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Confidental Care

Inspection Report

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Overall summary

We carried out this unannounced inspection on 23 and 25 July 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Confidental Care is based in the London Borough of Bromley. The practice provides NHS and private treatment to patients of all ages.

The dental team includes three dentists, a practice manager, two qualified dental nurses, a trainee dental nurse and a receptionist. The practice has five treatment rooms, two of which were not in operation at the time of the inspection.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

Summary of findings

During the inspection we spoke with all the dentists, the practice manager, the qualified and trainee dental nurses and the receptionist. We checked practice policies and procedures and other records about how the service is managed.

The practice is open at the following times:

- Monday to Thursday: 9am to 6pm
- Friday: 9am to 5pm
- Every other Saturday: 9am to 1pm

Our key findings were:

- The appointment system met patients' needs.
- The practice asked patients for feedback about the services they provided.
- The practice was providing preventive care and supporting patients to ensure better oral health.
- Staff felt supported, though not all felt involved, and not all felt there was a cohesive working culture.
- Not all staff knew how to deal with medical emergencies.
- Staff knew their responsibilities for safeguarding vulnerable adults and children, though staff were not clear on the designated safeguarding leads and external safeguarding contact details.
- The practice had complaints protocols but had not established an effective system to manage patient complaints.
- The practice did not follow current national guidance when undertaking dental treatment using conscious sedation.
- The practice had not adequately protected patients' privacy and personal information.
- There was equipment to manage medical emergencies. We found some of this equipment had passed its use-by date.
- The practice had infection prevention and control procedures, though they did not reflect published guidance.
- The practice had not established thorough staff recruitment procedures.
- There was a lack of effective processes to ensure all staff had received or updated key training.
- The practice had not established effective systems to help them manage risks and there was a lack of effective systems and processes to ensure good governance.

We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

There were areas in which the provider could make improvements. They should:

- Review the practice's protocols for completion of dental care records, taking into account guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the current staffing arrangements to ensure all dental care professionals are adequately supported by a trained member of the dental team when treating patients in a dental setting, taking into account the guidance issued by the General Dental Council.
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.
- Review the practice's protocols for referral of patients to ensure all referrals are monitored suitably.
- Review the practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

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 these actions in the Enforcement Action and Requirements Notice sections at the end of this report).

The practice had limited systems and processes to provide safe care and treatment. They did not always provide care and treatment in line with recognised guidance relating to the provision of dental treatment under conscious sedation in particular. We have taken enforcement action against the provider, which prevents them from providing dental treatments under conscious sedation until they have made the necessary improvements.

The practice had infection control processes but these were not all in line with current guidance.

The practice did not evidence the use of learning from incidents to help them improve.

Staff knew how to recognise the signs of abuse of children and vulnerable adults, though some were not clear on protocols for escalating concerns.

Dental nurses provided chairside support for the dentists, though we were informed there were occasions where the dentists worked without assistance.

Dentists did not use rubber dams when carrying out root canal treatments.

Enforcement action

Are services effective?

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of these actions in the Requirements Notice sections at the end of this report).

The dentists assessed patients' needs.

The dentists discussed treatment with patients so they could give informed consent and documented this in their records.

The practice had arrangements for patients who needed to be referred to other dental or health care professionals.

Staff had completed some key training but there was a lack of systems to ensure the training was up to date. There was a lack of evidence of recommended training.

The practice could improve the quality of dental care records by ensuring details about local anaesthetic administered, the non-use of rubber dam, oral health risk assessments, justification for recalls, and examination findings were consistently recorded.

Requirements notice

Summary of findings

Are services caring?

No action

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

We checked feedback about the practice from 36 patients; feedback was largely positive about the attitude of staff, the availability of appointments, and the explanation of their care and related costs.

Staff told us they were aware of confidentiality, though improvements were required to protect patients' privacy regarding the storage of dental care records.

Are services responsive to people's needs?

No action

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if they were experiencing dental pain.

The practice had made plans for the provision of facilities for disabled patients and families with children.

The practice had a system in place to help them manage complaints. They could strengthen this system by ensuring they could clearly evidence how complaints were managed and discussed to encourage improvements.

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 these actions in the Requirements Notice section at the end of this report).

Staff felt supported but described low morale and a desire for more engagement in the practice.

Dental care records were clearly written but several were not stored securely.

The practice carried out limited monitoring of clinical processes of their work to help them improve and learn.

