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The Dental Surgery

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection after receiving some information of concern on 22 June 2016 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 not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

We found that this practice was not providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was not 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

The Dental Surgery is a dental practice providing mostly NHS dental treatment, with private treatment options for patients. The practice is located in premises in Newhaven.

The practice has two treatment rooms, both of which are on the ground floor.

The practice provides dental services to both adults and children. The practice provides mostly NHS treatment (90%). Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are – Monday, Tuesday, and Thursday 9am to 5pm and Wednesday and Friday 9am to 12pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the 111 NHS service.

The principal dentist/owner is registered with the Care Quality Commission (CQC) as an individual. 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.

Summary of findings

The practice has two dentists; two qualified dental nurses, one student nurse, two receptionists, and a practice manager.

We did not provide CQC comment cards prior to our visit as this visit was unannounced. We spoke with patients and reviewed feedback that practice had received through the NHS Friends and family test (FFT) and NHS Choices.

Our key findings were:

- The treatment rooms were visibly dirty and lacked defined clean and dirty zones.
 - Records showed there were sufficient numbers of staff to meet the needs of patients.
 - Patients at the practice gave positive feedback about their experiences at the practice.
 - Patients said they were treated with dignity and respect.
 - Dentists identified the different treatment options, and discussed these with patients.
 - Patients' confidentiality was not always maintained and some dental records were not stored securely.
 - The building was not maintained to a suitable standard for a dental practice.
 - The practice did not carry out radiography practices in line with current regulations.
 - The practice did not follow the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning, storing and sterilising dental instruments.
 - The practice had the necessary equipment for staff to deal with medical emergencies, and staff had recently received training on how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.
- We identified regulations that were not being met and the provider must:
- Ensure the training, learning and development needs of staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff employed.
 - Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD)
 - Ensure the practice's infection control procedures and protocols are suitable giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum
 - 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
 - Ensure the practice undertakes a Legionella risk assessment and implements the required actions giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'
 - Ensure infection control audits are undertaken at regular intervals and learning points are documented and shared with all relevant staff.
 - Ensure the practice's sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
 - Ensure waste is segregated and disposed of in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
 - Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
 - Ensure the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
 - Ensure audits of various aspects of the service, such as radiography and dental care records are undertaken at regular intervals to help improve the quality of service. The practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

- Ensure audit protocols to document learning points are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Ensure the storage of records relating to people employed and the management of regulated activities is in accordance with current legislation and guidance.

We found this practice was not providing safe or well led care in accordance with the relevant regulations and identified regulations were not being met. We took urgent enforcement action to suspend the practice for seven weeks to allow improvements to be made.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the storage of dental care products to ensure they are stored in line with the manufacturer's guidance.
- 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
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and carry out a Disability Discrimination Act audit for the premises.
- Review the availability of an interpreter service for patients who do not speak English as their first language.

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 this practice was not providing safe care in accordance with the relevant regulations and identified a regulation was not being met. We took urgent enforcement action and the practice closed for seven weeks to allow improvements to be made.

All staff had received training in safeguarding vulnerable adults and children. There were guidelines available for reporting concerns. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

The practice was using items that are marked as single use more than once on patients.

Infection control did not reflect the guidance issued by the Department of Health, Health Technical Memorandum HTM 01-05. Environmental cleaning was not recorded and did not follow national colour coding. Processed instruments were stored unpouched and on the work surface, exposed to aerosol from the scrubbing of dirty instruments and in dirty cluttered draws before being used on patients. Clean and dirty areas were not defined in the treatment rooms. The decontamination area was combined with a staff area and areas of the practice were visibly dirty.

The practice kept three dogs on the premises in the reception area during surgery hours.

The building had not been maintained to a standard suitable for a dental practice.

Appropriate recruitment checks were not always carried out prior to staff starting employment and some documents required under Schedule 3 were not available.

The practice did not fulfil its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.

Enforcement action



Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We took urgent enforcement action and the practice closed for seven weeks to allow improvements to be made.

We could not be assured that patients received information regarding the risks and benefits and options available to them.

We were not shown sufficient evidence to be assured that some staff had completed mandatory training in radiography.

Enforcement action



Summary of findings

Staff had not completed training in the Mental Capacity Act 2005 (MCA) and had limited understanding and knowledge of its relevance in practice.

The practice made referrals to other dental professionals when it was appropriate to do so. However there was no system to follow up the referrals once they had been sent out.

