Oak Dental Care Ltd

Oak Dental Care Limited - Southport

Inspection Report

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Overall summary

We carried out this announced inspection on 26 June 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 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 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

Oak Dental Care Ltd, Southport, is based in a residential area of Southport, Merseyside. The practice provides private treatment to adults and children.

There is ramp access to the building and level access internally for people who use wheelchairs and those with pushchairs. Car parking spaces are available at the rear of practice, with street parking available to the front of the practice.

Summary of findings

The dental team includes one dentist, two dental nurses, one of whom acts as the receptionist, and one dental hygienist. Another dental hygienist from another practice within the group does work from the practice when required. The practice has two treatment rooms.

The practice is owned by a company, Oak Dental Care Ltd and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Oak Dental Care Ltd., Southport was the dentist. A second registered manager is also in place, who works at the other branches of the organisation.

On the day of inspection, we collected 10 CQC comment cards filled in by patients and spoke with one other patient.

During the inspection we spoke with the dentist, the dental nurse and practice receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open from 9am to 12pm, and from 2pm to 5pm Monday to Thursday, and from 9am to 12pm and 2pm to 4.30pm on Friday.

Our key findings were:

- The practice appeared clean but we did find cleaning required improvement.
- The practice staff had infection control procedures in place but these did not reflect published guidance in all areas.
- Although environmental cleaning schedules were in place, evidence collected on the day of inspection demonstrated that these were not being adhered to.
- There was a lack of oversight and governance in several areas of the practice, for example in the management of the decontamination process, infection control, environmental cleaning and dental unit water line maintenance. There was no COSHH information available on products used to clean the practice.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems to help them manage risk however these were not always correctly followed, for example, local rules in relation to operation of X-ray equipment in line with IRMER regulations, required review.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice had staff recruitment procedures in place but these did not take account of all staff checks as required by The Health and Social Care Act 2008.
- Staff training and associated to records to evidence this required review.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- The practice had leadership that was visible and approachable.
- There was some evidence of continuous improvement including audit and continuous professional development of staff.
- Staff felt involved and supported and worked well as a team.
- The practice staff dealt with complaints positively and efficiently.
- The practice staff had some information governance arrangements in place but this required improvement.

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.

Full details of the regulations the provider was not meeting are at the end of this report.

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

Summary of findings

- Review the security of prescription pads in the practice and ensure there are systems in place to track and monitor their use, including those in daily use in the practice.
- Register the use of dental X-ray equipment with the Health and Safety Executive in compliance with the Ionising Radiations Regulations 2017.

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. The impact of some of our findings, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

The practice had systems and processes in place to support safe care and treatment. When we reviewed these, we found some were not being applied consistently.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles at the practice. We found some staff required further role specific training where they were delivering lead roles, for example, in infection prevention and control.

All essential recruitment checks had not been completed, in line with the requirements of Schedule 3 of the Health and Social Care Act 2008.

The practice premises appeared clean but some areas required attention. The environmental cleaning of equipment and apparatus in clinical rooms required review to ensure this met recognised infection control guidance. Where some equipment showed signs of wear, these had not been renewed.

The practice had a disused toilet on the ground floor, which was not in use due to a leak and had not been in use for some time. There was no review or update of risk assessment in place to assess whether this should be decommissioned.

The practice staff showed a lack of understanding on the decontamination process, for example, in relation to validation checks on a vacuum autoclave, the protocol for manual cleaning of dental instruments, and the use of solutions for cleaning dental instruments.

The local rules in respect of management of risk from radiation required review.

The practice had arrangements for dealing with medical and other emergencies. We found some items of emergency medical kit were missing, for example, a child mask for operation of a bag valve mask.

Are services effective?

No action

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

The dentist assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as great or very good. The dentist and dental hygienist discussed treatment with patients so they could give informed consent and recorded this in their records.

Summary of findings

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

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this. Some further enhanced training was required for staff who were in lead roles, for example in infection control.

Are services caring?