We found the practice's leaders did not demonstrate a clear awareness of all responsibilities, roles and systems of accountability.

There was a consistent lack of assessment, identification, mitigation and monitoring of risks, and a lack of effective governance which resulted in shortcomings across several areas of the service. In particular these related to:

- The lack of effective processes to ensure all staff had received appraisals and completed key training.
- The lack of effective recruitment procedures.
- The lack of assurance regarding adequate immunity of a member of staff to vaccine-preventable diseases.
- The lack of systems to monitor quality.

Summary of findings

- The lack of availability of recommended medicines and equipment used to manage medical emergencies, and the lack of suitable processes to ensure medicines and equipment were in available in sufficient quantities and in date.
- The lack of suitable maintenance of equipment.
- Infection control procedures that were not in line with national guidance.
- The lack of evidence of safety checks of electrical equipment.
- The lack of suitable arrangements to ensure dental care records and prescription pads were stored securely.
- The lack of effective governance arrangements.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays)

Staff we spoke with knew their responsibilities regarding recognising signs of abuse, and the need to report concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. There was a system to highlight vulnerable patients in patient records.

The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse; however, these required updating as they contained information that was no longer applicable such as requesting consent before reporting safeguarding concerns.

The practice could improve their safeguarding policies by ensuring they clearly stated what action staff should take in the practice if they had any safeguarding concerns, and to include the details of the practice's safeguarding leads. Some staff we spoke with were not aware safeguarding policies were available, or where to find them. Some staff were not clear on who, if any the practice's safeguarding leads were.

We saw evidence that two of the practice's three dentists, and the practice manager, had completed safeguarding children training in 2011 though there was no indication as to whether this training was delivered at the appropriate level for the dentists. There was evidence the principal dentist had completed a safeguarding update in 2018 on safeguarding children and vulnerable adults, though there was no indication of the level of training received. There was no evidence of safeguarding adults training for any member of staff, and no evidence of safeguarding children training for a dentist.

The principal dentist was not clear on incidents requiring notification to external organisations such as the Care Quality Commission.

The practice had a whistleblowing policy.

The principal dentist told us they did not use rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. They told us they did not document this in patients' dental care records, and they did not formally assess the risks related to the non-use of rubber dam.

The practice had a business continuity plan describing how the practice would deal with equipment (radiography machines, autoclave and compressor) failing to work, adverse weather, and user licensing for the computer system. The plan could be strengthened by including a more comprehensive list of events that could disrupt the normal running of the practice.

The practice did not have a staff recruitment policy to help them employ suitable staff. We checked four staff recruitment records and found the practice had not carried out appropriate checks for all staff. For example, the practice had not carried out Disclosure and Barring Service (DBS) checks for three members of staff. There was evidence of a historic DBS check for one of these members of staff, from their previous place of employment.

There was no job description or photographic identification for any of these members of staff, or any records to show that the practice had obtained evidence of satisfactory conduct from their past employment. The practice manager told us they did not routinely ask for this for new staff.

There was evidence that clinical staff were qualified and registered with the General Dental Council (GDC); however, the practice had not taken adequate steps to check and assure themselves that these registrations were up to date. GDC registration certificates for two members of staff had expiry dates of 2017.

There was evidence that clinical staff had professional indemnity cover; however, the practice had not taken steps to assure their selves this was up to date. Indemnity certificates for two dentists showed expiry dates of 2017 and February 2018.

The principal dentist told us the practice carried out regular checks of electrical equipment, but they had no records of these checks.

The practice had some arrangements to ensure the safety of the radiography equipment, though they did not have the most up to date required information in their radiation protection file. For example, there were no records of maintenance records for radiography equipment, local

Are services safe?

rules, details of the radiation protection advisor and supervisor, an inventory of all the practice's current radiography equipment, registration with the Health and Safety Executive or any radiological risk assessments in any of the practice folders we were provided with.

We checked a sample of records and found dentists did not consistently record the justification or grading of radiographs they took.

There was no evidence the practice carried out radiography audits every year to monitor the quality of radiographs taken; this was not in line with current guidance and legislation. We found a radiograph audit in a folder the practice provided us with, though the audit was not dated to indicate when it had been carried out. The practice manager told us they thought it was very old due to the presence of a logo they told us the practice no longer uses.

