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Newnham Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 4 May 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 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

Newnham Dental Practice provides private dental treatment to patients of all ages. The principal dentist employs two dental nurses, two receptionists and two hygienists also provides services to the practice.

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 received feedback from 30 patients during the inspection process. All of the patients provided positive comments about the quality of care they received, cleanliness of the premises and told us that staff were respectful, professional and understanding.

Our key findings were:

- Staff were committed to providing a positive patient experience, were hard working and caring.
- The practice did not have robust systems in place to help ensure patient safety. These included responding to medical emergencies, managing infection control risks and the appropriate management of environmental risks.
- The practice did not meet the standards required to ensure compliance with Health Technical Memorandum 07-01 (HTM 07-01) and Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.

Summary of findings

- Staff completed continuing professional development to maintain their professional registration. However, there was no process in place to identify core training and monitor whether this had been completed.
- Patients' care and treatment was mostly planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients reported that they were well treated by staff and received sufficient information about their care and treatment.
- Appointments were easy to access and this included emergency appointments that were available each day for patients who required urgent treatment.
- The practice did not have robust quality monitoring systems and did not have a regular audit plan in place to ensure the quality and safety of key service areas, including infection control.

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 that infection control procedures are suitable and followed by staff. Undertake a Legionella risk assessment and implements the required actions. These actions must be in line with 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 that the storage and disposal of waste is in accordance with relevant regulations giving due regard to guidance issued in the Health Technical Memorandum 07-01 (HTM 07-01).
- Ensure the practice has a recruitment policy that is in line with Regulation 19 and 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 an effective system is established to assess, monitor and improve the quality of the service and to mitigate the various risks arising from undertaking of the regulated activities.
- Ensure systems are put in place for the proper and safe management of medicines.

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 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 practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurances and, ensuring that imporvements are made as a result
- Review the practice's safeguarding policy and staff training ensuring 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 training, learning and development needs of staff members including awareness of safeguarding procedures and of the Mental Capacity Act 2005. Introduce a system to monitor and review progress with training at appropriate intervals and an effective process for the on-going assessment and appraisal of all staff employed.
- Review staff awareness of safeguarding procedures and of the Mental Capacity Act 2005 so that staff are aware of their responsibilities in relation to their role.
- 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.
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely. Review all relevant documentation to ensure it is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.

Summary of findings

- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- 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 practice's protocols for completion of dental records ensuring this includes the formal recording of risks and benefits of proposed treatment options. This should give due regard for guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development.
- Introduce a system to monitor patient referrals and routinely offer patients a copy of their referral letters.
- Review the complaints policy and information available so that it is consistent. Introduce a process for recording the actions taken and the resulting outcomes following the investigation of complaints.

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 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 Requirement Notices section at the end of this report).

We found areas where improvements should be made relating to the safe provision of treatment. The practice did not have robust systems in place to help ensure patient safety. These included responding to medical emergencies, managing infection control risks and the appropriate management of environmental risks. The infection control procedures in use did not meet the national guidance.

The practice was not meeting the standards as required by the Ionising Regulations for Medical Exposure Regulations (IR(ME)R 2000.

The practice had not completed robust risk assessments to identify and manage risk for example; there was no risk assessment for latex allergy and some environmental risks had not been identified and managed for example, the risks of legionella.

Staff were not clear about reporting incidents, near misses, and concerns although there had been no reported incidents.

Most staff had worked at the practice for several years although one member of staff had been appointed less than a year previously. However, there were no recruitment records available and the practice did not have a recruitment policy in place. Disclosure and Barring Service checks had not been undertaken for all dental staff.

Regular professional registration checks were undertaken for registered dental professionals who took responsibility for maintaining their own professional development. However, there was no system in place to monitor core training completed by staff and records were not maintained.