No action ✓

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

We received feedback about the practice from 11 people. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly, caring and patient.

They said that they were given clear explanations and honest and helpful advice and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

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 in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to interpreter services if these were required. A hearing loop was available for those patients that may need access to this.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

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).

The practice had arrangements to ensure the smooth running of the service. There was a clearly defined management structure and staff felt supported and appreciated.

The practice team kept complete patient dental care records which were, clearly written or typed and stored securely.

Summary of findings

The practice were unable to demonstrate that they had completed the required declaration to the Health and Safety Executive in respect of compliance with IRMER 2017 Regulations. Local rules for each set of X-ray equipment placed in each surgery, required review.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn.

Governance in some areas required improvement. This included:

- checks in respect of staff recruitment
- staff appraisals
- checks on equipment
- sharing and recording of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and updates on National Institute for health and Care Excellence (NICE) guidance and on notifications to CQC on any circumstances that may affect the running of the practice.
- The environmental cleaning and infection control procedures within the practice.
- Addressing emerging risks, for example, in relation to management of legionella risk.
- Record keeping in respect of governance also required improvement.

Are services safe?

Our findings

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

The practice had systems to keep patients safe. We found that some of these were not followed or required review.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. We noted that there was no safeguarding information immediately available to staff. This was held on the practice computer and the staff member assisting us on the day took some time to locate this. We did note staff could name safeguarding leads and deputies and were confident about approaching these people to raise concerns.

The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

The dentist used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was suitably documented in the dental care record and a risk assessment completed.

The practice had a business continuity plan describing how the practice would deal with events that could disrupt the normal running of the practice.

The practice had a staff recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at two staff recruitment records. These records were incomplete as all checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, were not present, or there was no record of them having been undertaken. For example, indemnity cover for one staff member expired in November 2017; there were no records of staff immunity to communicable diseases, there was a lack of references for some staff and no record of employment history. For some staff there was no current record of Disclosure and Barring Service check.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities were safe including electrical and gas appliances.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced.

The practice had arrangements to support the safety of the X-ray equipment. When we reviewed these, we found that the local rules for each dental surgery and its X-ray equipment, were not specific for each room. On the front of each document, the name of the X-ray apparatus had been changed, to reflect the equipment in use, but both documents beyond this point were identical. We found the recommended maximum exposure times for children were missing, the name of the model of X-ray equipment was the same for both surgeries; when we checked each had differing X-ray equipment. The documents and arrangements required review to ensure they met current radiation regulations and had the required information in their radiation protection file. We further noted that the practice had not submitted the required declaration to the Health and Safety Executive, confirming they operated in accordance with IRMER Regulations 2017.

We saw evidence that the dentist justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation.

We were told the dentist was the only staff member at the practice carrying out X-rays. We saw evidence they completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety. Some of these required reviews.

Are services safe?

The majority of the practice's health and safety policies, procedures and risk assessments were up to date. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually. We particularly noted that there had been no sharps injuries since 2014. This demonstrated that staff followed protocols for the handling of sharps and the dismantling of matrix bands.

The provider assured us that they had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. Conversations with staff confirmed this, although records to demonstrate this could not be produced on the day and were not supplied following inspection, as part of the information requested from the practice, in line with Schedule 3 checks.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS). Some staff training required review. Also, some records in relation to staff training were not held by the practice, which made it difficult to assess when staff required updates and refresher training.

Emergency equipment and medicines were available, although some were not as described in recognised guidance. For example, guidance states that buccal Midazolam should be available for emergency use. The practice held ampoules of Midazolam, which we were told would be broken open and applied by use of a finger, inside the patient's mouth, which is not in accordance with recognised guidance. We found Glucagon kept in the emergency medicines kit, the expiry date on this had not been adjusted to reflect that this had not been refrigerated, in accordance with manufacturer's guidance.

Staff kept a tick sheet of checks carried out to make sure these were available, but there were no dates of when these checks were completed.

A dental nurse worked with the dentist and dental hygienist when they treated patients in line with GDC Standards for the Dental Team.