We found evidence that all three dentists had completed continuing professional development (CPD) in respect of dental radiography in 2009, 2011 and 2013; however, this training had not been updated after five years in line with guidance. None of the dental nurses had completed training in dental radiography; the practice manager told us undertaking this training was at the discretion of the dental nurses.

Risks to patients

The practice was undergoing extensive building works at the time of the inspection.

We checked the practice's arrangements for safe dental care and treatment.

The practice carried out dental treatment under conscious sedation for patients such as those who were very nervous of dental treatment and needed complex or lengthy treatment. Their processes for conscious sedation included patient information such as consent, discharge and post-operative instructions.

However, we found the practice had not established systems to help them provide conscious sedation safely.

The dental care records showed that patients having sedation had a detailed medical history, an assessment of health using the American Society of Anaesthesiologists (ASA) classification system, and patient checks before their treatment.

Some processes were not in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015 in relation to staff training, patient selection, management of medicines and equipment. The provider had not identified or mitigated the related risks. Our key findings are as follows:

- A dental nurse assisting with treatments provided under conscious sedation had not received the relevant training.
- None of the staff assisting with or providing sedation had received immediate life support training.
- The principal dentist was not able to demonstrate that they had undertaken any continuing professional development in conscious sedation since their initial sedation training in 2007.
- We checked a sample of dental care records to confirm our findings and discovered the dentist had not carried out certain monitoring of the patients during the sedation procedure, such as blood pressure, oxygen saturation and sedation drug titration.
- The dentist had treated a patient outside of the ASA's recommended remits for the safe provision of sedation in primary care.
- The practice was not able to demonstrate any policies in place for conscious sedation, including protocols for the evacuation of sedated patients in the event of an emergency and the disposal of controlled medicines.
- Sedation medicines had not been stored securely.
- Syringes used to administer sedation medicines appeared to have been re-used.

We have taken enforcement action against the provider, which prevents them from providing dental treatments under conscious sedation until they have made the necessary improvements.

The practice had carried out risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice had employer's liability insurance.

There were limited systems to assess, monitor and manage risks to patient safety. We found evidence of a health and safety risk assessment. The provider could make improvements to ensure the risk assessment was dated, practice-specific and regularly reviewed. There was no indication the risk assessment had been reviewed since 2012.

Are services safe?

We requested but were not provided with any assessments in relation to fire safety. The principal dentist told us they would consider carrying out a fire risk assessment after building works were complete. Records showed that a member of staff visually checked fire extinguishers regularly. There was no evidence staff had taken part in fire evacuation drills; some staff members told us they did not participate in fire evacuation drills. The practice manager told us the practice carried out fire evacuation drills in the past but did not log them.

There was some evidence the practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with what appeared to be an action plan from a risk assessment and regular flushing and disinfection of dental water lines. There was no evidence several recommendations had been addressed; for example, a Legionella management policy, quarterly descaling of water outlets, a yearly flushing regime, documentation of planned preventive maintenance tasks, implementation of Legionella training, and completion of a Legionella work log book with various preventive tasks carried out.

The practice did not use safer sharps techniques and had not formally assessed the risks associated with the use of sharp items in the practice. Sharps boxes had not been managed appropriately; in a surgery the lid on a sharps box was partially open, a sharps box in another surgery had visible blood and an exposed needle on the top surface, and none of the sharps boxes on the premises had been dated or signed.

Clinical staff had received appropriate vaccination to protect them against the Hepatitis B virus. The provider had a system in place to check the effectiveness of the vaccinations, though this information was not available for a member of staff. The practice manager told us they had made efforts in the past to obtain this information from the staff member. Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support.

The practice had emergency equipment and medicines. Not all staff were clear on where these were stored. We found a box of expired emergency medicines (such as Glucagon and Midazolam) stored in a cupboard next to medicines that were in date. All the practice's oropharyngeal airways had use-by dates ranging between 2002 and 2004. There were no sterile syringes available for the administration of adrenaline. The oxygen cylinder showed a use by date of 2008 and there was no evidence of regular maintenance of the cylinder. It took considerable effort for the specialist adviser and a member of the practice's staff to remove this cylinder from its bag as it had been tethered to the bag with straps. A member of clinical staff was not able to set up the oxygen for use when asked, and another non-clinical staff member told us they did not feel confident they would know how to do this. Shortly after the inspection the principal dentist told us they had ordered a new oxygen cylinder, and that they would arrange for the old one to be refilled.

