Mr Stephen Kirkup

S Kirkup Dental Surgeon - Frederick Street South

Inspection Report

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Date of inspection visit: 29 September 2016
Date of publication: 09/12/2016

Overall summary

We carried out an announced comprehensive inspection on 29 September 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 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

S Kirkup Dental Surgeon is situated in Meadowfield, Durham. The practice has two treatment rooms, a reception desk contained within one treatment room, a waiting area and an office. Car parking is available on the-streets outside the practice. Access for wheelchair users or pushchairs is possible via the ramp outside and both treatment rooms are located on the ground floor.

The practice is open Monday, Tuesday and Thursday 0900-1700, Wednesday and Friday 0900-1200 and provides predominantly NHS treatment to patients of all ages.

The dental team is comprised of the principal dentist, a dental hygienist who works one day a week and two qualified dental nurses / receptionists.

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

We reviewed 33 CQC comment cards on the day of our visit; patients were very positive about the staff and

Summary of findings

standard of care provided at the practice. Patients commented they felt involved in all aspects of their care and found the staff to be helpful, respectful, friendly and were treated in a clean and tidy environment.

Our key findings were:

- All staff were welcoming and friendly.
- The practice had systems for recording incidents and accidents.
- Staff received annual medical emergency training.
- Patients were very positive about their experiences at this practice.
- Patients could access urgent care when required.
- The practice did not have sufficient emergency medicines or equipment to manage medical emergencies.
- Staff were not clear on recent dental guidance in infection prevention and control, dental sharps and dental radiography.
- The practice did not have a structured audit cycle in place to monitor the quality and safety of dental treatment and administrative work.
- Staff lacked sufficient support for undertaking their continuous professional development.
- Dental care records were not detailed to provide continuation of care or as per guidance from the Faculty of General Dental Practitioners.

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

- Ensure the availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- 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's sharps handling procedures and protocols are in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Ensure audits of various aspects of the service, such as radiography, infection prevention and control 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.
- Ensure staff are up to date with their mandatory training and their Continuing Professional Development (CPD)
- 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 that systems and processes are established and operated effectively to safeguard patients from abuse.

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:

- Review the practice's safeguarding policy and staff training to ensure it covers both children and adults and all staff are trained to an appropriate level for their role and aware of their responsibilities.
- Review 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.
- 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 dental care records are maintained appropriately giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice protocols and adopt an individual risk based approach to patient recalls giving due regard to National Institute for Health and Care Excellence (NICE) guidelines.

Summary of findings

- 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 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'.

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?

Enforcement action 

We found that this practice was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report.

Infection prevention and control procedures did not follow recommended guidance from the Department of Health: Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. The decontamination area was located within one of the treatment rooms and we found it did not have a clear flow for sterilisation procedures. We also saw the dental nurses were not storing instruments in line with the guidance.

Equipment for decontamination procedures, radiography and general dental procedures were tested and checked according to manufacturer's instructions. Recommendations from the X-ray maintenance tests (such as reduction in radiation dose and use of a different film type) were not implemented.

Emergency medicines and equipment were not in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. We saw the practice did not have Midazolam on-site to use in the event of an epileptic emergency. Several items of emergency equipment were also not available within the practice including: self-inflating bag for children, various masks to attach to the bag, airways of specific size and an Automated External Defibrillator (An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). The Resuscitation council UK guidance suggests a defibrillator should be placed on a patient within three minutes of collapse. If a practice does not have their own defibrillator, it is important to have arrangements to access one in an emergency. The registered provider explained they did not have such an arrangement.

Staff we spoke with were not knowledgeable about safeguarding systems for adults and children.

The practice's safeguarding policy was specific to children only and did not contain any contact references for advice in the event of a safeguarding issue.

The practice had processes for recording and reporting any accidents and incidents.

Risk assessments (a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm) were in place for the practice.

Are services effective?

Enforcement action 

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report.

Summary of findings

Dental professionals were not following and were not aware of the guidance from the National Institute for Health and Care Excellence (NICE) and the Delivering Better Oral Health toolkit (DBOH) to ensure their treatment followed current recommendations. One example includes patients deemed to be in a “high risk” category were not recalled at the recommended intervals.

We enquired about referrals to other services; dental nurses advised us the practice rarely referred patients elsewhere.

Staff who were registered with the General Dental Council (GDC) did not meet the requirements of their professional registration by carrying out regular training and continuing professional development (CPD). We found staff had not undergone recent training in infection prevention and control or safeguarding and they did not understand the concept of information governance and mental capacity.

Are services caring?

