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Ashurst Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 May to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Ashurst Dental Surgery offers mainly (more than 80%) NHS dental care services to patients of all ages. Approximately 40% of patients attending the practice do

not speak English as their first language. Staff spoke a number of languages including Polish, Lithuanian and Russian which supported patients to communicate their needs. The services provided include preventative advice and treatment and routine and restorative dental care. The practice has a treatment room on the ground and one on the first floor of the premises.

The practice has two dentists, one of whom is the principal dentist; a dental nurse, a trainee dental nurse and a receptionist/administrator. The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Opening hours are Monday, Tuesday and Thursday from 9.00am to 5.00pm with extended opening hours on a Wednesday until 7.00pm. The practice closes at 3.00pm on Fridays.

We spoke with four patients who used the service on the day of our inspection and reviewed seven completed CQC comment cards. Patients commented staff were caring, helpful and respectful and that they had confidence in the dental services provided.

Our key findings were:

Summary of findings

- There were systems in place in the areas of infection control and the management of medical emergencies. However incident reporting, managing substances hazardous to health and seeking advice regarding the safe use of X-ray equipment could be improved.
- Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. The practice had a range of detailed consent forms for different treatments; in order to provide patients with relevant information
- We reviewed seven CQC comment cards that had been completed by patients and spoke with four patients who used the service on the day of the inspection. Common themes were patients felt they were involved in their treatment, listened to and received good care in a clean environment.
- Staff spoke a number of languages including Polish, Lithuanian and Russian; which supported patients to communicate their needs. Consent forms and medical questionnaires were available in several languages
- Overall we found the practice did not have effective clinical governance and risk management systems in place. For example, they did not audit areas of their practice as part of continuous improvement and learning. Patient care records we looked at were not sufficiently detailed and up to date to reflect the care and treatment provided.

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

- Assess, monitor and improve the quality and safety of the services provided. This should include a system of auditing areas of their practice as part of continuous improvement and learning.
- Establish and implement a process to regularly Identify, assess and manage risks to the health, welfare and safety of patients, staff and visitors to the practice.
- Ensure accurate and contemporaneous clinical patient records are always maintained.
- The practice must seek and act upon feedback from patients and staff on the services provided to continually evaluate and improve services

You can see full details of the regulations not being met at the end of this report.

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

- Ensure there is a clear incident reporting system in place relating to the safety of patients and staff members.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Ensure records are maintained regarding the Control of Substances Hazardous to Health 2002 (COSHH) regulations; and staff are familiar with them.
- Review the arrangements in place for maintaining and servicing autoclaves and the ultrasonic cleaner to ensure they are in working order and working effectively.
- Review the arrangements for seeking advice from a radiation protection advisor (RPA) regarding The Ionising Radiation Regulations 1999 (IRR99)
- Ensure the training, learning and development needs of individual staff members are reviewed at appropriate intervals and an effective process is established for the on-going supervision of all staff.
- Ensure the practice considers the Delivering Better Oral Health guidance regarding the selection criteria for fluoride varnish applications.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were effective systems in place in the areas of infection control, management of medical emergencies, recruitment of staff and safeguarding children and adults from abuse.

There was no clear incident reporting system in place and the practice did not have up to date documentation regarding the Control of Substances Hazardous to Health 2002 (COSHH). Some equipment did not have maintenance and service contracts in place and records did not identify if a radiation protection advisor (RPA) was available to provide advice when required.

Are services effective?

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

The dentists considered current Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE) guidelines in relation to prescribing antibiotics and assessing each patient's risks and needs to determine how frequently to recall them. However, staff were unaware of the Delivering Better Oral Health (DBOH) toolkit guidance regarding the selection criteria for fluoride varnish applications.

The practice worked with other professionals in the care of their patients and referrals were made to hospitals and specialist dental services for further investigations or specialist treatment.

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. The practice had a range of detailed consent forms for different treatments; in order to provide patients with relevant information.

The practice had not identified what mandatory training staff should undertake and there was no system in place to record when staff had completed training such as basic life support, safeguarding and infection prevention and control.

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. We looked at seven CQC comment cards patients had completed prior to the inspection and spoke with four patients. Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity.

Patients commented they felt involved in their treatment, it was fully explained to them and they were listened to and not rushed.

Are services responsive to people's needs?

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

Staff spoke a number of languages including Polish, Lithuanian and Russian which supported patients to communicate their needs. Consent forms and medical questionnaires were available in several languages. CQC comment cards and patients we spoke with felt they were able to contact the service easily and had choice about when to come for their treatment.