There was a sign at the entrance to the practice indicating oxygen was on the premises. The practice could make improvements by ensuring there were additional signs inside the practice to indicate to emergency personnel the location of the oxygen.

The practice did not have eyewash available.

Staff kept records of their checks of equipment and medicines to make sure the medicines and equipment available were within their expiry date, and in working order. However, we found large amounts of expired dental materials, surgical gloves and haemostatic agents in the practice with expiry dates ranging between 2011 and 2017.

Some staff were not clear on the appropriate method to use to clean spillages of bodily fluids. We found there was no spill kit available for bodily fluids; the practice told us during the inspection that they had ordered a spill kit for blood but that it had not yet arrived.

The trainee and qualified dental nurses worked with the dentists when they treated patients in line with the General Dental Council (GDC) Standards for the Dental Team. The practice manager told us the dentists had occasionally needed to work without any chairside assistance whenever they had been understaffed; the practice could strengthen arrangements by formally assessing and mitigating, as far as possible, the associated risks.

The practice had not carried out infection prevention and control audits every six months in line with national guidance; they provided us with infection control audits they completed every seven to 12 months up to 2016. There was no evidence to show the practice had completed any further infection control audits since 2016.

Are services safe?

The practice did not have an infection control annual statement.

Records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.

The practice followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05), published by the Department of Health, when transporting, checking, and sterilising instruments. However, their procedures for storing dental instruments were not in line with HTM01-05. For example:

- We noted several instrument storage pouches left uncovered on dust-covered surfaces in two surgeries.
- Several dental instruments and materials including endodontic files, rubber dam clamps, ultrasonic scaler tips, radiograph film holders, matrix bands, articulating paper, amalgam dispensers and periodontal probes had been left uncovered in surgery drawers.
- Dental impression trays had been left uncovered in a storage cupboard that was left open during the inspection.
- Ultrasonic handpiece keys were left exposed on a table in a surgery where we saw three flies. The door to this surgery was left open during the inspection.
- We found many pouches containing dental instruments that had not been dated. Dates on pouches had not been written in a way that would allow staff to determine whether the date indicated when the instrument was pouched, or the use-by date of the instrument. Some pouched instruments were dated as far back as 2015.
- Some pouches containing dental instruments were torn and others had not been properly sealed.

In addition, we found materials including gloves, masks, cotton wool rolls, and saliva ejectors uncovered in surgeries. There was visible dust on keyboards in the surgeries. There were numerous dead flies in the waiting room; the provider cleared these after we brought it to their attention. A clinical tunic had been left hanging on a dental chair in a surgery where we observed surfaces had visible dust; it was not clear whether this tunic was used or clean, or whether it would be used the following day.

There was visible dirt on a ceiling, and visible stains on a wall, from a water leak several staff told us had been caused by rodents. The practice told us the water leak had been fixed. There was evidence they had implemented some control systems to manage the rodent problem.

We saw cleaning schedules for the premises and records showing practice staff had completed infection prevention and control training.

The practice had policies and procedures in place to ensure clinical waste was segregated in line with guidance.

Information to deliver safe care and treatment

We discussed with the principal dentist how information to deliver safe care and treatment was handled and recorded. We checked a sample of dental care records to confirm our findings and noted dental care records were legible. The practice could improve the quality of record keeping by ensuring key information about patients' care, such as review of medical histories, justification and grading of dental radiographs taken, oral health risk assessments, oral hygiene/lifestyle advice given, and periodontal measurements.

The provider had not stored all dental care records securely. On 23 July 2018 we found several patient records left unattended on work surfaces and in unlocked cupboards in three surgeries; the doors to these surgeries had been left open to the area that was accessible by contractors and near the rear exit of the premises which had also been left open and led to an area accessible by the public. This was not in compliance with data protection requirements. On 25 July 2018 we found the records had been removed from two of the surgeries, but several remained in an unlocked cupboard in a third surgery.

Safe and appropriate use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines.

They did not have a suitable stock control system of medicines on the premises to ensure medicines did not pass their expiry date. The practice used controlled medicines but there was no evidence of any policies to provide staff with guidance on the safe disposal of controlled medicines.

Are services safe?

We found five syringes labelled with names of medicines and water used in the provision of conscious sedation. These syringes appeared to have been reused and contained fluid residue.