There were several items of equipment and some medicines that had expired and there were no systems in place to complete regular checks.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). The dentists was also able to demonstrate an awareness of the Faculty of General Dental Practice Guidelines, a professional membership body that supports standards of dentistry practice. Patients received a comprehensive assessment of their dental needs including taking a medical history. Explanations were given to patients in a way they understood. Patients told us they were made aware of risks, treatment options and costs. Patients were referred to other services in a timely manner and staff followed appropriate guidelines for obtaining patient consent. There had been no audits of dental care records to support that patients were assessed and received treatment in line with best practice guidelines.

Dental staff maintained their professional development although no core training programme was in place for all staff working at the practice. There was no system in place to monitor progress with training. Staff did not receive a regular performance appraisal to formally review their role and identify personal learning and development.

Are services caring?

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

Summary of findings

Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially.

Patients with urgent dental needs or pain were responded to in a timely manner, usually on the same day.

Feedback we received from patients showed that they were positive about the service and the support and treatment they received from staff.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Information about emergency treatment was made available to patients and the practice leaflet explained the services that were provided. The practice had made some adjustments to accommodate patients with a disability. Patients who had difficulty understanding care and treatment options were supported, although staff would benefit from a review of the Mental Capacity Act 2005 training. The practice had a complaints policy in place although this required a review to ensure that all complaints information was consistent.

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).

We found a number of shortfalls in the practice's governance and leadership. Robust policies and procedures to govern the practice's activities were not always in place. For example, there was no recruitment policy and no clear process for identifying and addressing any significant events or incidents. Many policies were undated and it was not clear when they were due to be reviewed. There were no clear systems in place to communicate with staff. Although there were few staff employed, they were not kept informed about developments or quality issues within the practice.

Performance monitoring processes were not well established. For example there was no audit plan in place to monitor the quality of key aspects of care such as the completion of dental records and infection control systems. When an X-ray audit and a patient survey had been completed there were no documented learning points or action plans identified. Staff training and performance was not actively monitored.

Newnham Dental Practice

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 4 May 2016 and was conducted by a CQC inspector and a specialist dental advisor.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications, and proof of registration with their professional bodies. We also reviewed the information we held about the practice.

During the inspection we spoke with the principal dentist, a dental nurse, a receptionist and a hygienist. We reviewed policies, procedures and other documents. We received feedback from 30 patients who used the service.

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

We found the practice did not have a policy in place to support the identification, reporting and investigation of incidents. Although a reporting template was available, this was not readily accessible to staff and there had not been any recorded incidents. Staff told us that if anything were to go wrong, they would raise it verbally with the dentist although there was no evidence to confirm this happened. Not all of the practice staff we spoke with had an understanding of what might constitute a significant incident.

We asked to view the practice's current accident book; we were shown a note book which contained one accident from 2007. No other accidents had been recorded and the principal dentist told us no accidents had occurred since.

The dentist had not signed up to receive communication from the Medicines and Healthcare products Regulatory Agency (MHRA) and did not have a clear system in place to ensure that action was taken in response to safety alerts.

Reliable safety systems and processes (including safeguarding)

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. We discussed this with dentist and found that a rubber dam was used in all root canal treatments and for restorative work.

We spoke with staff about safeguarding vulnerable patients and found their level of knowledge varied. One member of staff was uncertain of the term vulnerable adult and two staff were not familiar with the Mental Capacity Act 2005. We looked for certificates of training in safeguarding adults and children and could not locate evidence that all staff had completed this as there was no system for monitoring training progress. One member of staff had completed child protection training in 2012. There was no evidence that this training had been updated or that they had completed any training in safeguarding vulnerable adults.

The practice had policy statements for safeguarding vulnerable adults and children. The policies did not direct staff on how to recognise and report any safeguarding concerns and did not contain information on how to contact local authority safeguarding teams. The dentist was the lead for safeguarding. No safeguarding concerns had been reported.

