Mr. Antony Borthwick

Westgate Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 17 July 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 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

Westgate Dental Practice is in Newcastle upon Tyne and provides NHS and private treatment to adults and children.

There is a step in front of the practice which may be a barrier for people who use wheelchairs and those with pushchairs. To aid these people, a small portable ramp is available. Car parking is available near the practice.

The dental team includes a principal dentist, two associate dentists, five dental nurses (one of whom is a trainee), a dental hygienist, a practice manager and a receptionist. The dental practice is in a three-storey Victorian building and has four treatment rooms.

Summary of findings

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 15 CQC comment cards filled in by patients.

During the inspection we spoke with the two associate dentists, four dental nurses and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Thursday 8.45am to 5.45pmFriday 8.45am to 5pm

Our key findings were:

- The practice appeared clean and well maintained.
- The practice had infection control procedures which reflected published guidance with the exception of a few minor areas and sterilisation equipment records.
- Staff knew how to deal with emergencies. Not all appropriate medicines and life-saving equipment were available as described in recognised guidance.
- The practice had very few systems to help them manage risks. The principal dentist had not undertaken a legionella risk assessment, a fire risk assessment of the premises nor had undertaken risk assessments for hazardous substances held on-site.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children. Staff underwent safeguarding training annually; the level of this training was unknown.
- The provider did not undertake thorough staff recruitment procedures.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The practice was providing preventive care and supporting patients to ensure better oral health in line with current guidelines.
- The appointment system met patients' needs.
- The practice leadership required reviewing. A culture of continuous improvement could be demonstrated and the principal dentist was aware this process required further strengthening.
- Staff felt involved and supported and worked well as a team. The practice manager was empowered and required more support to perform their role effectively.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.
- The practice had suitable information governance arrangements.

We identified regulations the provider was not meeting.

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.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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 systems for monitoring referrals to ensure they are efficient.
- Review the current staffing arrangements to ensure all dental care professionals are adequately supported by a trained member of the dental team when treating patients in a dental setting taking into account the guidance issued by the General Dental Council.
- 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.

The practice had systems and processes to provide safe care and treatment.

They used learning from incidents and complaints to help them improve. The practice's incident recording procedures could be improved.

Staff received annual training in safeguarding and knew how to recognise the signs of abuse and how to report concerns. The level of this training was unknown.

Staff were qualified for their roles. The provider did not undertake thorough staff recruitment procedures.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments with the exception of a few areas.

The practice did not have suitable arrangements for dealing with medical and other emergencies. We found several items of equipment and medical emergency drugs were expired or not present; these were ordered immediately.

The principal dentist had not received recent national safety alerts from the central alerting system or related organisations.

The practice had minimal systems to help them manage risk. Risk assessments were not carried out for all the risks posed. For example; legionella and fire risk assessments of the premises had not been undertaken. Some measures were in place to mitigate these risks, including fire extingushers and an annual legionella test.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as excellent, professional and of a high standard. 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. A referral monitoring system was not in place.

The practice supported staff to complete training relevant to their roles. A system to help monitor their training was not in place.

Summary of findings

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 15 people. Patients were positive about all aspects of the service the practice provided. They told us staff were kind, professional and extremely friendly.

They said that they were given helpful, honest 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.

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 was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing a ground floor treatment room for disabled patients and families with children. The practice had access to face to face interpreter services. An assessment of the needs of various patient groups was in place; there was no action plan for implementing any reasonable changes.

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

Are services well-led?

Requirements notice 

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 minimal arrangements to ensure the smooth running of the service.

There were limited systems for the practice team to discuss the quality and safety of the care and treatment provided. The principal dentist's system for audits, risk assessments, policies and protocols was not sufficient to support the running of the practice.

There was a defined management structure which required strengthening in implementing processes. The practice manager's role required support from the principal dentist to bring about effective change.

Summary of findings

Staff said that they felt appreciated.

The practice team kept patient dental care records which were clear and stored securely.

The practice monitored clinical and non-clinical areas of their work to help them improve and

learn, this needed to be done more frequently.