Are services caring?

We found that this practice was not providing caring services in accordance with the relevant regulations. We took urgent enforcement action and the practice closed for seven weeks to allow improvements to be made.

Patient confidentiality was not always maintained as dental care records were not stored in a secure way.

Patients said staff were always friendly, polite and professional and they were treated with dignity and respect by staff.

Patients said they received fair dental treatment and they were involved in discussions about their dental care.

Patients said they were not able to express their views or opinions.

Enforcement action



Are services responsive to people's needs?

We found that this practice was not providing responsive care in accordance with the relevant regulations. We took urgent enforcement action and the practice closed for seven weeks to allow improvements to be made.

Patients said they were usually able to get an appointment and patients who were in pain or in need of urgent treatment were generally seen the same day.

The practice had suitable access for patients with restricted mobility with a small flight of steps providing access into the practice. Patients also had the option of access at the rear of the premises which was level. Both surgeries are located on the ground floor. The practice had not conducted a disabled access audit to consider the needs of patients with restricted mobility

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the practice.

There were systems and processes to support patients to make formal complaints. The complaints policy was out of date and did not refer patients to the correct external agencies. Where complaints had been made these were acted upon, and apologies given when necessary.

Enforcement action



Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We took urgent enforcement action and the practice closed for seven weeks to allow improvements to be made.

Enforcement action



Summary of findings

We found a number of shortfalls in the practice's governance and leadership. Policies and procedures to govern the practice's activities were not sufficient.

Staff did not receive regular reviews of their performance and did not have personal development plans in place.

Staff training was not actively monitored and staff training was mostly completed online.

The practice did not monitor water temperatures in the building as a precaution against the development of legionella.

Audits had been undertaken for infection control, but the content had little value to drive improvement as areas marked as completed or done did not reflect the actual circumstances. Other auditing activity to measure the quality of radiographs taken and the content of dental care records had not been conducted.

The Dental Surgery

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

The inspection took place on 22 June 2016 and was conducted by a CQC inspector and a specialist dental advisor.

We did not request any information from the provider as this inspection was unannounced. We reviewed information we held about the practice and information shared with us from NHS England following an inspection they carried out on 20 April 2016 where issues were identified.

During the inspection we spoke with dentists, two qualified dental nurses, one student dental nurse and the practice manager. We spoke with two patients on the day of our inspection and two more via telephone following 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 a system to manage significant events, safety concerns and complaints and staff could demonstrate understanding of the procedures to follow. There had been three reported significant events within the last year. Significant event forms had been completed and each situation discussed on a casual basis and rectified.

There was also an accident reporting book. There had been two entries in the last 12 months both of which had involved staff. None of the accidents recorded were serious enough to have been reportable to either RIDDOR or CQC.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which had been not been updated. However, the policies were localised and contained the direct contact details of the local authority safeguarding team and what to do out of hours. This information was displayed prominently and all staff were aware of the procedure to follow.

All staff had completed safeguarding training to the appropriate level. Staff we spoke with were confident when describing potential abuse or neglect and how they would raise concerns.

Staff were not aware of the procedure for whistleblowing if they had concerns about another member of staff's performance. Staff told us they would raise such issues with either the practice manager or principal dentist.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had a rubber dam kits available for use when carrying out endodontic (root canal) treatment. However, we asked to see the rubber dam kit which was incomplete. Staff told us that it was used consistently but could not locate the missing components or could identify what was missing when asked.

Medical emergencies

The practice had recently implemented arrangements to deal with medical emergencies following the inspection carried out by NHS England. Staff had all attended medical emergency training on 21 June 2016. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). The practice had the emergency medicines set out as advised in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. We found that the practice held two oxygen cylinders, one was newly purchased. The second cylinder had expired but was stored in surgery two. We were concerned that in an emergency situation this expired oxygen would be used and asked the provider to remove it from the practice.

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to staff. The practice had recently implemented the monitoring of the expiry dates of medicines and checking of the equipment to reduce the risk of medicines and equipment expiring. This had been highlighted by NHS England and the practice had introduced a checking system. On examination of the check list, we noted that it had been completed weekly from April until 20 May 2016. The check list did not include the AED and the new oxygen cylinder. We asked staff to add these items to the checklist and ensure that the weekly checks are carried out and recorded.