Medical emergencies

On the day of our visit, staff did not have access to an automated external defibrillator (AED) in line with current guidance; however the provider had ordered one and was waiting for it to be delivered. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

The emergency equipment items did not meet the minimum recommendations for dental practice issued by the Resuscitation UK Guidelines 2013. The equipment required during an emergency situation was difficult to access quickly because items were not stored in a container together. Some items were stored loosely in a drawer such as masks and airways. Some of the airways available had expired and there was no size 4 airway available. We found other items of equipment that were out of date. This included water for injection (expired 2014) needles (expired 1997) and butterfly needles (expired 2006). These were in the drawer beside needles that were in date.

The practice held most emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that midazolam was not available in the recommended oral form. The practice held a medicine to treat patients who had an allergic reaction although this was out of date and had not been discarded. Glucogon injection was stored out of the fridge, and had not had the expiry date reduced to ensure it was safe to use. Glucagon is a medicine used to quickly increase a patient's blood sugar level in an emergency.

One medicine was due to expire at the end of the month. There was no system in place to ensure that medicines and emergency equipment was checked on a weekly basis.

Staff recruitment

Are services safe?

The practice had a small and stable workforce although a temporary member of staff had been recruited last year. The prinicipal dentist told us there was no recruitment policy in place. We also found that Disclosure and Barring Service (DBS) checks were not in place for staff who had been more recently recruited. The dentist was unaware that dental nurses required a DBS check. There was no policy or process to determine which staff roles required this check. We referred the practice to the DBS website and CQC guidance for dental providers.

Monitoring health & safety and responding to risks

The practice had a health and safety policy displayed on a noticeboard in the staff area. We noted this made reference to the management of sharp instruments advising staff to be careful when resheathing needles. This did not support best practice guidelines.

There was a first aid kit and an eye wash kit available in the office. However the eye wash kit had expired on September 2015 and the first aid kit contained sterile dressings that had expired in 1998.

A short fire risk assessment was displayed on the staff noticeboard and we noted the fire extinguishers had been checked in February 2016. Staff had not received fire training or other health and safety training. No fire drills had taken place.

There was a Control of Substances Hazardous to Health (COSHH) folder in place that contained chemical safety data sheets for products used within the practice. It was not clear when these had last been reviewed. A cupboard in the staff room contained some cleaning materials that were not locked away. In addition there were bottles of fluid in unmarked containers some of which resembled bottles used for children's drinks. Although these were stored on a high level shelf, the area was accessible to visitors and children. The risks had not been assessed to ensure the safety of staff and patients at the practice.

A legionella risk assessment had been attempted by the principal dentist but was not fully completed and had no identified actions. When we spoke with him we found that his knowledge of legionella management was limited. Water temperature checks were not routinely carried out in the building as a precaution against the development of legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

We reviewed other risk assessments that included issues such as clinical waste, administration of medicines, hot water and lifting heavy objects. There was no risk assessment for latex allergy. The risk assessments were not dated, had not been completed in detail and were not followed in practice. For example; the assessment for hot water did not include potential risks of legionella, sharps boxes were not stored out of reach of children and clinical waste was not stored in a locked cupboard.

Infection control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. However, we found the practice did not follow robust infection control procedures.

The practice was visibly clean, tidy, and uncluttered in most areas although one treatment room was cluttered and this could prevent adequate cleaning. Treatment rooms contained two sinks and it was not clear that one had been designated as a dirty sink to avoid any risks of cross contamination. Clean and dirty areas had not been designated in one of the treatment rooms we reviewed.

There was an infection control policy in place that was reviewed on an annual basis although there was no evidence that staff had read it and we found that safe decontamination practice was not always followed. The dentist was responsible for infection prevention and control and the practice team were responsible for cleaning the practice. Cleaning equipment for the premises was not in line with NHS guidelines.

The practice did not have systems for testing and auditing the infection control procedures; there was no evidence that any audits had been undertaken, this did not meet the requirements as recommended in The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05). This document is published by the Department of Health and sets out in detail the essential processes and practices to prevent the transmission of infections.

