Care Quality Commission

Rodericks Dental Limited

Blackbrook Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 31 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Blackbrook Dental Practice is situated in a modern purpose built building in a residential area and close to bus routes. The practice provides NHS general and restorative dental services to children and adults and some private patients.

The facilities include four surgeries and a purpose built, dedicated decontamination/ sterilisation room plus spacious waiting areas. The facilities are fully equipped to cater for people of all ages and abilities. Children are made welcome. The practice has wheel chair access to the three ground floor surgeries. There is a hearing loop at reception and information materials can be provided in large font. Access to translation services is available on request.

Fees for both NHS and private were displayed in information leaflets for patients available in the practice and on the practice website. There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours service which can be accessed by calling NHS 111. These arrangements were displayed in the practice and on a telephone answering service.

At the time of the inspection the practice did not have a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice is open Monday, Wednesday and Thursday 8.15am to 5.15pm, Tuesday 8.15am to 7.00pm, Friday 8.15am to 4.15pm. The service is closed at weekends but offers an Out of Hours service via the local NHS community dental services.

We reviewed 10 CQC comment cards that had been left for patients to complete prior to our visit. In addition we spoke with six patients on the day of our inspection.

Feedback from patients was positive about the care they received from the practice. They commented the staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided. Patients we spoke with and the comment cards told us staff were kind, caring, competent and put patients at their ease. Three patients spoke of the fast turnover of staff especially at reception.

Our key findings were:

- There were systems in place to help ensure the safety of staff and patients but some were not operated effectively. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies.
- We observed and were told by staff the practice ethos provided patient centred dental care in a relaxed and friendly environment.
- Leadership had been lacking until two weeks prior to the inspection when a new practice manger had commenced in post.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The dental practice did not have effectively operated clinical governance and risk management processes in place for health and safety.
- Patient care and treatment was delivered in line with evidence-based guidelines, best practice and current legislation including National Institute for Care Excellence (NICE) guidelines.
- Patient dental care records were electronic, detailed and comprehensive.
- The practice had a system to monitor and improve the quality of the service; including through a detailed programme of clinical and non-clinical audits.
- The use of digital radiographs to help explain necessary treatment to patients while in the chair.
- Premises appeared well maintained and visibly clean. Good cleaning and infection control systems were mostly in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- There were sufficient numbers of suitably qualified staff who maintained the necessary skills and competence to support the needs of patients.
- Staff were up to date with current guidelines, supported in their professional development and the practice was led by a proactive principal dentist.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required with information for out of Hours service clearly available.
- Staff received training appropriate to their roles and were supported in their continuing professional development (CPD) by the company.
- Staff we spoke with were committed to providing a quality service to their patients but had not felt well support until the very recent arrival of the new manager.

There were areas where the provider could make improvements and MUST:

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities including fire and health and safety.

Summary of findings

There were areas where the provider could make improvements and SHOULD:

- Review the practice infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance with particular attention to the Annual Infection Control statement.

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

There were systems in place to help ensure the safety of staff and patients, but identified risks were not acted upon for the safety of patients. Systems included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. The practice carried out and reviewed risk assessments to identify and manage risks.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency. In the event of an incident or accident occurring the practice documented, investigated and learnt from it.

Are services effective?

No action

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

The practice kept detailed electronic records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. They monitored any changes in the patient's oral health and made referrals as appropriate to primary care providers such as a nearby dedicated orthodontic practice and to secondary care such as hospital specialist services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition (DBOH).

Comments received via the CQC comment cards and patients interviewed reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced. In the waiting room we saw evidence of health promotion information and patients could purchase dental products at reception to assist in maintaining good oral hygiene.

Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan and in line with General Dental Council requirements for registrants.

Are services caring?

No action

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

We reviewed 10 completed CQC comments and received feedback on the day of the inspection from six patients about the care and treatment they received at the

Summary of findings

practice. The feedback was positive with patients commenting on the excellent service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was fully explained to them.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

No action ✓

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

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

There was level access into the building for patients with limited mobility, prams and pushchairs. There was a waiting room and three treatment rooms on the ground floor level, and the area was spacious enough to manoeuvre a wheelchair; another waiting areas and treatment room was upstairs.

We observed the reception desk was compliant with the requirements of the Equality Act 2010 and had information and forms available in large print if needed. The practice had a hearing loop at reception and information materials available in a large font. Access to translation services was available as needed.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

Requirements notice ✗

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

The practice assessed risks to patients and staff but had not acted to mitigate the risks. They carried out a programme of audits as part of a system of continuous improvement and learning.