We saw evidence of the practice team listening to the views of patients and staff.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, equipment & 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. We saw evidence that staff received safeguarding training and annual refresher training. The level 2 training is recommended for clinical staff involved in the treatment of children and vulnerable adults by national guidance. The practice manager told us the level of their training was unknown and assured us they would enquire about this. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. They were unaware of the need to notify the CQC about safeguarding referrals and we told them where they could find further information with regards to this.

There was a system to highlight vulnerable patients on records, for example, 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 staff were aware of the need to identify adults that were in other vulnerable situations, for example, those who were known to have experienced modern-day slavery or female genital mutilation.

The practice had a whistleblowing policy. This did not contain details of the external organisations that staff could approach. Staff told us they felt confident they could raise concerns without fear of recrimination.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The practice manager was not able to describe how the practice would deal with events that could disrupt the normal running of the practice.

The practice did not have a staff recruitment policy to help them employ suitable staff.

We looked at the recruitment records for four members of staff.We were told the principal dentist had not carried out a Disclosure and Barring Service (DBS) check for staff prior to recruitment. This check ensures staff are suitable to work with vulnerable groups, including children. Risk assessments were not carried out to mitigate the risk associated with this. The practice manager told us they applied for DBS checks for all staff members following the announcement of our inspection. We saw evidence of this on the inspection day.

The practice manager told us photographic identification, such as a passport or driving license, and references were not sought as part of the recruitment process for any staff. We requested to see evidence of the four members of staff' evidence of continuous employment and contracts. We were told contracts were not provided to two of the four staff and a CV was only available for one member of staff.

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

We saw evidence of staff undergoing inductions at the start of their employment. The practice's induction schedule did not cover medical emergencies, safeguarding and radiography. The most recently recruited staff member was a trainee dental nurse who began working for the practice approximately three weeks prior to the inspection. They had not undergone training in any of these areas.

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

The practice manager told us the premises had not had a formal documented fire risk assessment carried out in line with the Regulatory Reform (Fire Safety) Order 2005. The premises had fire extinguishers on all floors, fire detection systems and we saw evidence of a recent fire drill. Records showed that fire extinguishers were regularly tested and serviced. We spoke to the practice manager about the need to carry out a fire risk assessment of the premises in line with the regulations. They assured us this would be arranged.

Are services safe?

The practice had a dedicated room for dental radiography. The arrangements to ensure the safety of the X-ray equipment and procedures required improving. They did not meet current radiation regulations and did not have all the required information in their radiation protection file. We saw the local rules were not detailed in line with guidance. There was no radiation protection supervisor mentioned and the local rules were not specific to the machines within the practice. They were not dated and we were told they had not been reviewed. We did not see any evidence of protocols for the operators or employer's procedures and were told these were not present. A quality assurance process was not available for the manual development of the X-rays. The dentists were not using rectangular collimation whilst taking X-rays as recommended by their radiation protection advisor. A collimator was available and the principal dentist wrote to us later to assure us they would use it from now on. We noted that when an X-ray operator was stood behind the lead screen within the X-ray room, they would not be able to observe the patient during the procedure. We discussed these findings with the practice manager and they confirmed they would address them.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. We were told all the dentists kept their own record of X-rays gradings and one associate dentist demonstrated a written radiograph audit. Staff told us there was no analysis or action plans for the radiograph grades for the other staff every year following current guidance and legislation.

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

Risks to patients

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

The practice's health and safety policies and procedures were up to date.

A health and safety risk assessment had been carried out and was reviewed regularly 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.

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. We found there were inconsistencies in assessing the effectiveness of the vaccinations. Immunity statuses could not be confirmed for three members of clinical staff. The practice also did not have a risk assessment in place in relation to these staff working in a clinical environment when the effectiveness of the vaccination was unknown.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. BLS with airway management and Immediate Life Support (ILS) training for sedation was also completed.

Emergency equipment and medicines were not available as described in recognised guidance. We found insufficient amounts of adrenaline (used for anaphylactic emergencies) and the incorrect form of aspirin. We also found the glucagon (used for diabetic emergencies) was not stored according to manufacturer's guidance and there were items of expired emergency equipment – airways, self-inflating bags and oxygen masks which had not been identified or removed. These were ordered the following day and we received evidence of this. Staff kept ineffective records of emergency medicines and equipment checks. We spoke with the practice manager of the need for these checks to be effective to make sure all medical emergency drugs and equipment was available, within their expiry date, and in working order.