Decontamination of dental instruments took place in a room which also served as a staff area. The principal dentist had no plans in place to upgrade this facility. Observation of the area caused concern as there were insufficient numbers of sinks to prevent cross contamination and segregation of the area was unclear. We spoke with a dental nurse who described the

decontamination system they followed. Used dental instruments were transferred to the decontamination area and manually scrubbed in a sink clearly marked for this purpose. Once cleaned a magnifier and light were available to inspect the instruments to ensure that all debris was removed before placing them into an autoclave machine (a device for sterilising dental and medical instruments). Sterilised instruments were then placed in a clean box and returned to the treatment rooms where they were placed into sealed bags and dated with an expiry date.

However, when we observed the process, we found this was not followed in line with HTM 01:05. Staff did not check the water temperature before manually cleaning instruments to ensure it was kept below 45 degrees Celsius. Following a manual clean, items were not always checked under the magnifier to ensure that all debris has been removed. We also found the nurse did not use full personal protective equipment (apron, visor or mask) and did not dry sterilised instruments on a lint free cloth prior to them being packaged.

We observed a dental nurse clean a box that had been used for the transfer of dirty dental instruments into the decontamination area. She did not wear gloves and washed her hands in the sink used for washing up staff cups. This put staff at risk of cross contamination.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). Dental nurses described the method they used which was in line with current HTM 01 05 guidelines. We saw that records of the water measurements were not made. This would help improve the monitoring process as staff would be alerted to any increased measurement of bacteria in the water supply and could take further action before unsafe levels were reached.

The practice did not have a robust sharps management policy or risk assessment. We saw that a sharps bin in one treatment room was stored on the floor posing a risk that children could access it. We found that dental nurses handled sharp instruments and the "safer" syringe systems were not in use. Staff we spoke with were aware of the immediate first aid steps that should be taken in the event of an injury but did not know what follow up they would require through an occupational health team or their own GP and this information was not displayed. There had been no reported sharps injuries. Records indicated that appropriate staff had been immunised against Hepatitis B.

Clinical waste was not appropriately stored. We found that clinical waste and sharps boxes were stored under worktops in the staffroom/decontamination area. Staff told us the waste contractor removed the waste every eight to nine weeks and waste consignment notices verified this. The storage of clinical waste posed a risk to staff and members of the public who had access to the area as it was stored in an unlocked area for lengthy periods of time before it was removed by the waste contractor.

Equipment and medicines

The practice had equipment to enable them to carry out the full range of dental procedures that they offered and staff told us they had sufficient equipment to carry out their work. The dental chairs, equipment and furniture we saw in the treatment rooms were in an acceptable condition.

We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were regularly completed although they did not include a log of temperatures and pressure. Quarterly and annual checks were also in place. Electrical equipment had been checked in September 2014 and was due to be retested in 2017.

Private prescription pads were stored in a locked drawer. However, we also saw several brown medicine bottles containing coloured capsules in the drawer. The bottles were not labelled to identify the name of the medicine, the strength or an expiry date. This was unsafe practice.

The oxygen cylinder was in date although there was no evidence to demonstrate that the regulator had been serviced. There was a self- inflating bag and mask with the oxygen suitable for use in children but no adult sized mask. There was no evidence to show the oxygen was regularly checked.

Radiography (X-rays)

Are services safe?

We asked the practice to provide us with evidence that they were registered with the Health and Safety Executive as required under Ionising Radiations Regulations 1999 (IRR99). This was made available to us following the inspection.

The practice had a radiation protection file that contained a contract with a radiation protection advisor (RPA) that had been in place until the end of March 2016. The dentist told us the contract had been agreed with an alternative RPA but the paperwork to support this had not yet been received.