They told us the new manager was providing clear leadership.

The practice had structured arrangements for sharing information across the team, including holding regular meetings which were documented for those staff unable to attend. Staff told us they felt supported by the dentists and new manager and would feel able to raise any concerns with them.

The practice had systems in place to seek and act upon feedback from patients using the service.

Blackbrook Dental Practice

Detailed findings

Background to this inspection

This inspection took place on 31 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

During the inspection we toured the premises and spoke with practice staff including four dentists; a dental hygienist; five dental nurses and two receptionists. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

To get to the heart of patients experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The practice maintained a significant event folder. There had been two incidents in the previous 12 months. We saw the documentation for incident recording included sections for a detailed description, the learning that had taken place and the actions taken by the practice as a result.

The practice manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a recurrence. This was in accordance with the Duty of Candour principle. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

The practice manager knew when and how to notify CQC of incidents which cause harm. Staff reported since the new manager had commenced there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The practice manager told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

All the dentists we spoke with confirmed that a latex free rubber dam was used where possible when performing root canal treatments. We observed relevant entries in specific dental care records and the equipment in place in the treatment rooms. The dentists described what alternative precautions were taken to protect the patient's airway during the treatment when a rubber dam was not used and showed us the risk assessment written in the dental care record.

[A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured].

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments).

Most staff files seen contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff. We checked with the practice and area managers and were told no risk assessments had been completed for staff who had commenced working in surgery but had not received hepatitis immunisation.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automated

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external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines.

The emergency medicines and equipment were stored in a central location, clearly labelled and known to all staff.

Staff we spoke with showed us documentary evidence which demonstrated regular checks were done to ensure the equipment and emergency medicines were in date and safe to use. Records showed all staff had completed on site training in emergency resuscitation and basic life support. Staff demonstrated they knew how to respond in the event of a medical emergency.

Staff recruitment

The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the practice policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff.

These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Records confirmed these checks were in place. We looked at the recruitment files for five members of staff and found they contained appropriate recruitment documentation.

The practice manager told us newly employed staff had been taken through an induction process to ensure they were familiarised with the way the practice operated. This was corroborated with documentary evidence which had been signed to demonstrate completion of the process.

The practice had a system in place for monitoring staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and on going.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety.

We were shown the fire risk assessment which had been completed in November 2016 and saw no action had been taken to address the risks identified and there were no plans to do this. Staff told us the fire panel upstairs kept sounding a fault and no action was being taken so they had reset it on several occasions. On the day of inspection the fault light was not showing but the manger was not able to evidence it had been repaired or reviewed by a competent person.

Records showed that fire fighting equipment such as smoke detectors and fire extinguishers were regularly tested.

The practice had a risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, we saw a practice risk assessment both of which had been completed in November 2016. In the health and safety risk assessment we saw an entry which stated there was no evidence the actions identified in the risk assessment of 2015 had been completed and there were several outstanding issues. In discussion with the new practice manager they told once they had completed their induction they would give this priority attention.

The practice had a comprehensive file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva.

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

Infection control

Are services safe?

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05)' and complied with the requirements of the DOH publication 'Code of Practice' July 2015. These documents and the practice policy and procedures for infection prevention and control were accessible to staff. We were shown the recent audits of infection control processes carried out in 2016 which confirmed compliance with HTM 01-05 guidelines.

We observed all basic instruments were stored in a box in drawers. Staff told us the unused instruments would be reprocessed at the end of the day. We asked to see evidence to corroborate this and none was available.

There was not an annual statement in relation to infection prevention control as required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. The principal dentist assured us they would take action immediately to complete one.

There was a dedicated decontamination room in the practice which was used for cleaning, sterilising and packing instruments. There was clear separation of clean and dirty areas in the treatment room and the decontamination room with signage to reinforce this. These arrangements met the HTM01- 05 essential requirements for decontamination in dental practices.

During the inspection we observed the decontamination room there was no airflow through the room. We also saw that the decontamination room was in an unobserved patient area and was not locked. The provider should review the security of this room.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean instruments between the treatment rooms and decontamination room. The practice used a washer disinfector for the initial cleaning process, then following inspection with an illuminated magnifier the instruments were then placed into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. It was observed the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

All recommended tests utilised as part of the validation of the washer disinfector were carried out in accordance with current guidelines thus ensuring safe decontamination of the dental instruments. The results for the above were recorded in an appropriate log file.