A dental nurse usually worked with the dentists when they treated patients in line with GDC Standards for the Dental Team. We were told occasionally (for example in an emergency or domiciliary situation) the dentist would work without chairside support. The dental hygienist did not have a dental nurse continuously assisting. The dental nurse assisting the principal dentist would support the dental hygienist in between the dentist's patients. A risk assessment was not in place for when the dental hygienist or dentists worked without chairside support.

We looked at the Control of Substances Hazardous to Health (COSHH) file. COSHH files are kept ensuring providers record information on the risks from hazardous substances in the dental practice. We saw the COSHH file contained all the products' safety data sheets but not actual risk assessments of any of their materials, as required by the Health and Safety Executive.

Are services safe?

We were assured this would be addressed immediately and each substance would be risk assessed and recorded.

The practice had an infection prevention and control policy and procedures. Staff completed infection prevention and control training and received updates as required. They did not follow the guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments – these could be improved to be in line with HTM01-05. For example, we were told the practice staff perform manual cleaning of instruments, along with use of the steam autoclave within each of the four treatment rooms. We were told there was no use of aprons or detergent whilst scrubbing instruments, nor a magnifying light for two of the four surgeries. Each surgery has a sink for handwashing and one sink for cleaning. HTM01-05 recommends the use of a removable bowl where there is only one sink for cleaning – we were told there was no removable bowl in one of the surgeries as it would not fit into the sink. An alternative equivalent method had not been risk assessed. Heavy duty gloves were changed monthly rather than weekly as recommended in HTM 01-05. There was no log to ensure all steps in the manual cleaning procedures were being followed accurately.

We saw evidence that the equipment used by staff for cleaning and sterilising instruments was validated and maintained. HTM01-05 recommends maintaining logs of all cycles. There were data loggers for recording the temperature and pressure in only two of the four machines.

We were shown some instruments were not bagged and dated appropriately, whilst others would be sterilised at the end of the day. We noted several instruments in the principal dentist's treatment room had not been sterilised since the previous week when they were last working. We also saw some forceps in the principal dentist's surgery that were chipped and rusty. Dental materials and equipment in the surgery drawers had passed their expiry date.

The practice manager assured us they would rectify all the issues identified and ensure all records are maintained appropriately.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The principal dentist did not have a legionella risk assessment of the premises. Legionella is a bacterium found naturally occurring in water systems.. The practice manager showed us they did an annual test to confirm the water in the building did not contain Legionella bacteria. They assured us they would have a complete risk assessment undertaken.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual.

The practice 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 twice a year. The latest audit showed the practice was meeting the required standards. This did not reflect our findings on the inspection day. For example, it was recorded in the infection prevention and control audit that all records were available for the sterilisation equipment; we found two of the four autoclaves did not have a data logger recording the temperature and pressure readings.

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 dentists 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 complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements, (formerly known as the Data Protection Act).

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance. We saw the practice did not keep detailed logs of all referrals to ensure they were received appropriately.

Safe and appropriate use of medicines

Are services safe?

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

The stock control system of medicines and equipment held on site required improving. We found expired dental materials and medical emergency equipment on the inspection day.

The practice stored NHS prescriptions safely but a record of all prescription numbers was not kept in line with current guidance.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety

The practice had a good safety record.

The practice monitored and reviewed incidents inconsistently. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. We noted some incidents were not recorded. In the previous 12 months there had been three safety incidents. One safety incident was investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future. Other incidents were not recorded not shared with the practice team, for example dealing with aggressive patients.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

The staff were aware of the Serious Incident Framework and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework.

There were systems for reviewing and investigating when things went wrong. These required improving in consistency. The practice learned and shared lessons, identified themes and acted to improve safety in the practice for some incidents. For example, we noted there was one accident documented within the last 12 months relating to sharps injuries. These were addressed appropriately and shared with the whole team during staff meetings, to minimise recurrence.