The dentist was listed as the radiation protection supervisor and should ensure that the equipment was operated safely and by qualified staff only. The last full assessment (critical examination) of the X-ray equipment was conducted in October 2014 which showed that the equipment tested at that time was functioning to a satisfactory standard. The next test was due in 2017. No additional annual maintenance visits were evidenced and the dentists confirmed there had been no installations of new equipment for several years.

Local rules were available in the radiation protection folder. Those authorised to carry out X-ray procedures were named in all documentation and had signed their agreement to follow them. We saw evidence that the dentist had been booked for attendance at radiology update training. The attendance certificate was not available although the dentist has since followed this up and informed us that a copy will be provided.

We asked the dentist if he followed the Faculty of General Dental Practice guidelines. He told us that the frequency of taking X Rays was based on the patient's risk of disease as advised by the Faculty of General Dental Practice.

The dentist monitored the quality of the X-ray images on a regular basis and completed regular audits.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with the dentist about the care and treatments offered to patients. Dental assessments and treatments were carried out in line with recognised general professional guidelines. Patients completed a questionnaire about their medical history, current health, medication and any known allergies when they registered with the practice. This was updated verbally at each check-up visit and formally reviewed every two years. Any potential health issues were considered as part of each patient's dental assessment and treatment plan. Dentists then completed an assessment that included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health, whether it had changed since the last appointment and any recommended treatments options were discussed.

Dental care records (paper and digital formats) shown to us by the dentist indicated that the National Institute for Health and Care Excellence (NICE) guidance was being followed. X-rays taken were graded and recorded but the justification for the X-ray was not recorded. This was not in accordance with the Ionising Regulations for Medical Exposure Regulations (IR(ME)R 2000).

Patients requiring specialised treatment such as conscious sedation were referred to other dental specialists. Their treatment was then monitored after being referred back to the practice once it had taken place to ensure they received a satisfactory outcome and all necessary post procedure care.

Patients spoken with and comments received on CQC comment cards reflected that patients were satisfied with the assessments, information they received and the quality of their dental care.

Health promotion & prevention

During our discussion and a review of dental records we found that most elements of the Delivering Better Oral Health toolkit were followed in practice. This is an evidence based toolkit by the Department of Health, used by dental teams for the prevention of dental disease in a primary and secondary care setting. The dentist provided patients with advice on the impact of diet, smoking and alcohol consumption on oral health. High fluoride treatments were provided to adults where needed. We found that fluoride varnish was not available for children although there were very few children registered with the practice.

The dentists employed the services of two dental hygienists who each worked one day a week to support preventative dental care. Appropriate internal referrals were made and patients could also self- refer.

The waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

The practice was led by a principal dentist who employed two dental nurses (one was on maternity leave) and two reception/administrative staff. Two dental hygienists worked at the practice for one day each week. All registered dental care professionals had evidence of their current registration with the General Dental Council.

Planned and unplanned staff leave was covered within the team and staff were able to work flexibly if required. Agency staff were not used. When the dentists was on leave he made arrangements with another private dentist to provide emergency cover for patients at the practice.

Although there was an appraisal process available, the provider told us this was not used. There was no process in place to identify core training requirements of all staff or to monitor training. Staff told us the principal dentist was supportive of any staff training requests if these were relevant to their role. The dental nurse told us she had access to eLearning training to help maintain her own professional development and she maintained her own training file to support this. Certificates demonstrated training in areas such as decontamination, data protection, oral health and sharps management. Child protection training had been completed in 2012 and required updating. There was no evidence of training in safeguarding vulnerable adults or the Mental Capacity Act (2005).

Are services effective?

(for example, treatment is effective)

We found that all staff had received medical emergencies training at the practice and this was updated every year. The dental nurses had not completed any extended role training.

Working with other services

The practice had a system in place for referring patients for dental treatment and specialist procedures for example root canal treatment, suspected oral cancer and endodontics. We found there was no referral log to ensure that patients received care and treatment needed in a timely manner. Patients were not routinely offered a copy of their referral letters for information.