Staff recruitment

The practice showed us evidence that they did not always obtain all of the required information for members of the team before they had contact with patients.

The practice's written policy for the recruitment of staff was outdated. The policy did indicate some of the required checks that would be required for new staff. The policy stated that all staff employed would be required to submit a full CV and that positions of employment would only be offered on the receipt of suitable references. Staff files we looked at did not contain a CV or any references.

The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an

Are services safe?

official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had obtained DBS checks for all of the staff employed at the practice.

Staff files contained evidence of Hepatitis B inoculation and their current cover status for some staff. We found that this information was not available for one of the dentists. The cover status for another member of staff was very low and could not ensure they were covered. We brought this to the attention of the provider and staff member who said they would arrange for a blood test immediately. We received information following our inspection that this had been carried out.

Monitoring health & safety and responding to risks

The practice had limited arrangements in place to deal with foreseeable emergencies. The practice did not have a health and safety policy for staff to refer to. The provider was responsible for assessing the premises for risk of fire, and fire extinguishers were placed throughout the building. Staff told us they were regularly engaged in fire drills and we saw records of this.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored.

We were not assured that the practice received communications from the Medicines and Healthcare products Regulatory Agency (MHRA) or if any actions had been taken if needed.

There were arrangements to refer patients to another practice in close proximity, should the premises become unfit for use. There was a business continuity plan with key contacts, such as for electrics or plumbing, which could be referred to in the event of service failures.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures.

We were not assured that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices. One of the nurses had overall lead responsibility for infection prevention and control (IPC)

We saw that dental treatment rooms and decontamination room were dirty and draws were cluttered. Staff at the practice were responsible for general cleaning at the practice. We looked at the equipment used to clean the premises and we saw that mops were stored head down, were wet and smelt unpleasant. The mops did not correspond with the correct coloured buckets and there were limited cloths used for cleaning. Staff had not completed a cleaning schedule so it was unclear what cleaning was completed and when or its frequency.

During the inspection we observed that the dental nurses cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the practice had a supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel available. The decontamination room and treatment rooms did not have designated hand wash basins separate from those used for cleaning instruments. NHS England had highlighted this at their inspection in April 2016. The principal dentist gave us an invoice to show that the installation of new sinks had been arranged. The provider was unable to give an exact date as to when the new sinks would be installed.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. We saw that dirty instruments were scrubbed in a sink in the surgeries. New instruments were stored on trays intended for use in close proximity to the sink used for scrubbing the dirty instruments and were exposed to the aerosol created when manually scrubbing. The practice did not separate dirty instruments from clean ones in the decontamination room or whilst they were waiting for use in the surgeries. We noted that clean and dirty areas in the treatment rooms and decontamination area were not defined and there was a risk of cross contamination.

The practice had a decontamination area, where the dental nurses cleaned, checked and sterilised instruments but we noted that the decontamination area was not separate from other activities such as tea and coffee making. Staff

Are services safe?

had undertaken some training in infection control via an online course. We did not feel that staff had been trained sufficiently so that they understood this process and their role in ensuring it was correctly implemented.

Clean and dirty instruments were transported on open trays to and from the surgery. The practice had purchased two lidded boxes for transporting instruments but had yet to use them. We advised staff that they would need four boxes to facilitate safe and compliant transportation of instruments. One clean box and one dirty box for each surgery.

The dental nurse showed us the full process of decontamination including how staff manually scrubbed and rinsed the instruments in cold water, checked them for debris and used the ultrasonic bath and autoclaves (equipment used to sterilise dental instruments) to clean and then sterilise them. Clean instruments were not packaged according to current HTM01-05 guidelines, but stored loose in draws or on open trays in the surgery. We noted that the drawers where the sterilised instruments were stored prior to use also contained other items such as a used toothbrush and a used comb. This posed a risk of recontamination. Staff could not tell us when instruments would expire, therefore staff did not know if these instruments had expired. In the treatment rooms a few instruments were pouched but were blank with no date of expiry.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. Staff were confused on what they needed to do to ensure that the ultrasonic bath was working effectively. We signposted them to HTM01-05 guidance on the maintenance of ultrasonic baths. They showed us the paperwork they used to record and monitor these checks. These had been completed in part but were not all up to date. We saw maintenance information showing that the practice had maintained some of the decontamination equipment to the standards set out in current guidelines such as the autoclave. We saw that the practice was using a cold water bath to process some of their equipment. This process is not included in the HTM 01-05 guidance as it is not effective. NHS England had requested at their inspection previously to stop the use of cold water baths for the purpose they were used for.

