inspection visit: 7 November 2017
Date of publication: 22/02/2018

Overall summary

We carried out this announced inspection on 7 November 2017 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 principal dentist 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.

We told the NHS England area team that we were inspecting the practice. They did not provide any information.

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

Hillcrest Dental Surgery is in Wolverhampton and provides mainly orthodontic NHS and private treatment to patients of all ages.

There is a small step to gain access to the premises; the practice does not have a portable ramp for people who use wheelchairs and pushchairs. The practice does not have a car park but parking is available in local side roads.

Summary of findings

The dental team includes one dentist (the principal dentist), two dental nurses, and one receptionist. The practice has two treatment rooms, only one of which is in use.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection we collected 46 CQC comment cards filled in by patients. This information gave us a positive view of the practice.

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

The practice is open: Monday 9am to 4pm and Tuesday to Thursday 9am to 5.30pm. The practice is closed for one hour each lunchtime.

Our key findings were:

- The practice was clean and patients commented that this was always the case. There had been some damage to the windows of the practice (which were boarded up) due to a recent burglary.
- Evidence was not available to demonstrate that all equipment was serviced or maintained in accordance with manufactures instructions.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Not all of the required life-saving equipment was available.
- The practice had some systems in place to help them manage risk although some risk assessments were overdue for review.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice had a detailed staff recruitment policy but recruitment files did not demonstrate that the practice adhered to this policy on all occasions.
- The clinical staff provided patients' care and treatment in line with current guidelines, although the dentist was not grading or justifying the need to take X-rays in patient dental care records.
- Staff appeared to have a good relationship with patients and staff were seen to speak with patients in a respectful manner. The door to the treatment room was left open when the dentist was with a patient and the computer on the reception desk was left on when the reception desk was not staffed.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked patients for feedback about the services they provided.
- We were told that the practice had not received any formal written complaints. Verbal complaints were dealt with as soon as they were received and details of these concerns were recorded on patient's dental care records.

We identified regulations the provider was not meeting. They must:

Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the radiograph, the reporting and quality of the radiograph ensuring the practice is in compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review staff awareness of guidelines relating to competency principles when treating any child aged under 16 years and ensure all staff are aware of their responsibilities.
- Review its responsibilities to the needs of people with a disability, including those with hearing difficulties and the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice's systems and processes to provide safe care and treatment were not effective. For example the practice were not always using rubber dam and were not recording in patient records when they used this. The practice was not working in accordance with the European Union (EU) directive on the use of safe sharps.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Information made available to us on the day of inspection did not demonstrate that the practice completed essential recruitment checks. Not all of the information detailed in Schedule three of the Health and Social Care Act had been obtained for all staff.

The practice had not notified the Health and Safety Executive regarding the use of X-ray equipment although following this inspection we were notified that the Health and Safety Executive had been notified on 8 November 2017. There was no critical examination pack for the intra oral X-ray machine and no maintenance information for the orthopantamogram. Following this inspection we were forwarded the critical examination report for the intra-oral X-ray machine and provided with evidence to demonstrate that the majority of actions had been taken to address recommendations recorded in the report.

Premises were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice did not have suitable arrangements for dealing with medical and other emergencies. For example, not all of the required medical emergency equipment was available and some was out of date.

Are services effective?

No action

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

The dentist assessed patients' needs and provided care and treatment in line with recognized guidance. Patients described the treatment they received as gentle and professional. The dentist 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 practice was not monitoring referrals to ensure they were received and dealt with in a timely manner.

Summary of findings

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

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 46 people. Patients were positive about all aspects of the service the practice provided. They told us staff were kind, friendly and understanding. They said that they were given detailed explanations about dental treatment, and said the dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff did not protect patients' privacy on all occasions. The door to the treatment room was left open when the dentist was seeing patients and the computer on the reception desk had been left on when the reception was not staffed, giving patients access to confidential information. 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 was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

The practice did not provide level access for people who use wheelchairs and pushchairs as there was a small step to gain access to the front of the building. There was a small internal step to the X-ray room and the practice's arrangements to help patients with hearing loss were limited. The patient toilet was on the ground floor of the building but there was no emergency pull cord and the toilet had not been adapted for use by disabled patients. The practice had access to face to face interpreter services.

The practice had not received any formal complaints but we were told that they took patients views seriously.

Are services well-led?