Consent to care and treatment

The practice ensured valid consent from patients was obtained for all care and treatment. We spoke with the dentist who told us that individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and estimate of costs. However there was no evidence of the risks and benefits of treatment being recorded in the dental records. Patients were given time to consider and make informed decisions about which option they wanted and this was recorded in their dental care records. Appropriate levels of consent were gained for each treatment and records we saw confirmed this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The dentist was unable to demonstrate an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. Most staff had not received this training with the exception of one who had an awareness of MCA through training completed while working in another practice.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. We observed that staff at the practice treated patients with dignity, respect, and maintained their privacy. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality The reception area was well laid out and conversations were managed to maintain patient confidentiality. Treatment rooms were situated away from the main waiting area.

An undated data protection policy was available. We observed the interaction between staff and patients and found that confidentiality was being maintained. We saw that dental care records were held securely.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to share their experience of the practice. We collected 28 completed CQC patient comment cards and obtained the views of two patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good, staff treated them with respect, were professional and very understanding.

Staff were able to describe the ways they were able to support patients with anxiety for example by ensuring they were able to go straight into the treatment room on arrival. During the inspection we observed that practice staff were polite and helpful towards patients and that the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice discussed clear treatment plans with their patients that detailed possible treatment options and indicative costs. A poster detailing treatment costs was displayed in the waiting area and the information was also available in the practice leaflet. Patients told us they were involved in decisions about their care and they received information in a way they could understand.

The dentist paid particular attention to patient involvement when drawing up individual care plans. Dental nurses we spoke with confirmed this. We found that the dentists recorded the information they had provided to patients about their treatment and the options open to them although improvement in recording the risks and benefits of treatment was not detailed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information about private dental payment plans and the practice information leaflet. This contained details of how to raise a complaint or concern to the principal dentists. In addition there was some information about the promotion of good dental health and cosmetic treatments.

The dentist decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment. Routine appointments were usually booked for 15 minutes. The appointments diary was not overbooked and staff told us they had enough capacity to meet the demand for dental appointments. There was a longer wait for appointments with the hygienists of about nine weeks although the practice had a cancellation list available in order to offer earlier appointments if they became available.

Patients we spoke with told us they had good access to suitable appointments.

Tackling inequity and promoting equality

The practice was situated on two floors of the building and was accessible to patients with disabilities. There was an accessible toilet on the ground floor and patients could be seen in the lower treatment room if they had difficulty using the stairs as there was no lift available.

We spoke with the receptionist who told us that new patients were welcomed. Information about the costs of treatment were always explained so that patients were made aware of the private dentistry fees before they booked a consultation. Staff assisted patients with completing the relevant forms if they were unable to do so. For example if they were partially sighted.

Staff told us they rarely met patients with limited English language skills although access to translation services were available if needed. They used flags on the electronic records system to alert staff to any special needs such as patients who were deaf or had a learning disability.

Access to the service

The practice was open from 9am to 6pmMonday to Thursday although it opened from 8am on Tuesdays and closed slightly earlier at 5.30pm on Tuesday and Thursday. Emergency appointments could be accessed between 12.30 and 1pm on all four days.

When the practice was closed, patients were provided with a telephone number to call the dentist or if they had a private dental plan, a separate emergency helpline number was provided. This information was made available to patients in the practice information leaflet and on the telephone answering machine when the practice was closed.

Concerns & complaints

We found conflicting information about how to make a complaint and the process required a review. There was information available for patients in the practice leaflet giving them details of how to complain to the dentist. The practice had a separate statement about the complaints process that referred to patients making their complaint in writing and a member of staff confirmed this process. However, the dentist told us he accepted a complaint in any format.

The practice had received one complaint in the past 12 months. The complaint had been dealt with appropriately although there was no complaints records in place to evidence the process that had been followed or any learning identified as a result of it. We discussed the complaint with the dentists who confirmed their learning following the complaint which helped to inform his ongoing clinical practice.

