Gensmile Dental Care Limited

Guildhall Dental

Inspection Report

Guildhall Dental
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Overall summary

We carried out this announced inspection on 11 June 2019 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

Guildhall Dental is in Bury St Edmunds, Suffolk and provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs on the ground floor, and a lift for access to treatment rooms on the first floor. Staff rooms and offices occupy the second floor. Car parking spaces, including spaces for blue badge holders, are available in public car parks near the practice.

Summary of findings

The dental team includes nine dentists, one visiting orthodontist and one endodontist, four hygienists, eight dental nurses and the lead dental nurse, five receptionists, one treatment coordinator and a practice manager. The practice has nine treatment rooms and one patient coordinator room.

The practice is owned by a company 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 Guildhall Dental was the practice manager.

On the day of inspection, we collected 18 CQC comment cards filled in by patients.

During the inspection we spoke with two dentists, the lead dental nurse, four dental nurses, one dental hygienist, one receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Friday from 8.30am to 5.30pm.

Our key findings were:

- We received positive comments from patients about the dental care they received and the staff who delivered it.
- The practice appeared clean and well maintained.
- The practice staff had infection control procedures which reflected published guidance. The practice carried out infection prevention and control audits, but not as regularly as recommended by guidance.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect.
- The practice staff dealt with complaints positively and efficiently.
- The provider did not have all emergency medicines or equipment in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Risk assessments to identify potential hazards and the provision of audit to improve the service were limited.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

Full details of the regulation/s the provider was not meeting are at the end of this report.

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

- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities in relation to this.

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 practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

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 and the practice completed essential recruitment checks.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

We found that three of the six intra oral X-ray units were seven months overdue for a full survey by the radiation protection advisor. The cone beam computed tomography (CBCT) machine was 16 months overdue for its full survey. Following discussion, the practice manager took immediate action and agreed to stop all use of the intra oral units and CBCT machine until this equipment had been serviced and was confirmed. The impact of our concerns with regards to the use of X-rays and radiation has been reduced due to the practice manager taking urgent action.

We were not assured any recommended actions which had been identified in the legionella risk assessment had been actioned and completed, or any recommended prevention methods such as flushing water lines between patients and water temperatures maintained within recommended guidelines, were appropriate and in place. We found that audits had not been undertaken by all clinicians, those that were undertaken were sporadic, and with a limited sample size.

Appropriate life-saving equipment were not all available. We noted the practice was missing some clear face masks. The practice confirmed those missing masks had been replaced following the inspection. Dental care records were not stored securely.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as excellent and very good. The dentists 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.

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 18 people. Patients were positive about all aspects of the service the practice provided. They told us staff were helpful, pleasant and caring.

They said that they were given informative, helpful and honest explanations about dental treatment, 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 took account of patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for patients with a disability and families with children. The practice had access to telephone interpreter services and had arrangements to help patients with sight or hearing loss.

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 staff told us they enjoyed their work and felt supported by the principal dentist and practice manager. However, we found a number of shortfalls indicating that the practice's governance procedures needed to be improved. This included the oversight of surveying and annual testing of X-ray equipment and the CBCT scanner. We were not assured any recommended actions which may have been identified in the Legionella risk assessment had been actioned and completed, or any recommended prevention methods were appropriate and in place. Audits for dental care records, infection control and radiography were not

Summary of findings

undertaken in line with national guidance. There were no audits of sedation or justification of poly pharmacy in patient dental records. Patient dental care records were not stored securely. There was no risk assessment or oversight of the specific risks associated with the hygienist working without chair side support.

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays).

The practice had systems to keep patients safe.

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, including notification to the CQC.

The practice manager understood the formal reporting pathways required following serious untoward incidents as detailed in the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice had a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

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

The dentists used rubber dam 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 and also had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at four staff recruitment records. These showed the practice followed their recruitment procedure.