Requirements notice 

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

We noted that improvements were required to governance systems. For example the practice did not have all of the required emergency medicines and some of that which was available was out of date. The practice were monitoring emergency medicines to ensure they were within their expiry date but were not monitoring emergency equipment expiry dates. The practice had not undertaken any scenario training regarding medical emergencies.

Summary of findings

Information on the reception computer was accessible to patients when the reception desk was left unstaffed. The treatment room door was left open when the dentist was seeing patients which did not protect the patient's privacy or dignity.

The principal dentist had not submitted a notification to the Care Quality Commission in line with their procedure following a significant event at the practice in which the police were involved.

Service and maintenance records were not available for all equipment in use at the practice. For example there were no records regarding the compressor or ultrasonic cleaner. Apart from fire extinguishers, there was no evidence available to demonstrate that other fire safety systems were being serviced and maintained on a regular basis. Following this inspection we were forwarded a copy of a certificate which demonstrated that the compressor was serviced on 1 November 2017.

The practice had not obtained all of the required pre-employment information for staff as detailed in Schedule three of the Health and Social Care Act.

The dentist was not fully aware of guidelines relating to competency principles when treating any child aged under 16 years.

We saw some evidence to demonstrate that the practice 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. We saw that infection prevention and control audits were completed on a six monthly basis but we were not shown any X-ray or patient dental care record audits.

Prescription pads were not securely stored, the practice were not keeping a log of prescriptions and were not completing any audit regarding this. Following this inspection we were forwarded a copy of a newly developed prescription log.

The whistleblowing policy did not record any external organisation contact details for staff if they wished to raise concerns. There were no contact details of external professionals on the practice's business continuity policy. The practice had not completed a risk assessment for each COSHH product in use at the practice and some other risk assessments seen were overdue for review. Following this inspection we were sent the updated emergency contact list to be included in the business continuity plan.

The practice were not monitoring any referrals to ensure that they were received in a timely manner and dealt with promptly.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff knew about these and understood their role in the process. The principal dentist was the lead for accidents and incidents. We saw the practice's accident book and incident report forms. There had been no accidents at the practice and one incident. The practice had not notified the Care Quality Commission (CQC) about the incident in accordance with Regulation 18(2) and had not followed their own policy regarding notifications to the CQC.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

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 and the phone number for reporting suspected abuse was on display on the staff noticeboard. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. This did not record contact details for external agencies to which the staff could report concerns. Staff told us they felt confident they could raise concerns with the principal dentist without fear of recrimination and if needed they would contact NHS England for further advice.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments which staff reviewed, although some had a date for review 31 October 2017 and there was no evidence that the review had been completed. The practice did not follow relevant safety laws when using needles and other sharp dental items. The dentist used conventional sharps without any re-sheathing device and no risk assessment had been completed for the consideration of moving to safer systems. Rubber dam kits were available but the dentist confirmed that they rarely completed root canal treatment and only used the rubber dam kit on certain teeth. The principal dentist stated that they did not record in patient dental care records when they had used rubber dams.

The practice had a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice. This did not record contact details for external professionals in case of flood, electrical or computer failure. There were no details of any local practices who had agreed to see Hillcrest Dental Surgery patients in the case of an emergency. The principal dentist confirmed that they had these details separately and would ensure that these were kept with the business continuity plan. The emergency contact details were forwarded following this inspection and we were told that these would be kept with the business continuity plan.

Medical emergencies

Staff knew what to do in a medical emergency and the majority of staff completed training in basic life support every year. There was no evidence on the trainee nurse's recruitment file that this training had been completed but we were told that this would be completed as part of the dental nurse training at college. There was no evidence that staff had carried out scenario training regarding medical emergencies.

Not all emergency equipment was available as described in recognised guidance. For example the practice did not have portable suction, they did not have all of the required sizes of oropharyngeal airways and those available were out of date, oxygen masks were visibly dirty and were not kept in packaging; staff were unable to confirm whether this equipment was within its expiry date. Defibrillator pads had passed their expiry date. The emergency oxygen available was smaller than that recommended by the Resuscitation Council UK guidelines. Staff kept records of their checks to make sure that the equipment was available, although expiry date checks were not completed.

Emergency medicines were available, recognised guidance suggests that buccal midazolam should be available; the practice had a supply of midazolam which was not to be administered by this method. Staff kept records of their checks to make sure these were available, and within their expiry date.

Staff recruitment

Are services safe?

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We looked at three staff recruitment files. These did not show that the practice always followed their recruitment procedure and not all information was available in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example not all files contained proof of identity, information about any physical or mental health conditions relevant to a person's capability, after reasonable adjustments are made, to properly carry out tasks they are expected to perform or satisfactory evidence of conduct in previous employment relating to health or social care, or children or vulnerable adults.

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Monitoring health & safety and responding to risks

The practice's health and safety policies were up to date and reviewed to help manage potential risk. The practice had also completed risk assessments, some of which recorded a date for review of 31 October 2017; there was no evidence that these reviews had taken place. These covered general workplace and specific dental topics. For example we saw that the practice had risk assessments for pregnant mothers, dental surgeons, dental nurses, compressor, sharps, fire and a practice health and safety risk assessment. The practice had current employer's liability insurance which expires in April 2018.

The practice had two control of substances hazardous to health (COSHH) files. One file contained product data sheets. We were told that there was a product data sheet for each COSHH item used at the practice. The principal dentist confirmed that it was their responsibility to review these on a regular basis to ensure they were up to date and information for any products no longer used at the practice had been removed. There was no documentary evidence to demonstrate that these reviews had been completed. The second file contained COSHH assessments for three products used at the practice; a copy of the practice's COSHH policy and Health and Safety Executive guidance regarding COSHH. The principal dentist confirmed that they had not completed assessments for each COSHH product used at the practice.

We saw that regular checks were completed of fire safety equipment by the principal dentist but there was no evidence of routine service and maintenance completed by external professionals. We were shown a certificate which recorded that fire extinguishers had been serviced but this did not demonstrate that other fire safety equipment at the practice had been serviced.

We were told that the trainee dental nurse always worked with the dentist when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe, although the practice's annual statement seen was not complete. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Staff completed infection prevention and control training every year.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. Records showed that the autoclave staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance. There was no documentary evidence to demonstrate that the ultrasonic had been serviced in line with manufacturers' guidance.

The practice carried out an infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment which was completed on 30 October 2017. The practice were recording water temperatures on a monthly basis as required.

We saw cleaning schedules for the premises. Staff at the practice were responsible for all daily cleaning duties. The practice was clean when we inspected and patients confirmed this was usual.

Equipment and medicines

We did not see servicing documentation for all of the equipment used at the practice. For example we were not shown any evidence of servicing or maintenance of the

compressor and we were only shown the critical examination records for the Orthopantomogram and the maintenance log for the intra-oral X-ray machine. Staff carried out checks in line with the manufacturers' recommendations on other equipment in use at the practice. Following this inspection we were forwarded evidence to demonstrate that the compressor had been serviced on 1 November 2017 and we were forwarded the critical examination report for the intra-oral X-ray machine. One action identified on the critical examination report remained outstanding.

The practice had suitable systems for storing medicines.

The practice did not store and keep records of NHS prescriptions as described in current guidance. Prescription pads were not securely stored; the practice did not keep a log of prescription numbers and did not complete any audits regarding this. Following this inspection we were forwarded a copy of a newly developed prescription log.

Radiography (X-rays)

The Health and Safety Executive had not been notified that X-ray machinery was in operation at the practice. Records were not available to demonstrate arrangements to ensure the safety of the X-ray equipment. For example there were no critical examination records for the intra-oral machine and no maintenance logs for the orthopantomogram. Following this inspection we received evidence to demonstrate that the practice had notified the Health and Safety Executive on 8 November 2017 of their intention to work with ionising radiations and we were forwarded a copy of the critical examination report for the intra-oral X-ray machine. We were provided evidence to demonstrate that the majority of actions identified in the critical examination report had been addressed. One action remained outstanding.

We did not see evidence that the dentist justified, graded and reported on the X-rays they took. The principal dentist was not able to provide a copy of any completed X-ray audits.

Clinical staff completed continuous professional development in respect of dental radiography.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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 were not shown evidence to demonstrate that the practice audited patients' dental care records to check that the dentists recorded the necessary information. The principal dentist confirmed that they had not completed any audit of dental care records.

Health promotion & prevention

The practice believed in preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

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

The dentists told us that their medical history form asked questions about smoking and alcohol consumption and discussions regarding smoking were held with some patients during appointments. The practice did not provide patients with health promotion leaflets to help patients with their oral health.

Staffing

The practice had an induction policy and comprehensive induction documentation. Staff told us that when they were new to the practice they had a period of induction. There was no evidence of completed induction documentation on any staff recruitment files seen. The principal dentist confirmed that this documentation was available but was unable to locate this information during the inspection.

Staff told us they discussed training with the principal dentist. Some staff had recently registered to complete on line training. The principal dentist told us that annual appraisals took place. We did not see evidence of completed appraisals. One recruitment file contained documentation which had been completed by the appraisee but nothing had been recorded by the person completing the appraisal.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Working with other services

The dentist confirmed that they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included 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 did not monitor referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions and documentary evidence was available to demonstrate that the advantages and disadvantages of treatments were discussed with patients. All patients were given written treatment plans which included details of all options. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to guidelines relating to competency principles when treating any child aged under 16 years although the dentist was not aware of these principles. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly. Staff had completed on-line training regarding the Mental Capacity Act.

No action

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients commented positively that staff were polite, respectful and understanding. We saw that staff treated patients respectfully and kindly and were friendly towards patients at the reception desk and over the telephone. Nervous patients said staff were compassionate and understanding.

Staff spoken with were aware of the importance of privacy and confidentiality. We found the layout of reception and the combined waiting area on the ground floor meant that privacy was difficult to maintain when the receptionist was dealing with patients both face to face and on the telephone. Staff told us that if a patient asked for more privacy they would take them into another room and there was a sign on display in the waiting room informing patients that they could request this. The reception computer screens were not easily visible to patients. We noted that the reception desk had been left unstaffed and the computer screen left on. This could lead to patients in the waiting area being able to access personal information.

We saw that the treatment room door was left open when the dentist was dealing with patients, this did not maintain confidentiality or privacy. The dentist confirmed that the door was left open so that they could monitor the reception area and provide assistance to staff if required.

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

Music was played in the treatment room and there were magazines in the waiting room.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients described high levels of satisfaction with the responsive service provided by the practice. Responses on patient comment cards stated that the practice arranged suitable appointments quickly, were efficient and helpful.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they 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.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

Staff described how they tried to relax anxious patients. Staff tried to ensure that anxious patients were given appointments at quieter times or the last or first appointment of the day, if this met with patient's needs. These appointments were given to ensure that the waiting room was not busy which helped those patients who found it unsettling to wait in the waiting room before an appointment. The team were aware of anxious patients and tried to make sure the dentist could see them as soon as possible after they arrived at the practice.

Promoting equality

There was a very small step to enter the practice. The receptionist told us that they were aware when a patient with mobility difficulties or who used a wheelchair had an appointment and they offered assistance to enter the practice. Once inside the practice there was level access to enter the treatment room but a small step to access the X-ray room. The patient toilet was not wheelchair accessible and did not have a call bell. A magnifying glass was provided at the reception desk for those patients with sight difficulties but there was no hearing loop for patients with hearing difficulties.

Staff said they could provide information in different formats and languages to meet individual patients' needs. They had access to interpreter/translation services which included British Sign Language and braille. Staff at the practice could communicate in a number of languages for example, Arabic, Kurdish, Urdu, Italian, Hindi and Punjabi.

Access to the service

The practice displayed its opening hours in the premises and in their information leaflet. The practice did not have a website.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept four appointments free for same day appointments. They took part in an emergency on-call arrangement with another other local practice. The 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. Routine appointments were usually available to patients within a day of their request (the practice was closed on a Friday).

Concerns & complaints

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

The principal dentist told us they 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.

The practice had not received any formal written complaints. We were told that verbal complaints would be dealt with immediately and information regarding the complaint would be recorded on the patient's dental care records.

Requirements notice

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management and clinical leadership of the practice. Staff knew the management arrangements and their roles and responsibilities although we were told that the principal dentist held the majority of lead roles at the practice.

We noted that improvements were required to governance systems. For example not all of the emergency medical equipment was available and some equipment had passed its expiry date.

Prescription pads were not securely stored.

There was no critical examination pack for the intra oral X-ray machine and no maintenance information for the orthopantamogram. Following this inspection we were forwarded a copy of the critical examination report and evidence that the majority of recommendations made in this report had been addressed.

Service and maintenance records were not available for all equipment in use at the practice. For example there was no evidence of service of the ultrasonic cleaner. We were shown evidence that fire extinguishers were subject to regular review by external professionals but there was no evidence of service or maintenance of any other fire safety equipment at the practice.

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff. Improvements were required to some of these. For example the practice's whistleblowing policy did not record the contact details of any external organisation that staff could contact if they wished to raise concerns. The arrangements to monitor the quality of the service and make improvements were not effective and some of the risk assessments were due for review. The practice had not completed a risk assessment for each COSHH product in use at the practice.

The practice were not using safe sharps or any re-sheathing device in line with the EU directive on the safe use of sharps.

The practice had not obtained all of the required pre-employment information for staff as detailed in Schedule three of the Health and Social Care Act.

The practice were not monitoring any referrals to ensure that they were received in a timely manner and dealt with promptly.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information although we saw that the computer on the reception was left logged on when the reception desk was unstaffed and patients were seated in the open plan reception and waiting area having access to this computer. We also noted that the treatment room door was left open when the dentist was seeing patients which did not protect the patient's privacy or dignity. The principal dentist was not aware of guidelines relating to competency principles when treating any child aged under 16 years.

Leadership, openness and transparency

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the principal dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the principal dentist was approachable, would listen to their concerns and act appropriately.

The practice held monthly meetings which were dedicated to a specific topic of discussion, for example complaints, safeguarding or infection control. Brief minutes were available to demonstrate discussions held. Staff spoken with told us that at the end of these meetings they were able to discuss any issues and clinical and non-clinical updates. The minutes of meetings seen did not demonstrate these discussions. A member of staff also told us that as they were a small team they held informal meetings on a daily basis and would arrange meetings as and when required to share urgent information.

The principal dentist had not submitted a notification to the Care Quality Commission in line with their procedure following a significant event at the practice in which the police were involved.

Learning and improvement

The practice's quality assurance processes to encourage learning and continuous improvement were limited. The principal dentist confirmed that they had not completed

Requirements notice

Are services well-led?

any audits of dental care records and they were not able to provide X-ray audits during this inspection. We saw that infection prevention and control audits were completed on a six monthly basis.

The principal dentist said that they were committed to learning and improvement and valued the contributions made to the team by individual members of staff. Staff recruitment files did not contain evidence of completed induction or appraisal although we were told that these took place.

The principal dentist was unable to provide the documentary evidence of this during this inspection.

Staff told us they completed mandatory training, including basic life support, each year. We noted that the practice had not undertaken any scenario training regarding medical emergencies. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice provided support and encouragement for them to do so.

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

The practice used patient surveys and verbal comments to obtain patients' views about the service. We were told that satisfaction surveys were given to patients twice per year. We looked at the results of surveys completed by patients in August and September 2017 and saw that positive comments had been recorded.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. The latest FFT results available on the NHS Choices website showed that 100% of patients who responded to this survey (43 patients) would recommend this dental practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance The registered person did not have effective systems in place to ensure that the regulated activities at Hillcrest Dental Practice were compliant with the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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. In particular: The provider was not using safe sharps in accordance with the Sharp Instruments in Healthcare Regulations 2013. The practice did not have all of the equipment needed to manage medical emergencies. The practice had not assessed the risks of these items being absent. The checks made on this equipment did not identify whether the equipment was within its expiry date. The provider had not completed risk assessments for products in use at the practice in regard to the Control of Substances Hazardous to Health (COSHH) Regulations 2002. The provider had not ensured that routine maintenance and servicing had taken place on all equipment at the practice. For example the ultrasonic cleaner, some fire safety equipment and maintenance of the orthopantamogram X-ray. The provider had not reviewed the practice's audit protocols to ensure audits of various aspects of the

This section is primarily information for the provider

Requirement notices

service, such as radiography and dental care records were undertaken at regular intervals and where applicable learning points were documented and shared with all relevant staff.

There was additional evidence of poor governance. In particular:

There was no evidence in each staff recruitment file of proof of identification, evidence of good conduct in previous employment or information about any physical or mental health conditions relevant to a person's capability, after reasonable adjustments are made, to properly carry out tasks they are expected to perform.

The provider was unable to provide documentary evidence of staff induction demonstrating a structured assessment of competence of newly employed staff.

The provider was unable to demonstrate that ongoing and regular appraisal of staff had been completed.

The provider was not ensuring that the privacy and dignity of patients was maintained on all occasions.