The provider had some risk assessments to minimise the risk that can be caused from substances that are hazardous to health. When we reviewed materials used for cleaning the practice, there was no COSHH information held in relation to these items, so it was unclear whether any risk assessments should be in place when using these items.

The practice had an infection prevention and control policy and procedures. This reflected guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. When we reviewed processes in place we found the application of these fell short of what is required daily. For example, we found that the receptionist, who was also a qualified dental nurse, had received infection prevention and control training, and was acting as a lead in this area. Evidence on the day showed the training received did not fully support the staff member to deliver duties as an infection prevention and control lead. Environmental cleaning schedules were in place for each surgery, but no checks were carried out on these cleaning tasks. When we conducted visual checks in the surgeries, we found visible dirt and debris in both rooms. There was a tear in one of the dental chairs; fabric chairs and cushions were placed in the surgery, which are more difficult to clean to the standard required in a clinical environment. One of the surgeries had carpeting to the perimeter of the room. We found dental instruments in broken bags, leaving the tips exposed. We found items for use in the drawers that were not date stamped, so it was unclear as to when these were no longer suitable for use.

The practice told us they had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed some equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The practice staff told us they used a washer disinfector for cleaning instruments. Staff told us that no protein residue tests were being conducted to ensure the efficacy of the washer disinfector. There were two autoclaves available for use; one staff member told us they only used the non-vacuum autoclave. We were told later during the inspection that the vacuum autoclave was also being used. The daily start up checks and individual cycle checks on this were not available as staff did not know how to download the information from

the datalogger in the equipment. As a result, validation checks on this equipment had not been carried out daily or for each cycle. There were no historic records of these checks for us to review.

We asked staff to demonstrate how they would clean instruments that could not be placed in the washer disinfector, or if the washer disinfector was not working. We observed that there were no heavy-duty gloves available for use; there were no long handled brushes available to scrub instruments. When we asked about cleaning solutions used, there were no measuring cups or cylinder available to measure detergent to the correct amount for use. Staff showed a lack of awareness of how much detergent should be used in line with manufacturers guidance.

There was no thermometer available in the decontamination room for checking water temperature when manually cleaning instruments. The practice had carried out an infection control audit January 2018. We found the audit process was ineffective. None of the issues highlighted by our inspection had been identified by the audit, including checks made on environmental cleaning of the building and equipment, and on the decontamination processes in place at the practice. One area for action had been identified which was to have sharps boxes mounted to the wall. This had not been addressed.

The practice did have in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

The practice told us they had procedures to reduce the possibility of legionella or other bacteria developing in the water systems, in line with a risk assessment conducted in July 2017. We reviewed protocols in place to manage the risk of legionella. We saw records of water temperature checks from running taps which showed temperatures in the required range being consistently achieved. When we made checks on rooms that were not being used, we found there was a downstairs toilet, out of use, but leaking. This had not been decommissioned, so the basin in this room and the toilet was still on the water supply and feed system. This area was not subject to any legionella checks. There had been no risk assessment conducted by the practice to establish whether this toilet and basin should be removed and the water supply capped off, to prevent it becoming a dead-leg on the water system.

We found there was no protocol for staff to follow on flushing of dental water lines. We asked staff about this who gave inconsistent responses.

We saw environmental cleaning schedules for the premises. These listed all areas to be cleaned each day. We found there were no cleaning logs to confirm that all areas had been checked following cleaning. On the day we inspected the practice, we found visible dirt and debris in the surgeries.

All other areas of the practice appeared clean when we inspected and patients confirmed that this was usual.

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

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records to confirm our findings and noted that individual records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible and were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The practice stored prescriptions pads in a locked drawer in the practice but did not keep records or logs that enabled them to track and trace prescriptions issued.

The dentist was aware of current guidance with regards to prescribing medicines.

Are services safe?

Antimicrobial prescribing audits were carried out annually. The most recent audit demonstrated the dentist was following current guidelines.