No action

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

Patients were very positive about the staff, practice and treatment received. We left CQC comment cards for patients to complete two weeks prior to the inspection. There were 33 responses all of which were positive, with patients stating they felt listened to and received suitable care at that practice.

Dental care records were kept in lockable cabinets behind the reception desk in the main surgery.

We observed patients being treated with respect and dignity during our inspection. We also observed staff to be welcoming and caring towards patients.

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 had dedicated slots each day for urgent dental care and every effort was made to see all emergency patients on the day they contacted the practice.

Patients had access to telephone interpreter services when required and the practice implemented a range of aids for different disabilities such as a sloped entrance path for wheelchair users or people with pushchairs and large print leaflets/information sheets for those with visual deficiencies

Are services well-led?

Enforcement action 

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 Enforcement section at the end of this report.

The principal dentist was the lead for the overall management of the practice and for infection prevention and control, complaints and safeguarding.

Summary of findings

The practice did not keep essential documents, training logs and certificates of all employed staff.

Staff were encouraged to provide feedback on a regular basis through staff meetings and informal discussions. We found there were no formal records of this.

The practice had not carried out six-monthly infection control and prevention audits as recommended by HTM0105. We also found staff were not undertaking regular assessment and monitoring of radiographic processes in line with the Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000.

Patient feedback was sought through the practice suggestion box and satisfaction questionnaires.

S Kirkup Dental Surgeon - Frederick Street South

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 29 September 2016. It was led by a CQC inspector and supported by a second inspector and a dental specialist advisor.

We informed NHS England area team and Healthwatch County Durham that we were inspecting the practice; we received supporting information of concern from them which we acted upon.

During the inspection, we spoke with the registered provider (principal dentist), the dental hygienist and two qualified dental nurses /receptionists.

We reviewed policies, protocols, certificates and other documents to consolidate our findings.

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

Staff told us they were not aware of the Duty of Candour principle which states the need to be open, honest and apologetic to patients if anything was to go wrong.

Staff were not clear on what incidents or accidents needed to be reported, when and to whom as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013 (RIDDOR). Staff advised they would refer to their practice policy for reporting anything relevant; we checked the policy and there were no details that explained the process. The practice had systems in place for recording accidents and incidents such as an accident book and incident log. There were no accidents or incidents recorded by the practice within the last twelve months.

Staff meetings took place every month where various aspects of the practice were discussed so as to enable staff learning. We saw brief, unstructured minutes of meetings.

The principal dentist told us they had not received safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) since 2013. The MHRA is the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness. The alerts prior to 2013 were kept in a file so we queried why the provider had not contacted the MHRA about not receiving any since then; the provider did not feel it was necessary. This could endanger patients especially where alerts are for emergency medicines or equipment recalls.

Reliable safety systems and processes (including safeguarding).

We spoke with staff about the use of safer sharps in dentistry as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The practice had a generic sharps risk assessment as part of their overall practice risk assessment. This was not practice specific and not dated, nor reviewed. The registered provider confirmed they preferred to use traditional syringes and needles and they did not use any safety measures.

Flowcharts were displayed describing how a sharps injury should be managed. Staff advised us of their local policy on occupational health assistance.

The principal dentist and dental nurses told us they did not routinely use a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We were told the dentist used a safety chain for endodontic files (instruments used to clean out the root canals) to prevent these instruments from accidently being dropped. We saw the practice did not have a risk assessment to justify lack of use of a rubber dam for prevention of solutions being ingested or for moisture control measures.

We reviewed the practice's policy for safeguarding. This was specific to children only and did not contain any contact details of the local authority child protection and adult safeguarding teams. The principal dentist was the safeguarding lead and training records showed they had not undergone refresher training since 2012. We were told dental nurses had not attended any safeguarding training.

The practice had a whistleblowing policy which all staff were aware of. Staff told us they felt confident they could raise concerns about colleagues with the principal dentist without fear of recriminations.

Medical emergencies

The practice did not follow the guidance from the Resuscitation Council UK and British National Formulary (BNF) and they did not have sufficient arrangements in place to deal with all medical emergencies.

Staff had received training in basic life support in November 2015 and knew where emergency equipment /medicines were kept.

We saw the practice did not have Midazolam on-site since December 2015 and requested this to be ordered immediately. Midazolam is needed to treat an epileptic emergency. There were ampules of adrenaline available, however the syringes and needles that were required to use with the ampules had expired. Adrenaline is the medication required for a person who has an anaphylactic reaction.

Are services safe?

Several items of emergency equipment were also not available within the practice including the self-inflating bag for children, various masks to attach to the bag, airways of specific size and an Automated External Defibrillator (An AED is a portable electronic device that analyses the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). A defibrillator should be placed on a patient within 3 minutes of collapse and if a practice does not have their own, it is reasonable to have arrangements to access one in an emergency. The provider explained they did not have such an agreement.