Prescription pads had not been stored securely. We found a prescription pad had been left unattended in a surgery; the surgery door was left open at the rear of the property. A door at the rear of the property, which was accessible by the public, had also been left open. Throughout the inspection there were contractors on the premises.

The practice did not have an effective system in place to monitor the use of prescription pads or to prevent their misuse. They told us they did not keep a log of the serial numbers of the prescription pads or a log of prescriptions issued to patients.

Track record on safety

The practice had recorded accidents such as needle stick injuries to dental nurses. They could make improvements by ensuring they suitably recorded follow-up actions taken in response to these injuries.

Lessons learned and improvements

The practice did not have an effective system for monitoring and reviewing incidents to help staff understand risks. Staff told us about recent incidents such as a gas leak, and a water leak caused by rodents. However, none of these incidents were recorded. Some staff told us they were not aware of the gas leak.

The practice had incident recording forms available but had not recorded any incidents that were not accidents since 2010. There was no evidence of discussion of these incidents with the rest of the dental practice team to prevent such occurrences happening again in the future and to help the practice understand risks that would lead to safety improvements.

Understanding of significant events varied amongst staff; some staff we spoke with did not demonstrate a clear understanding of the practice's process for managing these. Some staff told us they did not know where to find incident recording forms or the practice's incident policy. They told us they had not been able to locate incident books that used to be stored in the surgeries since building works commenced.

The practice had a system for receiving national safety alerts such as those relating to medicines and equipment. The practice manager told us they received them by email and sent the relevant alerts to the principal dentist. They showed us evidence of alerts they had received up to March 2017. The practice could strengthen arrangements by implementing an effective system for sharing safety alerts with all relevant staff; some were not aware of any such system in place or of any recent alerts received by the practice

Staff did not demonstrate an awareness of the Serious Incident Framework for reporting safety concerns externally.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had some systems to keep up to date with current evidence-based practice.

Helping patients to live healthier lives

The dentists told us they were providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit; They said that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments.

The dentists used fluoride varnish for children based on an assessment of the risk of tooth decay.

The dentists described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice and taking plaque and gum bleeding scores and detailed charts of the patients gum conditions and alveolar bone levels.

The practice had a range of dental products available for sale.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The principal dentist told us that they gave patients information about treatment options and the risks and benefits of these so that they could make informed decisions.

Staff described how they involved patients' relatives or carers when appropriate and made sure that they had enough time to explain treatment options clearly.

Monitoring care and treatment

There was evidence to show the practice had carried begun an audit of patients' dental care records in 2012 to check that the dentists recorded the necessary information.

The practice kept dental care records containing information about the patients' care. The records contained key information about the patients' treatment, though the practice could improve the quality of the records by ensuring details about local anaesthetic administered, the non-use of rubber dam, oral health risk assessments, justification for recalls, and examination findings were consistently recorded.

Effective staffing

The practice had not assessed or mitigated risks relating to a lack of sufficient numbers of staff. They told us they had recently experienced a high turnover of dental nurses. They said they did not have sufficient numbers of dental nursing and reception staff at the time of the inspection.

The practice told us they had used the services of locum dental nurses employed from an agency. There were induction forms available to ensure permanently employed dental nurses new to the practice were familiar with the practice's procedures. They could strengthen arrangements by completing inductions for locum staff also; the practice manager told us they did not do this for locum dental nurses.

Several staff told us they did not have appraisals or discuss training needs. The practice manager told us they had been appraised by the principal dentist, but that the appraisal records were kept off-site for security reasons. We checked staff records but did not see evidence of any completed appraisals.

Co-ordinating care and treatment

The principal dentist confirmed that they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice was a referral centre for conscious sedation procedures.

The practice also had systems and processes for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by the National Institute for Care and Health Excellence (NICE) in 2005 to help make sure patients were seen quickly by a specialist.

The practice could strengthen arrangements for referrals by implementing a referrals log and tracker for all referrals made, and a referral policy to provide guidance to staff on the processes to follow.

Are services caring?

Our findings

Kindness, respect and compassion

During the inspection staff treated patients with kindness, respect and compassion. They were aware of their responsibility to respect people's diversity and human rights.

Staff were friendly towards patients at the reception desk and over the telephone.

We checked patient feedback from the practice's recent patient survey. There were 36 respondents. Feedback was largely positive about the attitude of staff.

Information leaflets were available for patients to read in the waiting area.