We observed how waste items were disposed of and stored securely until collection. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

We looked at the consultation and treatment rooms where patients were examined and treated and observed the rooms and all equipment appeared clean, uncluttered and well-lit with good ventilation.

A hand washing poster was displayed near the sink to ensure effective decontamination. There were good supplies of protective equipment for patients and staff members. The practice used latex free disposable gloves for the protection of patients and staff.

We reviewed the last detailed legionella risk assessment report from 2012 which was carried out by an external organisation. The cover manager told us a recent risk assessment had not been completed. However there were processes in place to prevent legionella contamination such as flushing of dental unit water lines with an appropriate disinfectant. Water temperature testing of the hot and cold sentinel taps in the practice was taking place.

There was a good supply of cleaning equipment which was colour coded and stored appropriately. It followed published National Patient Safety Association (NPSA)

Are services safe?

guidance about the cleaning of dental primary care premises. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. The practice had a system for monitoring the immunisation status of each member of staff for the safety and protection of patients and staff.

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the compressor, autoclaves, X-ray equipment and fire extinguishers. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use.

The practice had policies and procedures regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The batch numbers and expiry dates for local anaesthetics were recorded in patients' dental care records.

The local anaesthetic cartridges were stored safely and staff kept a detailed record of stock in each treatment room. Prescriptions pads were stored securely and details were recorded in patients' dental care records of all prescriptions issued.

Radiography (X-rays)

The practice radiation protection file was maintained in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). It was detailed and up to date with an inventory of all X-ray equipment and maintenance records**.** X-rays were digital and images were stored within the patient's dental care record.

We found there were suitable arrangements in place to ensure the safety of the equipment and its operation. We were shown how the practice had a process for on-going monitoring of the quality of radiographs as required by the IRMER regulations. We also observed in the patient dental records that radiographs were taken in line with The Faculty of General Dental Practice (FGDP) guidance and the clinicians justified, quality assured and reported upon each radiograph taken.

Local rules relating to each X-ray machine were maintained; a radiation risk assessment was in place to ensure patients did not receive unnecessary exposure to radiation.

Staff authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended appropriate training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic records of the care given to patients. We reviewed the information recorded in patient dental care records to corroborate information received from the dentists. We found they provided comprehensive information about patients' oral health assessments, treatment and advice given. They included details about the condition of the teeth, soft tissues lining the mouth and gums and an extra oral assessment.

For example, we saw details of the condition of patients gums were recorded using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were reviewed at each examination in order to monitor any changes in the patient's oral health.

Medical history checks were updated at every visit and patient care records we looked at confirmed this. This included an update about patients' health conditions, current medicines being taken and whether they had any allergies. Comments received via CQC comment cards reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health toolkit' (Delivering better oral health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England). The hygienists provided oral health education and appointments for these were available for direct access as well as following referral from the dentist.

The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

The practice provided health promotion information to support patients in looking after their general health using leaflets, posters, a patient information file and via their noticeboard situated in the waiting room. This included making patients aware of the early detection of oral cancer. Patients reported they felt well informed about every aspect of dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

The practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The company kept a record of all training completed by staff to ensure they had the right skills to carry out their work. Mandatory training included basic life support, hand hygiene, fire safety and infection prevention and control had been completed by all staff within the last 12 months.

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Dental nurses received day to day supervision from the dentists and support from the lead nurse.

The practice had six trainee dental nurses who were all currently undertaking a recognised training course for dental nurses. They told us and we spoke with the area nurse trainer who supports them in their training and with day to day issues. Staff spoken with told us the trainer was very good and ensured they understood what was required of them in their role.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs.

Working with other services

The practice worked with other professionals where this was in the best interest of the patient. For example, referrals were made to hospital dental services for further investigations or specialist treatment and to the dental hygienist service within the practice for patients with complex periodontal issues. The practice completed a detailed proforma and referral letter to ensure the specialist service had all the relevant information required.

Are services effective?

(for example, treatment is effective)

Dental care records contained details of the referrals made and the outcome of the specialist advice.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and their responsibilities to ensure patients had enough information and the capacity to consent to dental treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met.

Staff had undertaken specific MCA training and when asked they demonstrated a good working knowledge of its application in practice. All staff understood consent could be withdrawn by a patient at any time.