The practice manager told us they did not receive national safety alerts for medicines and equipment. These alerts identify faulty items that may need recalling. We saw two items of resuscitation equipment that the practice had were recalled items. We discussed the importance of receiving, and acting upon, these safety alerts.

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 needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The provider considered guidelines as set out by the British Society for Disability and Oral Health when providing dental care in domiciliary settings such as care homes or in people's residence. They did not take medical emergency equipment and drugs to domiciliary visits. A risk assessment had not been carried out to mitigate the risk of not taking these.

The practice offered dental implants. These were placed by the one of the dentists at the practice who had undergone appropriate post-graduate training in this speciality. The provision of dental implants was in accordance with national guidance. We examined all the dental implant equipment and found the drapes used to provide a sterile covering had passed their expiry date.

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 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 patients based on an assessment of the risk of tooth decay.

The dentists and hygienist told us that where applicable they 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 available in supporting patients to live healthier lives.

We spoke with the hygienist who described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice, taking plaque and gum bleeding scores and detailed charts of the patient's gum condition. We saw the prescriptions for treatment provided by the dentists to the dental hygienist were not detailed. Prescriptions from the dentist should clearly explain to the dental hygienist exactly what dental treatment to undertake. We observed the dental hygienist and dentists were not recording a measurement of the patients' gum health consistently. Several patients the dental hygienist saw were smokers and we were told verbal smoking cessation advice was provided appropriately. We saw this was not always recorded in dental records.

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance 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 told us they 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'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 Gillick competence, by which a child under the age of 16 years of age can give consent for themselves. The staff were aware 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 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 that the practice audited patients' dental care records to check that the dentists recorded the necessary information.

Are services effective?

(for example, treatment is effective)

The practice carried out conscious sedation for patients who would benefit. This included people who were very nervous of dental treatment and those who needed complex or lengthy treatment.

The practice had systems to help them do this; these required reviewing to be in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015. The practice did not have a sedation policy in place.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines management, and staff availability and training. They also included patient checks and information such as consent, basic monitoring during treatment, discharge and post-operative instructions. There were inconsistencies in the checks being actioned and recorded.

We observed the practice's transport tape, syringes, plasters and spare Nitrous Oxide gas had all past their expiry dates.

The dentist assessed patients appropriately for sedation; we noted this was not suitably recorded in the patient dental records we looked at. There was no evidence of alternatives being discussed or of anxiety scales being used to assess the need. The records showed that staff recorded important checks at regular intervals for intravenous sedation. These included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. We saw the recording and intervals of the monitoring could be improved to be in line with national sedation guidelines.

The records also showed that staff recorded details of the procedure along the concentrations of nitrous oxide and oxygen used in inhalation sedation.

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

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a period of induction based on a structured induction programme. We saw evidence of this for all staff and noted the programme did not cover medical emergencies, radiography or safeguarding. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council. We were told the level of safeguarding training was unknown.

Staff told us they discussed training needs at annual appraisals and during clinical supervision. We saw evidence of completed appraisals.

Co-ordinating care and treatment

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

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 and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems and processes 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 did not monitor all referrals to make sure they were dealt with promptly. The practice manager assured us they would implement a monitoring system.

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, caring and helpful. We saw that staff treated patients respectfully and appropriately. They were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding and they told us they could choose whether they saw a male or female dentist.

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

Information folders, patient survey results 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 privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they 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 be involved in decisions about their care and were aware of the Accessible Information Standards (a requirement to make sure that patients and their carers can access and understand the information they are given) and the requirements under the Equality Act:

- Interpretation services were available for patients who did not have English as a first language. We were told relatives were often used as interpreters which is not in accordance with national guidance.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- Easy read materials and braille were not available for patients who might need them.

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 dentists described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example photographs, models 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.

The practice met the needs of more vulnerable patients, for example, by arranging appointments at times convenient to the patient and ensuring a sufficient appointment length was provided.

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

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

A disability access assessment was carried out; an action plan was not in place to show the practice would consider various patient's needs. The practice had made few reasonable adjustments for patients with disabilities. This included step free access and a downstairs surgery.

Timely access to services

Patients were able to 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 practice information leaflet and on their website.

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.

They took part in an emergency on-call arrangement and with 111 out of hour's service.