Privacy and dignity

Staff told us that if a patient asked for more privacy they would take them into another room if one was available.

The reception computer screens were not visible to patients.

Staff password protected patients' electronic care records and backed these up to secure storage.

Involving people in decisions about care and treatment

Staff we spoke with were not aware of the Accessible Information Standards (a requirement to make sure that patients and their carers can access and understand the information they are given) and the requirements under the Equality Act. Some staff told us the practice had access to interpretation services but that the practice did not use these services. They told us patients' friends or family members translated information for them. Other staff were not clear on whether the practice had these services available.

Two dentists spoke languages other than English.

Feedback from patient respondents to the practice's patient survey was mixed regarding being given written treatment plans. The majority indicated the cost of treatment was adequately explained to them.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included a camera used to show patients 'before and after' photographs of treatment cases, information leaflets, and radiograph images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff were clear on the importance of emotional support needed by patients when delivering care.

Patients surveyed by the practice indicated they were satisfied with the responsive service provided by the practice.

We checked records and found a disabled access guide dated 2010. The guide had highlighted areas where the practice could make the practice more accessible. The practice did not have a hearing loop for patients with hearing problems, or any facilities to provide additional support to patients with visual impairment. The practice was undergoing building works and we saw building plans indicating the practice had made provisions for a fully accessible toilet including hand rails and an alarm call facility. A building contractor told us a plan was in place to make the flooring from the entrance of the building to the reception area level to enable unimpaired wheelchair access, and to widen a corridor on the ground floor.

Timely access to services

The practice displayed its opening times on their website.

Staff told us patients who requested an urgent appointment were usually seen the same day.

Most patients surveyed by the practice indicated they had waited less than 20 minutes when they arrived for appointments, though some indicated otherwise.

Listening and learning from concerns and complaints

Staff told us they took complaints and concerns seriously.

The practice had a complaints policy providing guidance to patients on how to make a complaint.

The practice manager and dentists were responsible for dealing with complaints. The practice manager told us they aimed to settle complaints in-house and contacted patients to speak with them to discuss these.

Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so that patients received a quick response.

We checked a complaint the practice received in the last 12 months. There was some evidence to show the practice had communicated with the patient in relation to the complaint, though the practice manager was not able to find the response a dentist had made to the complaint. There was no evidence to demonstrate that the practice discussed outcomes of complaints with staff to share learning.

Are services well-led?

Our findings

Leadership capacity and capability

Staff told us the practice manager was visible and approachable.

The practice manager demonstrated commitment to their role but expressed frustration at not having sufficient time to complete management tasks, due to what they told us was a lack of adequate staffing which required them to also undertake receptionist duties.

We raised the issues we identified with the principal dentist. They showed willingness to make improvements.

Vision and strategy

The principal dentist described a vision to provide high quality dental services in a pleasant environment, with a desire to provide more complex dental implant treatment for patients. Other staff expressed a desire to provide a good quality, friendly service for patients.

Culture

Staff told us they felt respected, supported by the practice manager.

The principal dentist was aware of the requirements of the Duty of Candour.

Staff we spoke with appeared to be committed to their roles but described low morale which they told us they felt could be attributed to the prolonged nature of the building works which had interrupted the normal running of the practice, and a lack of adequate staff. They described a culture that was autocratic and financially driven.

Some staff expressed a desire for encouragement for their work at the practice.

Not all staff had confidence that concerns they raised would be addressed; some concerns they had raised had not been addressed by the principal dentist.

Appropriate and accurate information

The practice had information governance arrangements but had not ensured patients' personal information was adequately protected at the time of the inspection.

Engagement with patients, the public, staff and external partners

The practice used verbal comments and their patient survey to obtain patients' views about the service. They obtained feedback from staff through verbal discussions, though staff described a lack of involvement and engagement in the practice.

Staff told us the practice did not have meetings; they expressed a desire for this to be implemented in order to encourage more cohesive working among staff at all levels, and better communication about issues, policies and changes in the practice.

Continuous improvement and innovation

The practice had limited evidence of audits of dental care records and radiographs. They had last carried out infection prevention and control audits in 2016. They had clear records of the results of these audits and the resulting action plans though they had not reviewed them regularly to monitor quality.

We noted there was no evidence of appraisals for any member of staff to discuss learning needs, general wellbeing and aims for future professional development.