The staff we spoke with were also aware of and understood the use of the Gillick competency test in relation to young persons (under the age of 16 years). The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We reviewed dental care records to corroborate our information. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Consent to treatment was recorded. Feedback in CQC comment cards and from patients spoken with confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed 10 completed CQC comments cards and spoke with six patients during the inspection. Comments from patients were consistently positive about how they were treated by staff at the practice. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

The principal dentist told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

All treatment room doors remained closed during consultations to maintain patient privacy and confidentiality.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected. Staff described to us how they involved patient's relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Dental care records we looked at corroborated and reflected this.

Patients were given a copy of their treatment plan and associated costs. This gave patients clear information about the different elements of their treatment and the costs relating to them. They were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet on noticeboards in reception and on their website. The services provided included prevention advice and treatment alongside the specialist dental care available**.**

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

Patients we talked with advised they had been able to obtain emergency treatment when needed and we observed space was left daily in the appointment book of clinicians so they could provide urgent care when required.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place and provided training to support staff in understanding and meeting the needs of patients.

They had completed a Disability and Discrimination assessment as required by the Equality Act 2010 and made adjustments, for example to accommodate patients with limited mobility. There was wheelchair access to the waiting area and to facilities on the ground floor. They had a hearing loop at reception and large print leaflets and forms were available if required. Access to translation services was available when required.

Access to the service

The practice displayed its opening hours on the website, in the waiting room and in leaflets.

The emergency contact numbers to be used when the practice was closed were displayed on their website. Contact information was also available from the practice telephone answering service. If patients had an emergency the practice would try to see them the same day.

The 10 CQC comment cards seen, and six patients spoken with, reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the principal dentist they ensured these were responded to appropriately and in a timely manner.

The practice had received six complaints in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient. The practice manager showed us documentary evidence that any complaints made were investigated and the outcome discussed amongst the team and implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to identify risks but these had not been appropriately managed and actions taken to mitigate identified risks.

Health and safety and risk management policies were in place but not effectively operated to ensure the safety of patients and staff members.

We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided.

We saw risk assessments but no control measures in place to manage those risks for example fire, use of equipment and infection control.

We saw the risks identified in the health and safety risk assessment in 2015 had still not been addressed.

Staff told us the cover manager had not taken action to address issues raised and their leadership in the practice was limited.

Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members. Staff we spoke with were aware of their roles and responsibilities within the practice

There were relevant policies and procedures in place to govern activity. There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, record keeping, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. There were monthly practice meetings to discuss practice arrangements and audit results as well as providing time for educational activity.

We saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed and sometimes a training topic had been covered. Minutes demonstrated staff meetings were held at a time when most staff could attend. For staff who were unable to attend the meetings there was a system in place to ensure meeting information was shared with them.

Leadership, openness and transparency

We saw from minutes of staff meetings, they were at regular intervals. The practice had a statement of purpose that described their vision, values and objectives.

Staff reported there was now an open and transparent culture at the practice which encouraged candour and honesty. Staff felt confident they could raise issues or concerns at any time with the practice manager who would listen to them.

We observed, and staff told us, the practice had a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff felt well supported by the dentists and worked as a team toward the common goal of delivering high quality care and treatment.

The service was aware of and complied with the requirements of the Duty of Candour. Staff we spoke with told us the principal dentist encouraged a culture of openness and honesty. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

We saw there was a system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits. These included for example, audits of infection control, record keeping, radiographs, the cleanliness of the environment, and hand hygiene.

Where areas for improvement had been identified in the audits, action had not always been taken.

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

Are services well-led?

Patients expressed their views and were involved in making decisions about their care and treatment. The practice used a patient feedback questionnaire to capture information about how the patients viewed the quality of dental care they received. It included sections about appointments, reception, staff and cleanliness. The questionnaire also asked for patients' individual comments.

We saw the results obtained showed patients were satisfied with the quality of service provided. Patients who used the service said the service was very professional, friendly and welcoming. There were several comments which demonstrated the practice was family friendly and that patients were at the heart of the practice.

The six patients we spoke with were very happy with the standard of care they had received. They described the practice staff as helpful and friendly. Patients were satisfied with appointment waiting times and the cleanliness of the practice. This was corroborated through comments in the Care Quality Commission comment cards. Two patients told us they were concerned about the turnover of staff at reception.

The practice also gathered feedback from patients through the NHS Friends and Family Test (FFT), NHS Choices, compliments and complaints.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to ensure that the regulated activities at the Blackbrook Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** • The provider did not have effective governance systems in place which assessed, monitored and improved the quality and safety of services provided. • The provider did not have fully effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients.