Mrs. Claire Jackman

Bottisham Dental Practice

Inspection Report

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Date of inspection visit: 20 June 2016
Date of publication: 30/09/2016

Overall summary

We carried out an announced comprehensive inspection on 20 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 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

Bottisham Dental Practice is situated in the village of Bottisham in a building adjacent to a GP practice. The service provides a range of dental services to NHS and private patients of all ages and has its own car park. The service has long outgrown the premises and plans to relocate to a newly refurbished building in 2017. The practice is situated on one level, has three dental treatment rooms, a decontamination room, a reception area and waiting area.

The principal dentist 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.

As part of the inspection, 17 patients provided feedback about the service. Patients said that the staff were caring and helpful to them, they were happy with the care and treatment they had received and that staff were very reassuring.

Our key findings were:

- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Information from completed CQC comments cards gave us a positive picture of a friendly, caring and professional service.

Summary of findings

- Dentists provided dental care in accordance with current guidelines from the Faculty for General Dental Practice guidelines and the National Institute for Care Excellence (NICE).
- Staff had good access to training and were supported to develop their knowledge and expertise.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained. However the medicines and equipment available for use in medical emergencies did not meet the guidelines issued by the resuscitation council (UK) or the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- There were systems to promote the safe operation of the service although the reporting of accidents, incidents and significant events required a review.
- Feedback from patients was used to improve the service.

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

- Ensure the practice's recruitment process is 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. This must include evidence of Disclosure and Barring service checks for relevant staff.
- Ensure there are systems and processes in place to identify, assess and manage risks in relation to the following:
- Medicines and equipment to manage medical emergencies are available in line with guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Prescription pads are stored securely in the practice and ensure that medicines supplied by the practice are labelled in accordance with The Medicines for Human Use Regulations 2012.
- Robust arrangements for managing patient safety alerts issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and for managing accidents, incidents and significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Robust procedures for the safe management of sharps giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- The secure storage of dental care records.

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 protocols for the use of rubber dam for root canal treatment and the use of hypochlorite giving due regard to guidelines issued by the British Endodontic Society
- Review the cleaning process and management of heavily soiled dental equipment.
- Review the consent policy to ensure that consent is sought from legal guardians for children below the age of 16 years.
- Review the training for staff in relation to medical emergency scenarios.
- Review and implement a system to monitor progress with staff training to ensure this is completed in a timely manner.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

Accidents were recorded and actioned although there was no system in place to enable actions to be monitored or followed up. Staff were not clear about identifying significant events and incidents and although action had been taken in response to some events, there was no established system to ensure investigations, actions and learning were completed and shared. The practice had not signed up to receive electronic safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) alerts although they took actions from alerts received from local commissioners. There were clear guidelines in place for reporting safeguarding concerns and staff had received relevant training. Recruitment procedures were in place although records showed that some recruitment checks were not completed.

Emergency medicines and equipment were available although some items were not in line with recommended guidelines. The practice had good infection control procedures in place to ensure that patients were protected from potential risks. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely. X-rays equipment was well maintained and record keeping in relation to X-rays clearly documented.

Are services effective?

No action

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) and 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. Risks, benefits, options and costs were explained. Patients were referred to other services in a timely manner and staff followed appropriate guidelines for obtaining patient consent. However, they needed to review guidelines relating to legal guardianship and consent for children as well as the Mental Capacity Act 2005.

The staff were able to access professional training and development appropriate to their roles and an appraisal process was in place. However, systems to monitor the completion of training required further development. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

Summary of findings

Are services caring?

No action

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. Patients told us that staff were very considerate, listened to their needs and put them at ease. Treatment was clearly explained to patients and they were provided with treatment plans and costs. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

No action

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. A practice leaflet was available in reception to explain to patients about the services provided. The service was accessible to patients with a disability and patients who had difficulty understanding care and treatment options were supported. However, not all staff understood their responsibilities in relation to Gillick competency and the Mental Capacity Act 2005. The practice had a complaints policy to deal with complaints in an open and transparent way and apologise when things went wrong. No complaints had been received.

Are services well-led?

Requirements notice

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

Although there were systems in place to monitor the overall quality of the service, some systems to identify, assess and manage risks were not effective and required improvement. For example systems to manage safety alerts, accidents, incidents and significant events was not established. Medicines and equipment to manage medical emergencies did not meet recommended guidelines. Recruitment procedures were not always followed.

Practice policies were reviewed on a regular basis and audits were in place to encourage improvement.

Overall leadership of the practice was clear and staff were aware of their own responsibilities as well as the role of others. The practice team met formally on a monthly basis and also had clear methods of communicating issues within the team where many staff worked on a part time basis. Staff told us they felt supported by the dentists and practice manager and they worked well together as a team.

Patient feedback was actively sought and used to help improve the service.

Bottisham 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.

This inspection took place on 20 June and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information for review which included a summary of complaints received and general practice information.

During the inspection we spoke with three dentists, three dental nurses, the practice manager and reception staff. We reviewed policies, procedures and other documents. We also obtained the views of two patients on the day of the inspection and received comment cards that we had provided for patients to complete during the two weeks leading up to the 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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Records indicated the practice had an accident book in place and the practice manager told us that each issue was addressed at the time and records were made on the dental records or staff personnel file as appropriate. However the accident book did not enable the tracking of records to show that accidents involving staff had been followed up. We saw a record of a sharps injury that had been sustained by a member of staff and reported using the accident form. However, there was no process for recording or logging the accidents so that any patterns or trends could be identified and actioned.

The practice did not have an incident reporting procedure or supporting documents to record significant events that occurred. However, we found that some issues that could have been classed as an incident or near miss, had been raised in a communication book, actioned and learning shared within the team during staff meetings. Staff we spoke with did not fully understand how to recognise an incident or significant event. As a result, the opportunity to review incidents and identify any learning and make improvement could be missed.

The practice was aware of, and understood RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). There had been no relevant incidents or RIDDOR notifications made by the practice.

The practice manager received some safety alerts from the local NHS team by email and these were saved as electronic documents and shared with staff if relevant. However the practice had not signed up to receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These alerts are sent out by email from a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment.

A policy for following the Duty of Candour was available and the practice manager was able to describe the principles of being open and honest with patients when things went wrong. The practice had not received any complaints to demonstrate that this approach was followed.

Reliable safety systems and processes (including safeguarding)

We spoke with staff about the prevention of needle stick injuries. They were able to explain the practice's protocol they followed should a needle stick injury occur and a needle stick injury policy was in place. However, the policy did not make clear that following immediate first aid, the injured party should always seek medical advice.in line with the current EU Directive on the use of safer sharps. We found the dentists used conventional syringes and matrix bands and were responsible for the safe disposal of sharp instruments in each treatment room to reduce the risk of injury. However we found a member of staff had received a sharps injury whilst cleaning dental instruments in March 2016. The dental hygienist used safer syringe systems and disposable matrix bands. These items help to reduce the risk of accidental sharps injury. Other clinicians however, had not switched to the use of these safer systems as recommended in the Sharps Regulations 2013.

We spoke with three dentists about the instruments used during root canal treatment. We found that one dentist always used rubber dams and the others told us they used it on occasions. (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). One dentist who did not regularly use rubber dam, told us they isolated the area using cotton wool rolls and hypochlorite solution. We saw there was only one rubber dam kit available for use in the practice. These procedures were not in line with guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The principal dentist acted as the safeguarding lead and had completed appropriate training for this. They acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who might be the victim of abuse or neglect and local contact numbers were available. Staff had received safeguarding

training and were knowledgeable about the process. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

We found that the provider was not paying due regard to the recommended guidance set out by the British National Formulary in relation to emergency medicines and the Resuscitation Council in relation to emergency equipment for dental practices..

The practice had an automated external defibrillator (AED), which is 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. This was stored in an accessible area and was checked by a dental nurse on a daily basis. Staff received annual training in how to manage medical emergencies although they did not practice medical emergency scenarios. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction. Records demonstrated that the oxygen was checked on a daily basis. We noted however, that the kit did not include any airways of various sizes for use in an emergency situation as recommended by the Resuscitation Council UK guidelines.

The practice had most emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. However we found the practice did not carry midazolam but had an alternative medicine as advised by an external trainer. In addition there was insufficient amounts of adrenaline available which was not in line with guidelines in the British National Formulary particularly in a situation where repeat doses may be required. Glucagon, used for treating patients with a low blood sugar level, was stored at standard room temperature which reduces the shelf life of the medicine. It did not have an amended expiry date to reflect that it was stored outside of the fridge. To prolong the life of this medicine, it can be stored in a fridge but it must also be marked with a relevant expiry date. The emergency medicines were checked each month and records were maintained to support this.

Staff recruitment

All of the dentists, dental hygienists and qualified dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that detailed the checks required to be undertaken before an employee started work. However, this did not include the dental practice's policy on requesting a Disclosure and Barring Services (DBS) check for staff although the practice manager informed us it was their policy to complete these for all staff. These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We reviewed four sets of recruitment records for staff employed within the last year. We found these did not include evidence that employment references or photo identification documents had been checked. DBS checks had not been completed for two staff in trainee dental nurse roles. In addition, two dentists worked on an occasional basis to support the advanced treatment provided by an associate dentist. There were no recruitment files in place for these staff. This was not in line with the information required in Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information.

The principal dentists and practice manager constantly reviewed the staffing levels and skill mix to ensure they were able to meet patients' needs. Many staff were part time and were able to cover planned annual leave for their colleagues and other short notice absences.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice had risk assessments in place which covered issues such as use of visual display screens, risks involved in use of the decontamination equipment, slips, trips and falls. A detailed fire risk assessment had also been completed and fire equipment had been serviced in February and October 2015. A fire evacuation plan was in place and a fire drill had been completed.

The practice had a health and safety law poster on display in the staff area. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

No action

Are services safe?

Staff were able to access information relating to the Control of Substances Hazardous to Health (COSHH) as an electronic file and regular checks of the substances held were made so that out of date items could be removed. Other assessments included radiation, water quality checks and the regular safety checks of electronic equipment. The practice had a disaster recovery plan in place to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service.

We were concerned to see that dental records, which we kept mostly in paper format, were not stored in lockable filing cabinets but on open shelving beside the reception desk. During opening hours, staff told us the area was always covered by a member of staff. However, records could be easily accessed if staff were not at the desk and the information was not held securely when cleaning staff accessed the practice out of hours. This arrangement could put the security of confidential patient information at risk. We discussed this with the practice who agreed to review the situation.

Infection control

The practice was visibly clean, tidy, and uncluttered. A current infection control policy was in place and the principal dentist had responsibility for infection prevention and control. All dental nurses were responsible for the decontamination of dental instruments and the senior nurse led on the decontamination process. The practice employed two cleaners and we saw that daily cleaning records were maintained and cleaning equipment was stored in accordance with NHS guidelines. The practice team also had some responsibility for cleaning the treatment rooms during use and after each surgery. The lead dental nurse had a system in place for checking the condition of the treatment rooms to ensure that infection control practices were being followed. There was also a cleaning rota in place to ensure that children's toys provided in the waiting room were checked and cleaned regularly.

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 essential processes and practices to prevent the transmission of infections. Decontamination of dental instruments took place in a dedicated room in the practice. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures.

We found that the practice was meeting the HTM01- 05 essential requirements for decontamination in dental practices. The equipment used for cleaning and sterilising was checked, maintained, and serviced in line with the manufacturer's instructions. Daily, weekly, and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. Records showed that the equipment was in good working order and being effectively maintained.

There were clear systems in place for transferring dirty and clean instruments to and from the treatment rooms. We spent time observing the decontamination process used by staff and found this was being completed in accordance with guidelines. However we also found areas where some changes should be made to improve the process. Heavily soiled dental instruments were cleaned under running water rather than being immersed in water first. On rare occasions when there was a delay in cleaning and reprocessing the dental instruments, the instruments were not kept wet to aid the removal of debris.

Cleaned and sterilised instruments were pouched and dated for reuse although the practice always used them within 21 days. Weekly checks of these items were completed to ensure that they were within their use by dates.

Within the treatment rooms there were dirty and clean areas, and there was a clear flow to reduce the risk of cross contamination and infection. The dental nurses followed very clear protocols for managing infection control procedures in the treatment rooms during each session.

Sharps bins were signed dated and not overfilled. A clinical waste disposal contract was in place and waste matter was securely stored within a designated, locked area at the rear of the property prior to collection.

To ensure that staff and patients were kept safe, the practice had a record of staff immunisation status in respect of Hepatitis B.

A risk assessment for the management of Legionella had been completed in 2013 by an external company and a safe water management certificate had been

provided. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of the development of the legionella bacterium. The practice also flushed the dental unit water lines used in the treatment rooms on a regular basis.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with the manufacturer's guidelines. Portable appliance testing took place on all electrical equipment and was next due in October 2016.

Medicines in use at the practice were in date, stored and disposed of in line with published guidance. We saw records that confirmed medicine expiry dates were regularly checked and batch numbers were recorded in dental records when antibiotics were issued to patients. However we found that antibiotics were not being labelled with the name and address of the practice in accordance with The Medicines for Human Use Regulations 2012. The practice should also review the storage of prescription pads to ensure these are kept securely.

There were sufficient stocks of equipment available for use and these were rotated regularly to ensure it remained in date for use.

Radiography (X-rays)

The practice had registered their use of X-ray equipment with the Health and Safety Executive in 2001. A radiation protection advisor (RPA) and a radiation protection supervisor had been appointed as required by the Ionising Regulations for Medical Exposure Regulations (IR(ME)R 2000), to ensure that the equipment was operated safely and by qualified staff only. Those authorised to carry out X-ray procedures were clearly named in all documentation. This protected people who required X-rays to be taken as part of their treatment. The practice's radiation protection file was well presented and contained the necessary documentation; this demonstrated the maintenance of the X-ray equipment at the recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested serviced and repairs undertaken when necessary. The last visit by the RPA had taken place in May 2016. The practice had just received the report following this visit and the principal dentist discussed the action that was planned to meet the report recommendation.

X-ray equipment was situated in suitable areas and X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These documents were displayed in areas where X-rays were carried out.

We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000. We saw that radiographic audits were completed over a three month period as part of an on-going audit cycle to ensure quality improvements were made. Dental care records included information when X-rays had been taken, how these were justified, reported on and quality assured. This showed the practice was acting in accordance with national radiological guidelines to protect both patients and staff from unnecessary exposure to radiation

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists were able to describe to us how they carried out their assessment of patients for routine care in line with guidelines from the Faculty of General Dental Practice and the National Institute for Health and Care Excellence. The assessment began with checking the patient's medical history which was updated regularly. This was followed by an examination covering the condition of the patient's teeth, gums and soft tissues and the signs of mouth cancer. The dentists took time to explain and discuss any dental issues with patients including the condition of their oral health, any changes since their last appointment and any relevant treatment options.

We saw clear evidence that dental care records were updated with the proposed treatment after discussing different treatment options and costs with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental records included detailed oral health assessments and included the condition of the patient's gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed in relation to a patient's gums. These were carried out where appropriate during a dental health assessment and appropriate referrals were made to the dental hygienists.

We received feedback from 14 patients who completed CQC comment cards and spoke with three patients during the inspection. All the comments we received gave a positive view of the care and treatment experienced by patients using this service.

Health promotion & prevention

Preventative dental information was given to adults and children in order to improve their health outcomes. This included dietary smoking and alcohol advice where appropriate in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate.

The waiting room and reception area contained leaflets and general information that explained the services offered at the practice. There were a limited number of health promotion leaflets available to patients in this area. The practice sold a range of dental hygiene products to maintain healthy teeth and gums. NHS patients could be referred to the hygienist employed at the practice. Private patients could make their own direct referrals.

Staffing

The practice was led by a principal dentist who employed four associate dentists and a dental hygiene therapist. They were supported by a practice manager who was also a qualified dental nurse, a team of four dental nurses and two trainee dental nurses. In addition there was a practice manager who was also a qualified dental nurse and three reception staff. Many of the staff worked on a part time basis and provided cover for any planned and unplanned staff leave. Staff we spoke with said they had sufficient numbers of staff to meet patient's needs. They usually worked with one spare dental nurse to ensure appropriate cover was available.

All of the patients we asked on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards and the compliment cards that were displayed in the practice.

Although there was no established system to monitor staff training that had been completed, there was good evidence to demonstrate that staff could access, and were supported to attend training. Training certificates demonstrated that staff had received core training such as infection control and responding to medical emergencies.

A clear induction process was in place for each staff role and records we reviewed supported this. This included practice policies such as confidentiality and fire procedures and was linked to job role descriptions. A new member of staff confirmed they had received an induction and that they had worked alongside an experienced member of staff to help them become more confident in their role. An

No action

Are services effective?

(for example, treatment is effective)

appraisal system was also in place and records demonstrated staff had received an annual appraisal. Practice meetings took place on a monthly basis and staff told us they were able to make a contribution to the meetings and feel involved in improving the service.

Working with other services

The practice had a robust system in place for referring, recording, and monitoring patients for dental treatment and specialist procedures and the practice aimed to refer to in-house specialists when possible. External referrals were made for patients who required for example, removal of impacted wisdom teeth, assessment for suspected oral cancer or specialist scans to assist with more complex work such as dental implants. The practice kept very detailed records of these referrals to ensure patients received care and treatment needed in a timely manner. Patients were contacted to ensure that they had understood and received the treatment they had been referred for.

Consent to care and treatment

We discussed the practice's policy on patients' consent to care and treatment with staff. We saw evidence that patients were presented with treatment options and consent forms which were signed by the them.

Staff were aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. Not all staff had received training in the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them.

The staff were knowledgeable of Gillick competency. GIllick competency is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.We found the practice policy for obtaining consent from young patients and their guardians required a review to ensure that only legal guardians signed consent to the treatment of a child under the age of 16 years.

No action

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. The reception area and waiting room was small and cramped and did not enable staff to hold private conversations with patients very easily. The anticipated move to new premises in 2017 is expected to mitigate these concerns. We found that staff made reasonable efforts to maintain patient's confidential information for example, by ensuring that paper records were not visible and by not disclosing confidential personal information during telephone or face to face discussions.

A data protection and confidentiality policy was in place. We observed the interaction between staff and patients and found that confidentiality was being maintained. Patients reported that they felt that practice staff were friendly, helpful, and caring and that they were treated with dignity and respect. We observed staff treating patients professionally, confidentially and with courtesy.

Involvement in decisions about care and treatment

Feedback from patients included comments about how professional the staff were and treatments were always explained in a language they could understand. Patients also commented that staff were very sensitive to their anxieties and needs. The dentists we spoke with paid attention to patients' involvement when drawing up individual care plans and this was detailed within the dental records we reviewed.

Are services responsive to people needs?

(for example, to feedback?)

No action

Our findings

Responding to and meeting patients' needs

The practice waiting area displayed a variety of information about the practice and the services offered. This included details and qualifications of the staff team, opening times, and access to appointments and the General Dental council's standards for good dentistry. An information file included a summary of the confidentiality policy, how to raise a complaint and the aims of the practice. NHS and some private treatments were available and the costs were displayed in the waiting room.

Reception staff demonstrated the appointment system they used. This ensured that enough time was scheduled to undertake patients' care and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient. The dentists decided how long a patient's appointments 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. Emergency appointment slots for the dentists were held each day to accommodate patients experiencing dental pain and in need of prompt attention. We observed a patient request an urgent appointment, and they were offered one to suit them within 48 hours because they were not experiencing pain or discomfort.

Tackling inequity and promoting equality

The treatment rooms at the practice were on the ground level, making good access for those in wheelchairs or with push chairs. Staff told us that if a patient could not move easily into a dental chair, they were examined in their own wheelchairs.

The practice had a small number of patients whose first language was not English and had access to translation services if it was required.

The practice did not have a hearing loop available and staff did not have any examples of patients they knew who required this. They were able to tell us about actions they took to enable patients with additional needs to access the service. For example a patient with a learning disability was welcomed to visit the practice and talk with staff on several occasions to help put them at ease, build their confidence and trust to enable them to access an appointment.

Access to the service

The practice opened weekdays from 9am until 5pm. Early morning appointments were available from 8am three days a week and late appointments until 7pm on two days a week. The practice saw some private patients on a Saturday by arrangement. Patients we spoke with were satisfied with access to routine and emergency appointments.

Access for urgent treatment outside of opening hours was provided by the 111 telephone number for access to the NHS emergency dental service. Private patients were provided with an emergency contact number. This information was provided to patients in an information leaflet and as a telephone answerphone message when the practice was closed. It will also be available on the new website once it is made available.

Concerns & complaints

There was information available for patients giving them details of how to complain. The practice had not received any complaints in the past three years. The complaints policy was last reviewed in April 2016. The practice staff encouraged patients to raise any concerns so that issues could be addressed in a timely way and before individual concerns became more complex.

Patients we spoke with told us they felt confident that staff would respond appropriately to any concerns they had. The staff were aware of how to deal with a complaint should they need to.

Requirements notice ✖

Are services well-led?

Our findings

Governance arrangements

There was a quality assurance policy in place which set out the governance process and procedures to help ensure that quality care was being provided. A range of other policies and procedures were in use at the practice. These included health and safety, infection prevention control, needle stick injury, safeguarding vulnerable adults and child protection. These policies and procedures had been updated regularly, and were available to staff. However, there was no robust system in place to identify significant events or incidents to ensure that a process was followed to promote improvement and mitigate the risk of reoccurrence. The provider had not followed published guidance in relation to the provision of medicines and equipment for use in an emergency situation. Storage of prescription pads and the labelling of medicines supplied to patients was not adequate. Procedures for the safe management of sharps were not robust across the practice and were not in line with relevant guidelines. Although a recruitment procedure was in place recruitment checks were not always completed.

The practice had an information governance policy, which staff were aware of to ensure compliance with the laws regarding how patient information is handled. However dental care records were not being stored securely which risked a compromise of patient confidentiality.

There were meetings involving all the staff where practice issues were discussed such as policies, administrative protocols and the appointment systems. Minutes of these meetings dated back to January 2016 and were available for staff who could not attend. Staff we spoke with told us they felt able to raise any issues at the meetings and they found them useful.

Systems were in place to ensure the safety of equipment such as X-ray machinery and fire safety equipment and a range of risk assessments were in place.

Leadership, openness and transparency

The principal dentist, lead nurse and practice manager had established leadership roles and communicated with each other and members of the team, on an ongoing basis. Staff were clear about their own responsibilities as well as the role of their colleagues and supported one another to ensure that the service ran smoothly for patients. They told us there was an open and honest culture.

Practice meetings took place on a monthly basis and staff were also encouraged to write any queries or share information through the staff communication book. If staff did not want to use this system, they were encouraged to send a weekly email to the practice manager or principal dentist to summarise their week and any issues they had had. This was then followed up with each individual and shared more widely if appropriate to do so.

The principal dentists had a clear vision for the development of the service and had several plans for the service once they had moved to the new premises.

Learning and improvement

Staff were supported and encouraged to maintain their professional development and complete core training. This was evidenced in the personnel files we were shown and confirmed through our discussion with staff. They were able to attend organised lunch and learn sessions; additional training could be accessed if this was in line with service developments for example a dental nurse had attended training in the application of fluoride varnish. However, there was no clear system in place to monitor the progress of training the practice considered essential to each role and this should be improved.

Records demonstrated that dental staff all had a valid GDC registration with the exception of the trainee dental nurses .The practice had an appraisal system in place and staff told us they found this was useful.

Although the staff had a system for reporting accidents this did not enable clear tracking and monitoring to ensure that actions had been taken and learning was shared. Although we saw that issues raised through the staff communication book had been actioned, these were not recognised as incidents.

The practice had completed regular audits for infection control, dental X-rays and the dental records for each dentist. The data collected had been used to improve practice and was shared with the wider team when relevant to do so.

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

Requirements notice

Are services well-led?

The practice had the plans for the new premises on display. This was due to open in 2017 in a location a few miles from the current practice. In March 2016 they held an open evening so that patients could come and discuss the relocation and raise questions or concerns directly with staff. This had been very well attended. There was also a comments book for patients to ask questions or give their feedback about the planned relocation. If patients left their contact details the practice responded.

The practice monitored feedback through the friends and family test and shared it at practice meetings. Although few comments were being received these recommended the practice to others. A comments box was also available in the waiting room although this was not well used.

The practice manager was able to provide examples of change that had been made in response to feedback from patients. This included the addition of extra phone lines and extended opening hours in the evenings on two days each week to help reduce appointment waiting times.

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 The provider did not have systems and processes in place to identify, assess and manage risks in relation to ; • Medicines and equipment used to manage medical emergencies were not available in line with recommended guidelines. • Prescription pads were not stored securely and medicines supplied by the practice were not labelled in accordance with The Medicines for Human Use Regulations 2012. • There were no robust arrangements in place for managing patient safety alerts, accidents, incidents or significant events to ensure that improvements were made. • Procedures for the safe management of sharps were not robust and were not in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. • Dental care records were not stored securely at all times. **Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not ensured the recruitment policy was followed to ensure the pre-employment checks were completed or that appropriate records of persons employed by the practice were held.

This section is primarily information for the provider

Requirement notices

Regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.