Are services well-led?

Our findings

Governance arrangements

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

We found several shortfalls in the practice's governance arrangements. Although there were some appropriate policies in place to support the management of the service, these had not all been dated and there was no system in place for the regular review of policies and procedures. There was no system in place to show that staff had read, understood, and agreed to follow the policies and we found they were not embedded into practice. Although staff had access to training and the provider completed professional registration checks, there was no system in place to monitor progress with training or review staff performance and development through an appraisal system. Recruitment procedures were not robust, there was no clear process for completing pre-employment checks. Staff did not received regular performance reviews and did not have clear objectives. Although staff had access to training, there was no system to monitor training required or completed by staff.

The systems and processes used to monitor the quality and safety of the service were not robust. For example, staff were not familiar with recognising and reporting significant events or incidents and there was no accessible process to do so. Risks were not identified and managed; emergency equipment and medicines were not easily accessible or fit for purpose, decontamination procedures did not follow national guidelines and risk assessments were not adequate.

The practice did not have team meetings to discuss the running of the practice, clinical updates or quality monitoring issues such as incidents, complaints or the outcome of audits or patient feedback. This made it difficult for staff who worked part-time to be well informed team members.

Leadership, openness and transparency

The principal dentist had overall leadership responsibility with support from the senior dental nurse. The staff had worked at the practice for several years and the small size of the team meant day to day communication was easy. However, there was no formal structure in place such as regular meetings so that records of discussions about safety and the quality of the service could be evidenced and decisions about improvement of the service could be made.

Staff we spoke with told us they would raise issues directly with the principal dentist or the senior nurse. However, some staff worked part time hours and this limited opportunities to do so.

It was apparent through our discussions with the staff that the provision of a positive experience for patients was their key priority. We found staff to be hard working, caring and committed to the work they did. However, staff did not fully understand the principles of clinical governance in dentistry and how they could contribute to developing the service.

Staff were not all familiar with the Duty of Candour. However they were aware that patients should be informed when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

Staff had access to eLearning training although there was no clear guideline on what core training they were expected to complete in relation to their role. We saw evidence that registered dental professionals maintained their professional development, as required through the General Dental Council (GDC), through completion of eLearning updates and attendance at dental training updates. Records demonstrated that these staff all had a valid GDC registration.

Although the practice had an appraisal system, it was not well established to ensure that all staff received feedback about their performance.

We found a limited number of audits had been completed at the practice. There were no infection control audits to monitor the decontamination procedures and no audits of dental records. Dental X-ray audits were established although there were no identified actions to help drive improvement.

There had been no reported incidents, significant events or accidents. However, systems to identify, report, review and learn from them were not sufficient.

Are services well-led?

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

The practice had conducted a patient survey in October 2015 and had received feedback from 13 patients. There was no analysis or summary of learning to inform any improvements to the service.

Staff told us they supported one another on a day by day basis. Staff did not all have the opportunity to communicate with the team and the principal dentist on a regular basis, although they felt able to raise issues at any time.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have systems and processes in place to ensure the service was operated effectively because; • The medicines and equipment used in the event of a medical emergency were not always appropriate and readily available for use • There was no system in place to ensure that suitable infection control procedures were in place and were being followed by staff An appropriate legionella risk assessment had not been completed and actioned to ensure that any identified risks were being managed. • The practice's sharps handling procedures and protocols had not been established and operated to promote the health and safety of staff and patients. • The system used for the storage and disposal of clinical waste could put the health, safety and welfare of service users and staff at risk. • There were inadequate systems in place for the proper and safe management of medicines. • The provider had not ensured there was a recruitment policy in place that was in line with Regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They were unable to demonstrate that a system was used for the safe recruitment of staff that included pre-employment checks or that appropriate records of persons employed by the practice were held. • There was no audit plan in place to help monitor the quality of the service provided and identify continual improvements. Regulation 17 (1)