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

The practice ensured that some facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. We found that the five-year fixed wire testing had been undertaken in July 2016. This had identified some areas for action. One reported 'danger was present' and others identified as 'potentially dangerous'. We discussed these with the practice manager who was able to confirm that some actions had been taken and others were on-going.

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.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits. However, we found these had not been undertaken by all clinicians, when they were undertaken they were sporadic, and with a limited sample size; there was no evidence of peer review across clinicians.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography. We found that three of the six intra oral X-ray units were seven months overdue for a full survey by the radiation protection advisor. We discussed this with the practice manager who confirmed this equipment was due to be serviced in July 2019. Following discussion, the practice manager took immediate action and agreed to stop all use of the CBCT machine until this equipment had been serviced.

We were told before we left the practice that this was now scheduled for Monday 17June 2019. Following the inspection, the practice manager sent us evidence that the survey of the three X-ray units had been undertaken.

The practice had a cone beam computed tomography (CBCT) machine. Staff had received training. We found that the CBCT machine was 16 months overdue for its full survey with the radiation protection advisor. The practice manager confirmed this equipment was scheduled to be serviced in July 2019. The practice could not provide evidence that this equipment was safe for patient use at the point of our inspection.

Are services safe?

Following discussion, the practice manager took immediate action and agreed to stop all use of the CBCT machine until this equipment had been serviced. We were told before we left the practice that this was now scheduled for 17June 2019.

Following the inspection, the practice manager sent us evidence that a full survey of the CBCT machine had been completed on 18 June 2019.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

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. We noted that not all sharps receptacles were signed and dated, not all staff were aware of the guidance on disposing of sharps bins within three months of opening.

A sharps risk assessment had been undertaken and was updated annually.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus. We noted the effectiveness of the vaccination was not recorded in one staff file.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. Immediate Life Support (ILS) training for sedation was also completed.

Not all emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. However, we found there were only two clear face masks available in the emergency equipment instead of the recommended five. Following the inspection, the practice sent us confirmation that the three missing masks had been purchased.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team. A lone worker risk assessment was not in place to ensure the provider had oversight of the specific risks associated with the hygienist working without chair side support.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health. However, these did not include any household cleaning products in use at the practice.

The practice had an infection prevention and control policy and procedures. They followed 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.

The practice had mostly suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. We noted the air flow in the decontamination room required reviewing as this was blowing air in the wrong direction. We also noted some damage to the surface of the hatch between the dirty and clean areas, with some exposed wood under chipped paintwork. The plywood/wooden top underneath the painted surface was exposed, was not water tight and therefore could not be effectively cleaned.

The practice had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice had some procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. There was no evidence or audit trail of recommended actions being completed. Records of water testing and dental unit water line management were in place. However, we noted from the records that procedures were not undertaken inbetween patients being seen. Not all cold and hot water checks met recommended temperatures. We noted that checks on some hot water outlets were under 45 degrees and on review of records had been consistently below recommended temperatures for several months; there was no action plan in place to rectify this concern. The practice manager told us that another legionella risk assessment would be shortly undertaken.

The practice cleaning was undertaken when the practice was closed by an external organisation, we did not see any cleaning schedules for the premises or control of

Are services safe?

substances hazardous to health (COSHH) records for cleaning products. We noted one mop head was soiled and the practice manager was unable to confirm how often mop heads were replaced. The practice manager told us cleaning products were retained off site by the cleaning company. We noted the practice was visibly clean when we inspected.

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

Staff uniforms were clean and their arms were bare below the elbows to reduce the risk of cross contamination. We noted staff changed out of their uniforms at lunch. The practice carried out infection prevention and control audits annually, but not as regularly as recommended by guidance which states completion on a six-monthly basis. The latest audit showed a low score due to the lack of flushing of dental water lines between patients. We noted that since the last audit undertaken on 4 June 2019, no action had been taken to rectify this. The practice did not have an annual infection control statement.

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 accurate, complete, and legible. We found the cleaners had full access to a room where patient dental care records were stored. Following the inspection, the practice manager told us the room would be locked in future.