Track record on safety

The practice had a good safety record.

There were comprehensive risk assessments in relation to safety issues. The practice monitored and reviewed incidents. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. For example, we particularly noted that there had been no sharps injuries at the practice for four years. Staff confirmed that the policy in the practice is that only dentists unsheathe needles and dismantle matrix bands; this is reflective of the practice policy.

In the previous 12 months there had been no other safety incidents.

The incidents that were recorded over 12 months ago, had been investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

Lessons learned and improvements

The practice learned and made improvements when things went wrong.

The staff were aware of the Serious Incident Framework. Staff could share examples of events recorded, responded to and discussed to reduce risk and support future learning in line with the framework.

There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. There was a system in place for receiving and acting on safety alerts. When one of the dental nurses, who had been at the practice for many years, was asked about these alerts, they required prompting. This suggested that all relevant alerts, for example, from the Medicines and Healthcare Products Regulatory Agency, are not routinely shared across the whole practice. The practice dentist told us that they had learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice had systems to keep the dentist up to date with current evidence-based practice. We saw that the dentist and dental hygienist assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients, based on an assessment of the risk of tooth decay.

The dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns and local schemes available in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentist described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice, taking plaque and gum bleeding scores and detailed charts of the patient's gum condition

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

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 dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

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

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist assessed patients' treatment needs in line with recognised guidance.

We saw that the practice audited patients' dental care records to check that the dentist recorded the necessary information.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles clinical roles, for example the dentist, dental hygienist and dental nurses. We found that some staff were acting as leads for the practice is some areas, and they had not received enhanced training to support this, for example, training as an infection control lead.

Staff new to the practice had a period of induction based on a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at appraisals. We found that some staff had not been appraised since 2013. When further copies of appraisal were provided after the inspection, this demonstrated that appraisal was not uniform and there were several gaps in each staff members appraisal records.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

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

The practice had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

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 NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were friendly, caring and patient. We saw that staff treated patients respectfully and compassionately and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding, and were flexible when offering appointments for follow-up treatment.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

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

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the

requirements of the Equality Act.

- Staff communicated with patients in a way that they could understand, for example, by using communication aids and easy read materials, which were available on request.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example use of photographs, models and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

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

For example, those living with dementia, autism and other long-term conditions.

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had made reasonable adjustments for patients with disabilities. This included step free access via a ramp to the surgery building, a hearing loop, and an accessible toilet.

Staff described how any patient who found it unsettling to wait in the waiting room before an appointment would be given an appointment with the dentist which meant minimum waiting time, and at a time when the dentist could see them as soon as possible after they arrived, for example, the first appointment of each surgery.

Staff told us that they telephoned some older patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their practice information leaflet and on their website.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day.

Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The Southport practice was part of a group of practices, and could offer emergency access to patients who required this.

The practice website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The dentist was responsible for dealing with these. Staff told us they would tell the dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The dentist told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received in the past two years.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The dentist, who was also the Registered Manager, had the capacity and skills to deliver high-quality, sustainable care and had the experience, capacity and skills to deliver the practice strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges they faced. The practice was part of a group of four dental practices and had recently moved from being a stand-alone practice, to a limited company. As the organisation had grown, some of the roles and responsibilities within each practice which required governance across all sites, for example, infection prevention and control, record keeping in relation to training and development and staff appraisals, had been grouped together and a staff member appointed centrally to manage these. When we inspected the practice, we saw that infection prevention and control lead duties were sitting with a staff member at Southport, rather than the governance lead maintaining checks and audits on this area of work. Similarly, we saw individual staff members were holding details of all training completed, meaning it was difficult to see quickly, which staff members required refresher training.

At a practice level, we saw, and staff told us, that leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

There was a clear vision to deliver high quality, patient focussed care and a shared set of values supported this. The practice had a realistic strategy and supporting business plans to achieve priorities.