The practice used single use dental instruments which we found had been re-used on other patients. Most of the

single use items being re-used were also being processed in the cold water baths. We found numerous rose head burs in each of the two treatment rooms with debris on them. Some were rusty and very dirty. We found items such as polishing brushes, suction tubes, dappen pots and files used in root canal treatment in the cold water baths. They were all dirty and the fluid in the baths was cloudy and contained debris.

We were told that a specialist contractor had carried out a legionella risk assessment for the practice on 15 June 2016 and the practice was awaiting the final report with actions they would need to address. Legionella is a bacterium which can contaminate water systems in buildings. We saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of Legionella. We requested a copy of the report following our inspection which we did not receive. The practice was not using any method to prevent a build-up of legionella biofilm in the dental waterlines. Regular flushing of the water lines had never been carried out in accordance with the manufacturer's instructions and current guidelines. Staff when questioned referred to the cleaning of the aspirator unit and were not aware of the need for the flushing of the water lines.

The practice had carried out audits of infection control every six months using the format provided by the Infection Prevention Society. We looked at the most recent audit staff had answered yes to the section 5.5.6 "instruments are stored pouched" which they were not.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. There were instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument including the contact details for the local occupational health department. We noted that one member of staff did not have their Hepatitis B status recorded. We spoke with the member of staff who informed us that they had just been to the doctors and the results would be sent through shortly. We requested this information to be sent to us following our inspection, which we did not receive. We did receive confirmation from NHS England that they had received this information and that it was satisfactory.

One member of staff had a low conversion rate; this means that they could not be assured that they were fully covered by the Hepatitis B immunisation. We discussed this with

Are services safe?

the member of staff who said they would make an appointment to have their levels checked and a booster vaccination if that was required. We received information following our inspection that this had been carried out.

The practice was not conforming to the clinical and dental waste guidelines from the Department of Health. Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. However, staff told us and we saw that amalgam waste and extracted teeth were disposed of in the hazardous waste bags. This poses an environmental risk, due to the way that the waste bags are processed following their removal from the practice as amalgam contains mercury which needs to be processed differently to make it safe. This was in direct contradiction to the Hazardous Waste Regulations 2009 and is not in line with HTM 01-05.

The practice used an appropriate contractor to remove dental waste from the practice with the exception of extracted teeth and amalgam and we saw the necessary required waste consignment notices.

Equipment and medicines

We looked at the practice's maintenance information which demonstrated that equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies was serviced regularly. Electrical equipment had been PAT tested by an appropriate person. PAT is the abbreviation for 'portable appliance testing'.

Some of the equipment in use at the practice was damaged. We found scaler tips that were rusty, pitted and not kept in a clean state in one of the surgeries. We asked staff if there were any other scaler tips available to use. Staff told us that this was all they had and were the ones in use on patients. The dental chair in surgery one was also in a damaged. Staff were using disposable covers on the chair. We discussed the chairs condition with the provider. We were shown an invoice for re-upholstery of the chair, and was due to be completed. However, we noted that the back of the chair was broken which the re-upholstery would not address and therefore would still make the chair difficult to clean effectively.

Prescription pads held by the practice were securely stored. We saw that the practice had written records of prescription pads to ensure that the use of these was monitored and controlled.

The batch numbers and expiry dates for local anaesthetics were always recorded in the clinical notes.

Temperature sensitive medicines had not been stored in a fridge which is optimal. However, if a particular medicine used for diabetic hypoglycaemia was not stored in a fridge, the expiry date must be reduced by 2 months to ensure it is safe to use. As the medicine had never been stored in the fridge, although the expiry date on the packaging had not expired, the medicine was in the 2 month reduction range and therefore not suitable to use. We received information following our inspection that this medicine had been replaced.

Radiography (X-rays)

The practice did not have a radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The practice had recently obtained the services of a Radiation protection advisor (RPA), which is a requirement of the regulations. Staff had been tasked to complete an online assessment for the RPA and to produce a radiation protection file. The staff in question were not sure what to do did not have the relevant experience or qualifications with regard to radiography and therefore were not competent to complete this task effectively. We discussed this with the provider who stated that they did not know how to complete this task.