Summary of findings

The practice had a procedure for acknowledging, recording, investigating and responding to complaints. Records showed they responded in a timely manner, learnt and made changes which were shared with staff at a team meeting.

Are services well-led?

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

Overall we found the practice did not have effective clinical governance and risk management systems in place. For example, they did not audit areas of their practice as part of continuous improvement and learning. The practice did not continually identify risks or review the effectiveness of the actions taken to manage risks.

Patient care records we looked at were not sufficiently detailed and up to date to reflect the care and treatment provided.

The practice did not have a formal system of seeking and acting upon feedback from patients and staff.

The practice had a range of policies and procedures to support staff carry out their work. These included guidance about confidentiality, complaints and infection control. Records showed these were reviewed annually and staff signed to confirm they were aware of any changes to them.

Ashurst Dental Surgery

Detailed findings

Background to this inspection

This announced inspection was carried out on the 18 May 2015 by an inspector from the Care Quality Commission (CQC) and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider and information from stakeholders.

During the inspection we toured the premises and spoke with both dentists, the dental nurse and the receptionist/administrator. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and their objectives and a record of any complaints received in the last 12 months.

We obtained the views of seven patients who had filled in CQC comment cards and spoke with four patients who used the service on the day of our inspection.

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 therefore formed the framework for the areas we looked at during the inspection

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). There were adequate supplies of personal protective equipment such as face visors and heavy duty rubber gloves for use when manually cleaning instruments. The practice's Health and Safety policy included information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice did not have effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. The practice had a set of safety data sheets in place which identified the risks associated with substances hazardous to health and actions identified to minimise them. However the information had not been reviewed or updated in the last three years. Staff were not familiar with the Control of Substances Hazardous to Health 2002 (COSHH) regulations and had not attended training about them.

There was a system in place to record and learn from accidents. However there was no clear incident reporting system or staff training about identifying and learning from incidents. The principal dentist told us there had been no incidents in the last four years.

The practice checked all safety alerts and these were shared with staff to ensure they were acted upon.

Reliable safety systems and processes (including safeguarding)

The practice had up to date child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The principal dentist was the safeguarding lead professional for the practice. Records showed staff had received safeguarding training in the last 12 months.

The principal dentist undertook root canal treatment and told us they used a rubber dam when possible. The British Endodontic Society provides guidance which states that root canal treatment procedures should be carried out only

when the tooth is isolated by a rubber dam (a rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site (one or more teeth) from the rest of the mouth). It prevents inhalation and ingestion of instruments and prevents irrigating solutions escaping into the oral cavity. The principal dentist told us there were occasions when the use of the rubber dam was not possible. However we found there was no risk assessment in place when not using a rubber dam and no protocol about the measures taken to ensure patient safety, for example by securing the instruments.

Medical emergencies

Staff were knowledgeable about how to deal with medical emergencies. The practice had an emergency resuscitation kit, oxygen and emergency medicines stored securely on the ground floor. This was in line with the Resuscitation Council UK guidelines and the guidance on emergency medicines in the British National Formulary (BNF). The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Records showed monthly and weekly checks were carried out to ensure the equipment and emergency medicines were safe to use. Staff had received annual training in emergency resuscitation and basic life support as a team until 2013. However staff now completed online training individually. Hands-on team training allows staff to practice their skills in managing an emergency together and reflect on any improvements they might make in their emergency procedures. Following discussion, the principal dentist confirmed they would consider if online training for individual staff fully met their training needs as a team to manage emergencies.

Staff recruitment

The practice maintained staff personnel files, including documentation regarding their recruitment. This included a completed application form, pre-employment health questionnaire and evidence of qualifications, identity and professional registration. Although the names of referees were provided by the applicants, there was no evidence references had been requested. The principal dentist confirmed they would ensure a clear set of

Are services safe?

recruitment procedures was developed and that references would be sought and retained for all new employees. Records showed the professional registration for clinical staff were up to date.

The practice carried out Disclosure and Barring service (DBS) checks for all staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Records showed these checks were in place. The practice had carried out risk assessments on two occasions when there was a delay in obtaining DBS clearance. This included the measures put in place to ensure staff worked under supervision until the documentation was in place.