Culture

The practice staff and dentist spoke of a culture of high-quality sustainable care.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability to support governance and management. This required improvement to ensure they were embedded and that staff from outside the practice delivering governance duties, fully met their responsibilities, and leads within the practice, were appropriately assessed, trained and supported to carry out their role.

The dentist had overall responsibility for the management and clinical leadership of the practice, and for the day to day running of the service. Staff demonstrated that they knew the management arrangements and their roles and responsibilities but when we asked about some of the processes, we found that they were not embedded. For example, there was a system in place at the practice for receiving alerts, safety notices and updates to clinical guidance but there was no evidence that these were shared and discussed with staff at the practice. For example, when we asked a longstanding staff member about recent MHRA alerts, they could not identify what MHRA alerts were, or refer to any examples over the past 12-24 months. There were no records of meetings were alerts and updates had been discussed with staff.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. Governance arrangements in place at the time and review of these, had not identified that there was no protocol in place for staff to follow when manually cleaning dental instruments or equipment. Throughout our inspection day we could see that staff completed duties assigned to them, but governance duties had been overlooked, for example, checks made on environmental cleaning of the practice and the surgeries. This also covered appraisal arrangements for some staff, which is why staff had not been consistently appraised annually. Also, were areas of potential risk presented, this was not dealt with quickly in order to address those risks.

Are services well-led?

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

The practice had information governance arrangements in place for the handling and storing of patient information, and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public and staff to support sustainable services.

The practice used all verbal feedback from patients about the service, to make changes or improvements. We saw examples of suggestions from patients/staff the practice had acted on, for example, any patients that were nervous about visiting the dentist had this information recorded in their records so that staff could offer the first appointment of each surgery, to keep any waiting times to a minimum. Information in the practice leaflet encouraged patients to share their views, good or bad.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records and radiographs; staff could show us clear records of the results of audits and the resulting action plans and improvements. The system to audit infection prevention and control standards was not effective and required improvement.

The dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. On the day of inspection, where we found some processes and practise required improvement, the whole practice team demonstrated a commitment to address these areas without delay.

The staff team told us they had received annual appraisals, but not in recent years. When we reviewed records, we saw that the dental nurse had not been appraised for at least two years. The dental hygienist had not been appraised for over two years. The receptionist who was also a dental nurse, had not been appraised since 2013. Staff told us the appraisal allowed them to discuss learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders, but these were several years old.

Overall there were significant gaps in staff appraisals.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

The General Dental Council also requires clinical staff to complete continuing professional development. Staff told us the practice provided support and encouragement for them to do so.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met** The registered person was not carrying out assessments of the risks to the health and safety of service users of receiving care or treatment, nor doing all that was reasonably practicable to mitigate these risks. In particular: 1. Not all the recommended medical emergency and life support equipment was available at the practice, namely, child sized resuscitation bag-valve-masks and buccal Midazolam. 2. Staff training required review to ensure that all staff had access to and were up to date with recommended training. 3. The cleaning of equipment in clinical rooms required review to ensure this met guidance set out in Health Technical Memorandum 01-05. 4. Decontamination processes require review to ensure that staff understand this fully and have the equipment available to complete these duties. 5. No risk assessment had been carried out on the need to decommission a disused toilet, in respect of legionella. Regulation 12(1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

There were insufficient systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

1. Records to demonstrate that all required staff checks had been conducted were not in place.
2. Records to demonstrate that all staff had received required training and that this had been refreshed in accordance with guidance, were not in place.
3. There were no records in place to demonstrate that environmental cleaning was monitored.
4. There was no protocol in place for the manual cleaning of dental instruments. There was no protocol in place for staff to follow in the flushing of dental water lines.
5. Staff had not been appraised for several years.
6. Records were not in place to demonstrate that alerts and updates, for example, from the MHRA, NICE and CAS were disseminated, shared and discussed with staff.
7. Local Rules for X-ray equipment were not specific for each surgery. Also, the provider had not completed the necessary declaration to the Health and Safety Executive regarding the safe use of equipment in line with IRMER 2017 Regulations.

Regulation 17(1)