Not all of the necessary documentation pertaining to the X-ray equipment was held at the practice. For example, the notification to the Health and Safety Executive (HSE). Critical examination and acceptance test report were available. The practice had equipment performance testing carried out on both of the X-Ray units in June 2015. However, without local rules and diagrams of the controlled areas we could not be assured that radiography at the practice was being carried out safely.

The practice did carry out some monitoring of the quality of each X-ray taken to demonstrate that the dental X-rays were graded and quality assured every time. However, this was just a grade and there had been no analysis or auditing to determine the percentage of grade 3 (undiagnostic) exposures taken. Therefore we could not be assured that the percentage of grade 3 exposures was within the 10% parameters or that patients were being exposed more than once to achieve a diagnostic image.

Are services safe?

Staff had not completed mandatory training for radiography which is a requirement for their registration

with the General Dental Council. One of the dentists had not completed the required IR(ME)R training ever. Three other members of staff had completed online training in radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice did not have robust policies and procedures for assessing and treating patients. This posed a risk to patients as X-rays could be taken at inappropriate intervals and not in accordance with the patient's risk of oral disease.

The dentists told us that they discussed each patient's diagnosis and treatment options. Although options were provided, there was no evidence that possible risks or benefits, advantages or disadvantages of each choice had been discussed.

We noted that dental care records lacked detail and were not in line with, the National Institute for Health and care Excellence (NICE) guidance or the, Faculty of General Dental Practice record keeping guidance. This would support the dentists in maintaining appropriate dental care records. As there were limited policies and procedures for promoting the maintenance of good oral health. We were not assured that the practice gave due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'

We spoke with two patients on the day of our inspection and two more on the telephone, a few days after our visit. Patients commented they were happy with the treatment they had received and felt that their treatment had been explained to them.

Health promotion & prevention

There was literature in the waiting and reception area that explained the services offered at the practice.

Staff told us how they advised patients on how they could maintain their oral hygiene. They also told us how they would discuss the impact of diet, tobacco and alcohol consumption on oral health. However we did not see any evidence in the dental care records we examined with regard to this advice given.

Staff told us they advised patients of the importance of regular check-ups to maintain good oral health.

Staffing

The majority of the staff had worked at the practice for a number of years. Two of the dental nurses and the two dentists were registered with the General Dental Council (GDC).

Although there had been a large amount of training completed, this had been mostly recent as a result of the NHS England inspection. We could not establish if staff were encouraged and supported to maintain their continuing professional development (CPD) to maintain their skill and competency levels. We were concerned that staff had not maintained their CPD throughout the five-year cycle as recommended in the GDC guidance. We noted that some staff had not completed their mandatory radiography training. We requested certification of this training following our inspection but did not receive it.

Working with other services

The practice had a system for referring and recording when patients were sent to other dental professionals for more complex treatments that were not provided by the practice. Staff showed us their referral log book. We looked at referrals to the hospital for the extraction of wisdom teeth, referrals for patients who were anxious and required treatment under sedation and patients who required orthodontic treatment. However there was no system to monitor referrals and their progress once they had been sent out.

Consent to care and treatment

We saw evidence that patients were given a treatment plan to sign, which detailed their proposed treatment. Staff were aware of the need to obtain consent from patients including patients who lacked the capacity to make decisions for themselves, however their understanding was limited. Staff had not received Mental Capacity Act 2005(MCA) training and were not fully conversant with its relevance to the dental practice. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Staff demonstrated limited knowledge of Gillick competency. There was no practice policy for obtaining consent from young patients. The Gillick competency is used to assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients we spoke with were happy with the care and treatment they received at the practice. Some highlighted that they had been patients for many years. Patients commented that they knew their dentist well and this made it easier when explaining problems. All the staff we met spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity.

We observed that the staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking with patients on the telephone.

Patients indicated that they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke

with told us that they had no concerns with regard to confidentiality; we noted that there had been no complaints or incidents related to confidentiality. However we noted that some dental care records were not stored securely. These records were stored on open shelves in surgery two. This had been noted by NHS England at their inspection. The principal dentist provided us with a quotation for cupboards to be installed to replace the open shelving and that these would be locked.

Involvement in decisions about care and treatment

We looked at dental care records and saw that information about the explanations they had provided to patients about the care and treatment they needed had not been recorded.

Patients told us that they felt involved in their care and they were given information about their treatment and fees.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS dental treatment. The practice leaflet provided information about the types of treatments that the practice offered.