We saw the practice was storing their Glucagon (used for diabetic emergencies) in the medical emergencies box and had not reduced the expiry date as recommended by the manufacturer's guidance.

We found the oxygen cylinder was due to be serviced in January 2016; we saw no evidence of this being carried out.

We requested all missing items to be ordered immediately; we did not receive any evidence to confirm this was done following the inspection. We contacted the practice regarding this and were advised the principal dentist would respond with the evidence; we have not received any communication from the principal dentist since the inspection.

We saw the practice kept logs which indicated the emergency equipment, oxygen cylinder and emergency drugs was fit for use and within the manufacturer's expiry dates. We advised the prinicipal dentist to review this system so as to ensure it is more effective.

Staff recruitment

We reviewed the staff recruitment files for all members of staff to check that appropriate recruitment procedures were in place. The practice had not recruited any new staff within the last 20 years. We found staff files did not contain all the required documents including proof of identity, qualifications, references and an enhanced Disclosure and Barring Service (DBS) check. A DBS check helps employers to make safer recruitment decisions and can prevent unsuitable people from working with vulnerable groups, including children. We saw that one member of staff had a DBS check carried out very recently. We found this was a standard check and was not suitable for employees who work with children and vulnerable adults.

Monitoring health & safety and responding to risks

We reviewed various risk assessments (a risk assessment is a system of identifying what could cause harm to people and deciding whether to take any reasonable steps to prevent that harm) within the practice.

We looked at the Control of Substances Hazardous to Health (COSHH) file, the practice risk assessment, health and safety risk assessment and fire risk assessment. These were not dated and there was no evidence to suggest these had been reviewed.

COSHH files are kept to ensure providers retain information about the risks from hazardous substances in the dental practice. We found the practice had access to the products' safety data sheets (these provide information on the general hazards of substances and give information on handling, storage and emergency measures in case of accidents) but did not have risk assessments for all materials as required by the Health and Safety Executive.

The practice had two fire exits; clear signs were visible to show where evacuation points were.

We saw annual maintenance certificates of firefighting equipment including the current certificate from April 2016.

Infection control

We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures. This was not in accordance with the The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health which details the recommended procedures for sterilising and packaging instruments.

We spoke with dental nurses about decontamination and infection prevention and control; the process of instrument collection, processing, inspecting using a magnifying light, sterilising and storage was clearly described and shown. We found instrument reprocessing and storage was not in line with the guidance. Used instruments were transported from one surgery to the other in a lidded box which was not secure. Water was used to soak instruments in dirty box rather than the recommended disinfectant. Sterilised instruments were kept in surgery in a clean lidded box for use that day and any unused instruments were not re-sterilised as recommended in HTM0105; they were packaged and sealed and dated for one year. Other instruments would be kept in a lidded box for up to a week

Are services safe?

in the treatment room. This is not in line with the storage guidance. The dental nurses told us they did not always wear correct PPE during sterilisation procedures. We found two high speed hand pieces that were rusty and the staff had not recognised this.

We saw the daily and weekly tests were being carried out by the dental nurses to ensure the decontamination equipment were in working order.

We inspected the treatment rooms. Surgeries were cluttered and we found one surgery had an extension plug and cables spread across floor which could be a potential trip hazard.

There were hand washing facilities, liquid soap and paper towel dispensers in each of the treatment rooms, decontamination room and toilets.

A Legionella risk assessment was carried out in November 2014 (Legionella is a term for particular bacteria which can contaminate water systems in buildings and a risk assessment quantifies this). We saw the recommended monthly temperature checks were implemented and recorded.

The practice stored clinical waste in a secure manner and an appropriate contractor was used to remove it from site. Waste consignment notices were available for the inspection and this confirmed that all types of waste including sharps and amalgam was collected on a regular basis.

Designated practice staff carry out daily environmental cleaning. We observed the practice used different coloured cleaning equipment to follow the National Patient Safety Agency guidance.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations.

We saw evidence of servicing certificates for X-ray machines, sterilisation equipment and compressor in August 2016 and the Portable Appliance Testing (PAT) certificate from March 2015 (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use).

We saw the fire extinguishers had been checked in April 2016 to ensure they were suitable for use if required.

Local anaesthetics were stored appropriately and a log of batch numbers and expiry dates was in place.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice kept a radiation protection file which included the local rules and maintenance certificates. The local rules were also displayed in the surgeries but did not contain all essential information, for example, the name of the radiation protection advisor. The practice was unable to demonstrate their notification to the Health and Safety Executive (this is a legal requirement which advises the government of radiation at the premises). Recommendations from the X-ray maintenance tests (such as reduction in radiation dose and use of a different film type) were not implemented.