Newly employed staff had a period of induction to familiarise themselves with practice procedures and complete training such as health and safety, safeguarding and infection control, before being allowed to work unsupervised.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. We found the practice had been assessed for the risk of fire and had a certificate of conformity from the Fire Protection Service in December 2014. A fire marshal had been appointed, fire extinguishers, serviced and staff carried out weekly fire safety checks. The risk of a sharps injury had been identified and procedures were in place in help prevent them occurring.

Infection control

The dental nurse was the infection control lead professional ensured there was a comprehensive infection control policy and set of procedures to help keep patients safe. These included hand hygiene, safe handling of instruments, disposal of clinical waste products and decontamination guidance. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)' and the 'Code of Practice about the prevention and control of infections and related guidance'. Posters promoting good hand hygiene and the

decontamination procedures were clearly displayed to support staff in following practice procedures. Staff received training regarding infection prevention and control as part of their cycle of continuous professional development (CPD) and updates were provided at staff meetings.

We looked around the premises during the inspection and found the treatment rooms and the decontamination room appeared clean and hygienic. They had sealed floors and work surfaces that were free from clutter and could be cleaned and disinfected between patients. Dental nurses cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There were hand washing facilities in each treatment room and staff had access to good supplies of protective equipment for patients and staff members.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

The practice cleaned their instruments manually. Instruments were then rinsed and examined visually with a magnifying glass and cleaned in an ultrasonic bath, checked and sterilised in an autoclave (Two autoclaves were in use in the decontamination room). At the end of the sterilising procedure the instruments were packaged, dated and returned to the dental surgery. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment used for cleaning and sterilisation was functioning properly.

The practice carried out daily quality testing of the two autoclaves in the decontamination room. Records confirmed these had taken place. However the date and

Are services safe?

time recorded on the validation printout was inaccurate and staff told us this could not be rectified. Staff ensured the sheet they attached the printout to had the correct date and time recorded to provide an audit trail of validation.

The practice had carried out the self- assessment audit in February 2015 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05). This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards. An action plan identified improvements required regarding ensuring that all validation and testing records were securely maintained.

Records showed a risk assessment process for Legionella had been carried out in March 2015. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). This ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk to patients and staff of developing Legionnaires' disease. These included running the water lines in the treatment rooms at the beginning of each session and between patients and monitoring cold and hot water temperatures each month. The risk assessment identified the boiler was heating the water in the practice to just above the minimum temperature required. Inspection visits were arranged to take place every six months to ensure safe temperatures were reached.

Equipment and medicines

Routine checks were completed, for example for portable appliance testing. (PAT- this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use).

The practice had two autoclaves in use in the decontamination room. The principal dentist told us they had a third autoclave stored in one of the surgeries which was not in use. The practice did not have service or maintenance records for any of the autoclaves. Regular servicing and maintenance help ensure equipment is in working order and working effectively. The principal dentist

told us they had been unable to arrange a service or maintenance contract as the manufacturer was no longer operating. They had access to an engineer who repaired the equipment on an ad-hoc basis as required. The practice did not have a service or maintenance contract for the ultrasonic cleaner.

The practice had systems in place regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The dentists used the British National Formulary to keep up to date about medicines. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored safely for the protection of patients.

Prescription pads were stored in the surgeries when in use and then in a locked cabinet overnight. Prescriptions were stamped only at the point of issue to maintain their safe use. The practice kept a detailed log of all prescriptions issued by each dentist, which provided a clear audit trail to ensure safe usage and prescribing. The dentists recorded information about any prescription issued within the patient's dental care record.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including their service and maintenance history. Records we viewed included critical examination reports and certificates of conformity that were valid until in 2016. However the practice had not identified a radiation protection advisor (RPA) or a radiation protection supervisor (RPS). The principal dentist told us he was the RPS. He confirmed he had not identified an RPA. A suitably qualified RPA must be consulted with to give advice on The Ionising Radiation Regulations 1999 (IRR99), IRR99. The RPA should be an expert in radiation protection.

The practice had three x-ray machines. X-rays were digital and images were stored within the patient's dental care record. Records showed those authorised to carry out X-rays had attended training. This protected patients who required X-rays to be taken as part of their treatment.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice maintained electronic and paper records of the care given to patients. The dentists considered current Faculty of General Dental Practice (FGDP) guidelines on antimicrobial prescribing for general dental practitioners in relation to prescribing antibiotics. They followed current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's oral health risks and needs and determine how frequently to recall them. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment

Medical history checks were updated at every visit and the paper and electronic records we looked at confirmed this. This included an update on their health conditions, current medicines being taken and whether they had any allergies. Patients were given a copy of their treatment plan, including any fees involved. Treatment plans were signed before treatment began.