The practice website, information leaflet 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 complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The principal dentist was responsible for dealing with these. Staff told us they would tell the practice manager 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 received three complaints within the last 12 months. These were acknowledged, responded to and acted upon appropriately.

Are services well-led?

Our findings

Leadership capacity and capability

The principal dentist was the overall leader of the practice. The practice manager oversaw the day to day running of the service.

They were not knowledgeable about all the issues and priorities relating to the quality and future of services. For example, they were not aware of the need to carry out DBS checks prior to employment.

Staff told us the principal dentist and practice manager were approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

The practice did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

There was a clear vision and set of values. The practice had a realistic strategy.

Culture

The practice had a culture of high-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.

The principal dentist acted on behaviour and performance inconsistent with the vision and values.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff were not clear on the duty of candour regulation. When we discussed the meaning of this with staff, they told us their approach towards any incidents and complaints. It was apparent the practice had systems to ensure compliance with the requirements of regulation though were not familiar with the terminology.

Staff told us they 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 to support good governance and management.

The principal dentist had the overall responsibility for the management and clinical leadership of the practice. There were not clearly defined responsibilities for other members of staff. The principal dentist had not assigned roles and systems of accountability to support good governance and management.

The provider had a 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.

The processes for managing risks, issues and performance could be improved. For example, the principal dentist did not have an effective recruitment procedure to eliminate the risks to staff and patients, they were not aware of the need of assessing the risk of Legionella. They did not understand the importance of having a risk assessment for all hazardous materials on-site nor for a fire risk assessment of the premises.

We were told the practice had regular staff meetings. They took place every two to three months and we were told these were not documented. We discussed the importance of documenting staff meetings to ensure any actions are addressed and a process for any absentees to review.

The practice manager assured us they would review all these shortcomings.

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.

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.

Are services well-led?

The practice used comment cards and verbal comments to obtain staff and patients' views about the service.

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 practice gathered feedback from staff through meetings, surveys, 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

There were systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records and infection prevention and control. They had clear records of the results of these audits and the resulting action plans and improvements. We were told all the dentists kept their own record of grading of X-rays and one associate dentist demonstrated a written radiograph audit. Staff told us there was no analysis or action plans for the radiograph grades for the other staff every year following current guidance and legislation.

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

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

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. We were told the principal dentist did not monitor staff training for all staff. We spoke to the practice manager about possibly implementing a training matrix (a plan to monitor the training needs of all members of staff). They assured us they would review their systems of monitoring staff training.

The General Dental Council also requires clinical staff to complete continuing professional development. Staff told us the practice provided support and encouragement for them to do so.

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 Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: · Medicines and equipment to manage medical emergencies were not in line with guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. · Infection prevention and control did not follow the guidance from HTM01-05 in use of personal protective equipment, storage and reprocessing of instruments. · Risk assessments were not carried out in the practice. In particular, the risks of lone working, Legionella, fire and hazardous substances. There was additional evidence that safe care and treatment was not being provided. In particular: · Several items had passed their expiry date. · Sedation protocols were not following national guidance. Regulation 12 (1).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 improve the quality and safety of the services beingprovided. In particular: Appropriate governance systems were not in place to: · Receive and act on patient safety alerts · Ensure that out of date medicines, rusty instruments and dental materials were identified and disposed of. · Carry out annual X-ray audits in line with IR(ME)R 2017. There was additional evidence of poor governance. In particular: · Continuous professional development and training of employees was not monitored effectively prior to the inspection. · Radiographic documents were not in line with national guidance. · Knowledge of the notifications to be sent to CQC and the regulation duty of candour was poor. · Staff meetings were not documented. Regulation 17 (1)
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed 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 improve the quality and safety of the services beingprovided. In particular:

This section is primarily information for the provider

Requirement notices

- The provider did not have a recruitment policy.
- The provider's staff recruitment procedures were not meeting regulations.
- The provider did not undertake DBS checks nor seek satisfactory evidence of conduct in previous employment, nor photographic proof of identity, nor provide employees with contracts for their employment.
- Hepatitis B immunity levels were not adequately obtained.
- Induction processes did not cover all relevant subjects. This section is primarily information for the provider

Regulation 19 (1, 2)