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 and kept records of NHS prescriptions as described in current guidance.

The dentists were aware of current guidance with regards to prescribing medicines.

Track record on safety and Lessons learned and improvements

There was a system for reviewing and investigating when things went wrong. The practice manager told us accidents such as sharps and needlestick injuries were added to the accident book and discussed at team meetings. We did not see any completed accident report sheets or significant event reports. We did see that some incidents were discussed in team meetings.

There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. We saw they were shared with the team and acted upon if required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

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

Not all clinical staff were aware of Local Safety Standards for Invasive Procedures (LocSSIPs).

The practice offered dental implants. These were placed by the dentists at the practice who had undergone appropriate post-graduate training in this speciality. The provision of dental implants was in accordance with national guidance.

The practice had access to intra-oral cameras to enhance the delivery of care. The practice was a member of a 'good practice' certification scheme.

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 dentists 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 children and adults based on an assessment of the risk of tooth decay.

The dentists 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 dentists and dental hygienists 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 for review 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 dentists 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 had a patient consent policy which included information and guidelines in relation to the Mental Capacity Act (MCA). We found some staff had a very limited knowledge of the MCA, some non-clinical staff had no knowledge of Gillick competence guidelines and how this might affect treatment options.

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

We saw that the practice audited patients' dental care records to check that the dentists recorded the necessary information. We found these had not been undertaken by all clinicians, were sporadic when undertaken, and with a limited sample size; there was no evidence of peer review across clinicians.

The practice carried out conscious sedation for patients who were nervous. This included people who were very nervous of dental treatment and those who needed complex or lengthy treatment. The practice had systems to help them do this safely. These were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in 2015.

The practice's systems included checks before and after treatment, emergency equipment requirements, medicines

Are services effective?

(for example, treatment is effective)

management, sedation equipment checks, and staff availability and training. They also included patient checks and information such as consent, monitoring during treatment, discharge and post-operative instructions.

The practice assessed patients appropriately for sedation. The dental care records showed that patients having sedation had important checks carried out first. These included a detailed medical history, blood pressure checks and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. The operator-sedationist was supported by a suitably trained second individual. The name of this individual was recorded in the patients' dental care record.

We noted there was no justification in patients' dental records when we looked at the use of poly-pharmacy/ multiple medicine in sedation, there was no policy for sedation and no audit of any sedations undertaken. There were no specific instruction sheets provided for sedation escorts. The practice manager told us there was a wheelchair available at the practice, however there were no records of maintenance for this equipment and in the event of a fire, the practice lift would not be accessible. The practice manager told us there were two sanctuary areas in the practice with intercom facility. However, there was no risk assessment in place for paramedic access and/or the evacuation of a sedated patient with regard to sedations undertaken on the first floor.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

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 annual appraisals, one to one meetings and during clinical supervision. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

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

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

The practice had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with dental 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 caring, gentle and excellent. We saw that staff treated patients appropriately and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding and they told us they could choose whether they saw a male or female dentist.

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

Information folders were available for patients to read.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. However, the layout of reception and waiting areas provided limited 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, if one was available. During our observations we noted patient names were used during telephone conversations and found that some computer screens on the reception desk were partially visible to patients standing to the side of the reception desk. Staff told us they asked patients to stand behind the computer areas.

All consultations were carried out in the privacy of the treatment room and we noted that the doors were closed during procedures. Staff password protected patients' electronic care records and backed these up to secure storage. We noted paper records were not stored securely and were accessible to the external cleaning staff when the practice was closed. We raised this concern with the practice manager who confirmed the room where these patient dental records were stored would be locked in future when practice staff were not in the building.

Involving people in decisions about 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. Dental records we reviewed showed that treatment options had been discussed with patients.

Interpretation services were available for patients who did not speak or understand English. There was no information about translation services for patients who did not speak or understand English in the reception area or on the website, and information about the practice was not produced in any other formats or languages. The practice manager told us there had been no demand for this, but information could be accessed if required. We were informed that patients could invite family relations to attend to assist. This could present a risk of miscommunications/ misunderstandings between staff and patients.