The principal dentist was not undertaking regular analysis of their X-rays through an annual audit cycle.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found the dental professionals were not consistently following guidance and procedures for delivering dental care.

A comprehensive medical history form was filled in by patients and this was checked verbally at every visit. An examination was carried out to assess the dental hard and soft tissues including an oral cancer screen. Dental professionals also used the basic periodontal examination (BPE) to check patients' gums. This is a simple screening tool that indicates how healthy the patient's gums and bone surrounding the teeth are.

Patients were advised of the findings and any possible treatment required although this was not always recorded.

The principal dentist told us they were familiar with current National Institute for Health and Care Excellence (NICE) guidelines for wisdom teeth removal and antibiotic cover though not for recall intervals. One example includes patients deemed to be in a "high risk" category were not recalled at the recommended interval. We spoke with the principal dentist who told us recalls were not based upon the patients' risk of dental diseases as suggested by the NICE guidance and were not documented in dental care records.

We spoke with the principal dentist who told us they did not take radiographs at the intervals recommended by the Faculty of General Dental Practitioners (FGDP). A justification, grade of quality and report of the X-ray taken was not documented in the patients' dental care records that we reviewed. An external mentor was supporting the principal dentist with a view to improve his general record keeping.

We used guidance from the Faculty of General Dental Practice (FGDP) to help us make our decisions about whether the practice records and record keeping were meeting best practice guidelines. We found no evidence to suggest the practice had systems in place that were equal to or better than what was recommended in the FDGP guidance.

Health promotion & prevention

We found staff were not familiar with the Department of Health's 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive care and advice to patients.

We discussed preventative measures and found the practice was providing patients with oral hygiene advice such as tooth brushing technique and dietary advice. Smoking and alcohol consumption was also checked where applicable. This was not always recorded. We found staff lacked knowledge in other preventive procedures and were not following the guidance from DBOH in recall intervals and risk category, application of fluoride varnish at appropriate intervals and prescribing high concentration fluoride toothpaste appropriate to the patient's age.

The practice held a range of dental products for sale and information leaflets were also available to aid in oral health promotion.

Staffing

The registered provider was the lead for infection prevention and control, safeguarding and complaints.

Prior to our visit we checked the registrations of all dental professionals with the General Dental Council (GDC); this was also confirmed on the day of the inspection. The GDC is the statutory body responsible for regulating dental professionals.

Staff who were registered with the General Dental Council (GDC) did not meet the requirements of their professional registration by carrying out regular training and continuing professional development (CPD). We found staff had not undergone recent training in infection prevention and control or safeguarding and they did not understand the concept of information governance and mental capacity.

Working with other services

We enquired about referrals to other services; dental nurses advised us the practice rarely referred patients elsewhere but they were aware of the need to do so if the treatment required was not provided.

Consent to care and treatment

We spoke with staff about how they implemented the principles of informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. The dentist was not aware of the term

Are services effective?

(for example, treatment is effective)

informed consent and their explanation of how to obtain this from a patient required much prompting. We reviewed the dentist's mentor's latest report which confirmed a lack of obtaining fully informed consent prior to treatment. Generally, once the treatment and options have been explained, the patient would sign their treatment plan and take the original document. A copy would be retained and documented in the patients' dental care record. We saw no evidence of consent being recorded in the dental record cards we reviewed.

Staff were not clear on the principles of the Mental Capacity Act 2005(MCA) and the concept of Gillick competence. The MCA is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment, without the need for parental permission or knowledge. The child would have to show sufficient mental maturity to be deemed competent. We spoke with all staff and it was apparent there was a general lack of knowledge, understanding and inability to apply the principles of informed consent (including in their documentation), MCA and Gillick competence. This could compromise patient safety and care.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We provided the practice with CQC comment cards for patients to fill out two weeks prior to the inspection. There were 33 responses all of which were very positive with compliments about the staff, practice and treatment received. Patients commented they were treated with respect and dignity and that staff were sensitive to their specific needs.

We observed all staff maintained privacy and confidentiality for patients on the day of the inspection. The reception desk being situated in the main treatment room could result in a breach of confidentiality and so staff were very aware of their responsibilities. If further privacy was requested, patients were taken to the principal dentist's office to talk with a staff member.

We saw that doors of treatment rooms were closed at all times when patients were being seen. Conversations could not be heard from outside the treatment rooms which protected patient privacy.