Health promotion & prevention

The practice used 'The Delivering Better Oral Health toolkit' (DBOH-This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). The practice recalled patients from six years upwards, as appropriate, to receive fluoride applications to their teeth to help ensure better oral health. However staff were unaware that DBOH guidance regarding fluoride applications recommends this is offered to patients as required between three and six years of age.

Patients completed a medical questionnaire which included questions about smoking and alcohol intake to support the dentists provide advice according to patient's individual needs.

A selection of dental products were on sale to assist patients with their oral health and there was a range of literature about effective dental hygiene. We observed staff providing patients with advice regarding the most appropriate product to meet their needs. Records showed higher- fluoride toothpastes were prescribed to high caries needs patients.

Staffing

Staff we spoke with told us they had access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC).The GDC is the statutory body responsible for regulating dental care professionals. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going continuous professional development.

The practice had not identified what mandatory training staff should undertake and there was no system in place to record when staff had completed training such as basic life support, safeguarding and infection prevention and control

Dental nurses were supervised by the dentists on a day to day basis. The practice had a system of annual appraisals and six monthly reviews in place to support the receptionist/administrator. However there was no system in place to identify the training and development needs of the dental nurses.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. Dental care records contained details of the referrals made and the outcome of the specialist advice.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. The practice had a range of detailed consent forms for different treatments; in order to provide patients with relevant information.

Staff described how they involved relatives and carers to help patients who required support with making decisions to ensure the best interests of the patient were met. Following discussion, the principal dentist confirmed they would ensure staff were knowledgeable about the Mental Capacity Act (MCA) 2005 and its relevance to dental practice.

Staff ensured patients gave their consent to care and treatment before treatment began. Staff confirmed

Are services effective?

(for example, treatment is effective)

individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. This was reflected in comments patients made on CQC comment cards and in patient records.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We looked at seven CQC comment cards that patients had completed prior to the inspection and spoke with four patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented they were treated with respect and dignity.

Staff explained to us how they ensured information about patients was kept confidential. Patients' clinical records were stored electronically; password protected and regularly backed up to secure storage. Paper records, such as signed consent forms and updated medical history forms were stored securely in locked cabinets.

Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. They told us there were always rooms available if patients wished to discuss something with them away from the reception area. Sufficient treatment rooms

were available and used for all discussions with patients. The practice had a confidentiality policy to support staff. It included information about data protection and how patients could access their records.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients we spoke with commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Patients were given a copy of their treatment plan and associated costs and allowed time to consider options before returning to have their treatment. Before treatment commenced patients signed the plan to confirm they understood and agreed to the treatment.

Patients were also informed of the range of treatments available and their cost in information leaflets and notices in the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice provided patients with information about the services they offered in leaflets and on posters. We looked at the practice's electronic appointment system and found each dentist had vacant appointment slots each day for urgent or emergency appointments. Staff told us patients were seen as soon as possible for emergency care and this was normally within 24 hours. One patient we spoke with confirmed they had been given an emergency appointment on the same day they contacted the practice.

Patients booked their next routine appointment either following their check-up or when their next appointment was due. Patients could opt for a text message reminder from the practice if they provided their mobile telephone number. The practice operated extended opening hours one day each week until 7pm to support patients to arrange appointments in line with other commitments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff told us approximately 40% of patients attending the practice did not speak English as their first language. Staff spoke a number of languages including Polish, Lithuanian and Russian which supported patients to communicate their needs. Consent forms and medical questionnaires were available in several languages.

The practice had treatment rooms on the ground and first floor of the premises. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. Staff told us they ensured patients who

were unable to use the stairs were treated in the downstairs treatment room. We observed the dentists were flexible in where they treated patients on the day of the inspection in order to meet patient needs. There were disabled toilet facilities on the ground floor.

Access to the service

The practice displayed its opening hours in their premises. Opening hours were Monday, Tuesday and Thursday from 9.00am to 5.00pm with extended opening hours on a Wednesday until 7.00pm the practice closed at 3.00pm on Fridays. There were clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed.

CQC comment cards reflected that patients felt they were able to contact the service easily and had choice about when to come for their treatment.