The practice's website, information booklet and social media pages 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 photographs, leaflets, models, websites, X-ray images and intra-oral cameras. The intra-oral cameras enabled photographs to be taken of the tooth being examined or treated and shown to the patient/relative to help them better understand the diagnosis and treatment.

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.

The practice had made reasonable adjustments for patients with disabilities. These included step free access, a hearing loop, a patient lift to the first-floor treatment rooms and accessible toilets on the ground and first floor with hand rails and a call bell. Baby changing facilities were available in the ground floor toilet. The practice had a wheelchair for assisting patients with limited mobility. However, there were no records of maintenance for this equipment. There was a hearing loop to assist those who wore hearing aids.

Staff told us that they used text messaging and e-mails to remind patients they had an appointment.

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

Staff described how they supported some patients for whom they needed to make adjustments to enable them to receive treatment.

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 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.

They took part in an emergency on-call arrangement with the NHS 111 out of hour's service. Private patients were referred to the on-call duty dentist.

The practice website, information booklet 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 policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

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

The practice manager 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.

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 practice manager had overall responsibility for the management and clinical leadership of the practice. Staff told us the practice manager was approachable and listened to them.

Culture

Staff stated they felt respected, supported and valued. We found that there was an expectation that some work should be undertaken in the staffs own time and the non-clinical practice manager was relied upon to undertake clinical areas such as audits.

The practice focused on the needs of patients.

Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The practice manager 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

We identified a number of shortfalls in the practice's governance arrangements including oversight to ensure that surveying and annual testing of X-ray equipment was undertaken when required.

We were not assured any recommended actions identified in the legionella risk assessment had been actioned and completed, or any recommended prevention methods such as flushing water lines between patients and water temperatures maintained within recommended guidelines, were appropriate and in place. There was no lone worker risk assessment in place to ensure the provider had oversight of the specific risks associated with the hygienist working without chair side support.

Audits for dental care records, infection control and radiography were not undertaken in line with national guidance. The infection control audit was not completed as frequently as recommended. Dental care record audits and radiography audits had not been undertaken by all clinicians, were sporadic, and with a limited sample size. There was no audit of sedations and no justification in patient dental care records for the use of poly pharmacy in sedation.

Patient dental care records were not stored securely.

There were only two clear face masks available in the emergency equipment instead of the recommended five. Following the inspection, the practice sent us confirmation that the three missing masks had been purchased and the X ray equipment had been serviced.

Appropriate and accurate information

Some 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 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, staff and external partners to support high-quality sustainable services.

The practice used patient surveys of patients new to the practice, a suggestion box in reception, social media and verbal comments to obtain staff and patients' views about the service.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. We did not see the results of FFTs.

The practice gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. We were told where there had been issues with staffing levels, staff had raised their concerns to the head office. The practice manager told us their concerns had been acted on.

Continuous improvement and innovation

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff.

Are services well-led?

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 practice manager told us they undertook annual appraisals for the hygienists, dental nurses and other non-clinical staff. We were told the practice manager was not clinically trained and on occasion they were supported by the lead nurse. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of some completed appraisals in the staff folders.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 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;** There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The provider had limited oversight of systems to monitor the servicing of the CBCT and X ray equipment at the practice. We were not assured any recommended actions which may have been identified in the Legionella risk assessment had been actioned and completed, or any recommended prevention methods were appropriate and in place. Audits of radiography, dental records and infection prevention and control were not undertaken at regular intervals to improve the quality of the service, had not been undertaken by all clinicians, were sporadic, and with a limited sample size.

This section is primarily information for the provider

Requirement notices

There was no audit of sedations undertaken at the practice and there was no justification in patients' dental records for the use of poly-pharmacy or multiple medicines in sedation.

Patient dental care records were not stored securely.

There was no risk assessment or oversight of the specific risks associated with the hygienist working without chair side support.

Regulation 17(1)