Dental care records were stored in paper form lockable cabinets.

We found staff had not undergone training in Information Governance (IG) and the principal dentist was not aware of the IG toolkit (an online guide by the government which enables healthcare professionals to understand their role in data protection).

Involvement in decisions about care and treatment

Posters showing NHS and private treatment costs were displayed in the waiting area.

We spoke to staff about involving patients in decisions about their care; we found this was described well although informed consent was not understood. We looked at dental care records which confirmed consent, treatment options and costs were not documented.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw the practice waiting area displayed a variety of information including patient leaflets, practice opening hours, emergency 'out of hours' contact details and treatment costs. Leaflets on oral health conditions and preventative advice were also available.

The practice had dedicated slots each day for emergency dental care and every effort was made to see all emergency patients on the day they contacted the practice. Reception staff had clear guidance to enable them to assess how urgently the patient required an appointment.

We looked at the appointment schedules and found that patients were given adequate time slots for different types of treatment.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place to support staff in understanding and meeting the needs of patients. The policy was reviewed annually.

The practice had made reasonable adjustments to prevent inequity for various patient groups. The practice had not carried out a disability access audit. This is an assessment of the practice to ensure it meets the needs of disabled individuals, those with restricted mobility or with pushchairs. The practice accessible to wheelchair and pushchair users in their ground floor surgeries and an external sloped pathway ensured step-free access. The ground-floor toilet was not spacious enough to accommodate wheelchairs or pushchairs and consequently was not equipped with any disability aids.

Access to the service

The practice is open Monday, Tuesday and Thursday 0900-1700, Wednesday and Friday 0900-1200.

These timings were displayed in their premises and in the practice information leaflet. There were clear instructions on the practice's answer machine for patients requiring urgent dental care when the practice was closed.

Concerns & complaints.

The practice had a complaints policy which provided guidance to staff on how to handle a complaint. The policy was detailed in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and as recommended by the GDC.

The GDC requires dental practices to display their complaints policy and procedures so that patients can easily access information. We found the practice had no information regarding their complaints procedures and advised the provider of this. They assured us their policy would be displayed immediately.

The practice received no complaints in the last twelve months.

Are services well-led?

Our findings

Governance arrangements

The principal dentist provided us with the practice policies, procedures, certificates and other documents. We viewed documents relating to safeguarding, whistleblowing, complaints handling, health and safety, staffing and maintenance. We noted policies and procedures were kept under review by all staff on an annual basis. We found some policies were signed off annually but not actually updated to reflect the changes within dentistry or within legislation.

Leadership, openness and transparency

The overall leadership was provided by the registered provider (principal dentist).

Staff told us they were not aware of the Duty of Candour requirements.

Duty of Candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

Learning and improvement

Clinical and non-clinical audits were not apparent within the practice. An audit is anobjective assessment of an activity designed to improve an individual or organisation's operations.

We found the practice was not carrying out six-monthly infection control and prevention audits as recommended by HTM0105. The previous infection control and prevention audit was by NHS England in 201. Radiography audits are a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000; none had been carried out in the practice since 2013.

Improvement in staff performance was monitored by appraisals. These were initialised in August 2015 and the principal dentist told us they would be carried out annually.

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

The practice had systems in place to seek and act upon feedback from people using the service. Patients and staff were encouraged to provide feedback on a regular basis verbally however there was no documentation of this. Patients were also encouraged to use the suggestion boxes in the waiting rooms and to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on the services provided. We did not see any written documentation or analysis of the FFT results.

Staff told us their views were sought and listened to and that they were confident to raise concerns or make suggestions to the registered provider however there were no formal staff satisfaction surveys.

This section is primarily information for the provider

Enforcement actions

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 The registered provider failed to consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate: 1. The registered provider did not follow infection prevention and control guidance from HTM0105, Sharps Regulations 2013 or Health and Safety Executive. 2. The registered provider did not have sufficient arrangements for managing medical emergencies as per the Resuscitation council UK guidance. 3. The registered provider failed to act upon the requirements suggested following their maintenance of X-ray machines and did not possess all essential documents in their radiation protection file. 4. The registered provider was not aware of their safeguarding protocols and staff were not trained in safeguarding. 5. The registered provider was not clear on the principles of informed consent, mental capacity act and Gillick competence.

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 provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity:

This section is primarily information for the provider

Enforcement actions

1. The registered person had not carried out audits in infection prevention and control or radiography within the last 12 months.
2. The registered provider did not monitor their staff in their development or training needs. There was very little training evidence in recommended GDC topics.
3. The registered provider did not ensure risk assessments were carried out for all materials and practice risk assessments were not reviewed or updated.