Concerns & complaints

There was a complaints policy which provided staff with information about how to handle patient complaints. Information for patients about how to make a complaint was available in the practice waiting room. Staff told us they raised any formal or informal comments or concerns with the principal dentist to ensure these were responded to.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints. The practice had received two complaints in the last 12 months, one of which was on-going. The practice had responded in a timely manner to the concerns raised and made changes to record keeping and documentation used to record consent. Records showed the changes were shared with staff at a team meeting.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was the registered manager and was responsible for the day to day running and quality monitoring of the service. They led on the individual aspects of governance such as responding to complaints and managing risks.

The practice did not have an effective and proactive approach for identifying where quality or safety was being affected and addressing any issues. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw a number of risk assessments in place which had been carried out by external agencies, for example regarding legionella and fire. These had been reviewed and updated to help ensure the safety of patients and staff members. However the practice did not have a risk management process in place for staff to continually identify risks or to review the effectiveness of the actions taken to manage risks. For example, the practice had completed a risk assessment regarding the handling of sharp dental hand instruments, however there was no evidence this had been reviewed or updated. The practice had not identified risks related to a lack of maintenance contracts for some equipment. Annual health and safety checks were completed each year, however there were no risks identified or action plans recorded to make improvements. For example, the practice had taken steps to ensure even flooring from the waiting area into the reception area was clearly marked for patients as a potential trip hazard. However the practice had not carried out a formal risk assessment of the premises and did not have a system in place to assess if this action was effective.

We looked in detail at 15 patient care records and found they did not consistently provide information about patients' oral health assessments, treatment and advice given. A standardised template was used to record details of the consultation in patient care records. However, in six care records the information recorded was identical and not personalised to reflect the assessment, treatment or advice provided to each patient. In four patient care records we looked at there was no information about the consultation that had taken place. The dentists told us they assessed the condition of the teeth, soft tissues lining the mouth and gums at each examination in order to monitor

any changes in the patient's oral health. However, these assessments were not consistently documented in the records we looked at, for example by recording a basic periodontal examination (BPE). BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patients' gums. We found the practice was not recording in the patient's records the justification for taking an X-ray, reporting on the X-ray or grading the quality of the X-ray image. For example in three records we looked at X-rays were taken infrequently leaving patients open to un-detected caries; and when X-rays were taken the justification for taking the X-ray was not clear and the grade was not recorded.

Leadership, openness and transparency

Staff told us they had opportunity on a daily basis to raise any concerns with the principal dentist. They met as a team each month to discuss aspects of the running of the service and written records were maintained to inform staff who were unable to attend. Minutes of a recent staff meeting included updates on the outcome of fire and risk assessments carried out by external agencies.

The practice had a range of policies and procedures to support staff carry out their work. These included guidance about confidentiality, complaints and infection control. Records showed these were reviewed annually and staff signed to confirm they were aware of any changes to them.

Management lead through learning and improvement

The lead dental nurse carried out self assessment audits regarding infection control and shared the results with the dental team to ensure standards were maintained. However the principal dentist confirmed they did not audit any other areas of their practice as part of continuous improvement and learning; and to ensure their procedures and protocols were being carried out and were effective. For example, the practice did not have a system of regularly monitoring the quality of X-ray images. They did not carry out audits of X-rays to check if the X-ray images taken were of the required standard; thus reducing the risk of patients being subjected to further unnecessary X-rays and to ensure they were consistent in their selection criteria for taking X-rays.

The practice did not gather information about the quality of care and treatment from a range of sources and opportunities for learning and making improvements had not taken place.

Are services well-led?

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

The practice did not have a formal system of seeking and acting upon feedback from patients and staff. The principal dentist confirmed that they did not undertake patient surveys or actively gather patients' suggestions or comments. The principal dentist told us patients would raise any concerns or suggestions with the staff directly. However there was no record of concerns or suggestions raised by patients in the last 12 months or of any changes made to the service as a consequence.

Staff told us they felt confident about raising concerns or making suggestions informally and through team meetings.

The practice gave patients the opportunity to complete the NHS family and friends test, which is a national programme to allow patients to provide feedback on the services provided.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met</p> <p>The practice did not have effective systems in place to:</p> <p>Assess, monitor and improve the quality and safety of the services provided.</p> <p>Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.</p> <p>Ensure accurate and contemporaneous clinical patient records were always maintained.</p> <p>Seek and act on feedback from relevant persons on the services provided to continually evaluate and improve services</p> <p>Regulation 17 (1)(2)(a)(b)(c)(e)(f)</p>