The practice arranged enough time to assess and meet patient's needs. The dentists had devised their own time frames for different treatments and procedures. Staff told us that although they were busy they had enough time to carry out treatments without rushing. The practice were able to book longer appointments for those who requested or needed them, such as those with a learning disability.

We found that the practice would accommodate emergency appointments. Patients we spoke with confirmed this and told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day.

Tackling inequity and promoting equality

The practice had recognised the needs of its patient population. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had access to a translation service, but very rarely had the need to use it.

The practice was not accessible to wheelchairs and patients with pushchairs with a small flight of steps at the

entrance. Staff explained how they would help anyone in a wheelchair or with mobility problems. Both treatment rooms were on the ground floor. There was one toilet in the practice which was through reception; this was not accessible for a wheelchair user. Staff explained that patients who could not access the practice at the front of the building would use the rear door and this would make the toilet accessible also. However, we noted that patients using the rear entrance would still need to negotiate a step and the area was quite compact which would make manoeuvring a wheelchair into the practice difficult.

Access to the service

The practice was open Monday, Tuesday, and Thursday 9am to 5pm and Wednesday and Friday 9am to 12pm. Staff told us that on Wednesday and Friday afternoons the practice did not routinely offer appointments and that staff conducted cleaning and administrative tasks.

Concerns & complaints

There was information available for patients giving them details of how to complain. The practice had not received any complaints in the last 12 months. We reviewed the practice complaints policy which was out of date. The information it contained was also incorrect such as the external organisations patients could complain to should they feel that their complaint has not been rectified to their satisfaction. We could not be assured that patients would be signposted to the correct organisation should they need to take a complaint further.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was the registered provider and had responsibility for the running of the practice including its finances and personnel functions.

The practice had conducted some governance activity, although it did not result in any improvements or remedies as a result. We found significant shortfalls in the practice's governance arrangements. Although there were a few basic policies for staff to refer to and to support the management of the service, these were out of date and not wholly implemented. There was no system to show that staff had read, understood and agreed to abide by the policies.

There were limited systems or processes to ensure that quality and safety was appropriately monitored or actions taken to address issues. As a result, staff were not adhering to HTM 01-05 guidance, not monitoring water temperatures or flushing waterlines, auditing information collected was incorrect and we found some materials and medicines that had expired. We found equipment that was damaged and not fit to use which was still in use.

The practice did not have team meetings to discuss the running of the practice or share learning. Staff communicated daily on an informal basis.

Recruitment procedures were not robust, although all staff had undergone a DBS check, references were not obtained and checks in past employment had not been conducted. Staff had received a form of appraisal but had not reviewed performance or have any clear objectives. The practice did not monitor or keep a record of training for staff.

Leadership, openness and transparency

We found there was a lack of leadership provided by the principal dentist who is the registered provider and responsible for the management of the practice. We were concerned that skills had lapsed and in some areas no

training had been completed for a number of years. During our inspection we noted that there were vast gaps in knowledge pertaining to infection control, radiography, the GDC standards and equipment maintenance.

The practice had a whistleblowing policy which was out of date and did not contain up to date information for staff to refer to. Staff when questioned were unsure of what would constitute a whistleblowing or what their duties were under their professional registrations.

Learning and improvement

The practice did not have a structured plan to audit quality and safety. The only audits that had been conducted contained incorrect information or did not conclude to show any outcomes which could be measured or actions to be taken. There was no evidence that learning was shared or that improvement of the service was prioritised.

There was little evidence to show that staff working at the practice were supported to maintain their CPD. There had been no training by one member of staff for radiography. Three members of staff had sourced and completed some training independently. Therefore we could not be assured that training completed was effective, pro-active, implemented change and improvement or would be completed in the appropriate timescales.

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

Patients gave verbal feedback to staff at the practice at each appointment; however this information was not collated and they did not collect any written feedback. Therefore patients were not able to influence how the service was run.

Staff at the practice told us that they could discuss things with the principal dentist and gave feedback on a casual basis. Staff informed us that they had mentioned concerns regarding processes and current legislation in regard to infection control, training and personal development to the provider on many occasions but nothing had arisen from these discussions

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The provider did not operate robust recruitment procedures to ensure that only fit and proper staff were employed. There was no evidence of references, an interview record, or a job description for any staff member. <p>This was in breach of regulation 19(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>