The General Dental Council (GDC) requires clinical staff to complete continuing professional development. We saw evidence some staff had completed training that was 'highly recommended' by the GDC, such as radiography, medical emergencies and infection prevention and control, though some of this training had not been updated and there was no evidence staff had undertaken other recommended training. The provider could make improvements by implementing an effective process for tracking and monitoring training undertaken and training needs.

Governance and management

The principal dentist had overall responsibility for the clinical leadership of the practice. The practice manager was responsible for the day to day running of the service.

We found the practice's leaders did not demonstrate a clear awareness of all responsibilities, roles and systems of accountability. For example, they were not clear on requirements for good and safe practice, the location of various documents, or whether certain tasks had been carried out. Key staff were not clear on requirements for the safe provision of conscious sedation, significant events of the process for managing them, processes for managing safety alerts, interpretation services, the practice's

Are services well-led?

safeguarding leads, responsibilities relating to the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) and recent changes in regulations for the disposal of amalgam.

The provider had a system of clinical governance in place which included policies, protocols and procedures, though some staff were not aware of how and where they could access these. It appeared the practice had reviewed some polices, though others appeared not to have been reviewed since 2012. The practice could make improvements by ensuring all policies contained information that was up to date, and that key policies, such as those relating to referrals, sedation and recruitment, were readily available.

The provider had not established effective systems to assess, review and mitigate risks in relation to:

- The lack of effective processes to ensure all staff had received appraisals and completed key training.
- The lack of effective recruitment procedures.
- The lack of assurance regarding adequate immunity of a member of staff to vaccine-preventable diseases.
- The lack of systems to monitor quality.
- The lack of availability of recommended medicines and equipment used to manage medical emergencies, and the lack of suitable processes to ensure medicines and equipment were in available in sufficient quantities and in date.
- The lack of suitable maintenance of equipment.
- Infection control procedures that were not in line with national guidance.
- The lack of evidence of safety checks of electrical equipment.
- The lack of suitable arrangements to ensure dental care records and prescription pads were stored securely.
- The lack of effective governance arrangements.

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 **Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met** **The registered person had systems or processes in place that operated ineffectively, in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular this was in relation to:** • The lack of evidence of adequate immunity against vaccine preventable infectious diseases for a dental nurse. • The lack of oversight of fire safety, electrical safety, health and safety, significant events, Legionella prevention, infection prevention and control processes, and the non-use of rubber dam. • Prescription pads that had not been stored securely. • The lack of sufficient equipment used to manage medical emergencies. • Medicines, equipment and dental materials that were expired. • The lack of suitable maintenance of equipment used to manage medical emergencies. • The lack of suitable policies to provide guidance to staff.

This section is primarily information for the provider

Requirement notices

- The lack of engagement and cohesive working among staff at all levels, and the consistent lack of understanding of governance arrangements and requirements among the practice's leaders.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- They had not carried out regular audits to monitor the quality of safety of clinical systems and processes.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- They had not stored patients' dental care records securely.

Regulation 17 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met** The registered person had failed to ensure that persons employed in the provision of a regulated activities received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

This section is primarily information for the provider

Requirement notices

- Staff had not received appraisals.
- There was no evidence to show staff had completed and updated key training and continuing professional development.

The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 18 (1)(2)

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 **How the regulation was not being met** The registered person employed persons who must be registered with a professional body, where such registration is required by, or under, any enactment in relation to the work that the person is to perform. The registered person had failed to ensure such persons were registered. In particular: • There was no evidence to demonstrate registration with the General Dental Council was up to date for a dental nurse and a dentist. • There was no evidence to demonstrate indemnity cover for two dentists was up to date. The registered person's recruitment procedures did not ensure that only persons of good character were employed, and they did not ensure they had the specified information available regarding each person employed. In particular:

This section is primarily information for the provider

Requirement notices

- The registered person had not carried out checks for all recently recruited staff to ensure they did not have a criminal background that might prevent them from carrying out their role suitably.
- They had not sought evidence of satisfactory conduct from past employment of recently recruited staff.
- There was a lack of evidence of photographic identification for recently recruited staff.

Regulation 19 (1)(3)(4)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment delivered under conscious sedation. In particular: • There was a lack of required training and continuing professional development for conscious sedation. • A lack of maintenance of contemporaneous records in relation to monitoring of patients undergoing conscious sedation procedures. • The correct equipment was not available and the facilities did not conform to accepted standards for health and safety. **Regulation 12 (1)**