Mr. David Beardmore

D Beardmore Dental Surgery

Inspection Report

30 Solihull Road
Shirley
Solihull
West Midlands
B90 3HD
Tel: 0121 7458560
Website:

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Overall summary

Background

D Beardmore Dental Practice has one dentist (Mr Beardmore) who works part time and a qualified dental nurse who is registered with the General Dental Council (GDC). The practice's opening hours are from 8.40am to 5.40pm on a Tuesday and from 8.40am to 12.40pm on a Wednesday.

D Beardmore Dental Practice provides private treatment for adults and children. The practice is situated in a converted residential property. The practice had one dental treatment room on the first floor; decontamination of dental equipment for cleaning, sterilising and packing dental instruments takes place in the treatment room. The reception and waiting area is in one room located next to the treatment room.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 24 completed cards and spoke with three patients. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

We carried out an announced comprehensive inspection on 15 December 2015 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- The practice had mechanisms in place to record significant events and accidents.
- Staff had been trained to handle medical emergencies.
- Information from completed CQC comment cards was positive and indicated a friendly, caring and professional service.
- Suitable arrangements were in place for making referrals to other dental professionals.
- Patients were treated with dignity and respect and confidentiality was maintained
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practices radiography file did not contain all information as required in the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000.

Summary of findings

- The practice was visibly clean and well maintained. However there were some shortfalls in infection prevention and control practices.
- The practice was not always keeping an accurate, complete and contemporaneous record in respect of each patient, including a record of the decisions taken in relation to the care and treatment provided.
- Systems were not in place to assess, monitor and mitigate risks. For example there were no systems to maintain and monitor emergency equipment, first aid packs and fire systems including risk assessments. X-ray signage was not in place.
- Governance arrangements were not effective in improving the quality and safety of services.

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

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. This should include systems to maintain and monitor emergency equipment, first aid packs and fire systems including risk assessments. Assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. Ensure that a Legionella risk assessment is undertaken by a competent person and any actions identified are undertaken.
- Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000 This includes undertaking necessary action to address issues identified in the Radiation Protection Adviser's risk assessment; and reviewing the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the practice's procedures for fire safety. Ensuring that the fire safety policy contains information related to the practice; actions identified in the fire risk assessment have been completed and provide evidence that all fire safety equipment at the practice has been serviced as required.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's procedure for providing patients with accessible information on how to make a complaint and the practice's complaints procedure.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the practice's safeguarding policy; ensuring it covers both children and adults.
- Review the practice's recruitment procedures and develop a policy to ensure that there is a consistent approach to recruitment and selection.
- Review the practice's audit protocols of various aspects of the service, such as radiography, consent and dental care records at regular intervals to help improve the quality of service. The practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

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?

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

Emergency medicines in use at the practice were stored and checked to ensure they did not go beyond their expiry dates. There was no defibrillator on the premises but agreement had been reached to use the defibrillator at a local supermarket when required. (A defibrillator is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

There was no policy regarding the protection of vulnerable adults and there were no contact details for external support which would enable staff to share their concerns with the appropriate people.

We identified some issues that compromised good infection control in the environment. Arrangements in place regarding dental radiography were not robust.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. Patients told us that explanations were given to them in a way they understood and risks, benefits, options and costs were explained. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

Feedback from patients was that they were treated with dignity and respect. We were told that all staff were friendly, professional and caring. All of the patients commented that the quality of care was very good, they were involved in decisions about their treatment, and they did not feel rushed in their appointments. We observed that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

Are services responsive to people's needs?

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

Appointments were easy to book and appointment slots for urgent appointments were available each day for patients experiencing dental pain. Patients confirmed that they had good access to treatment and urgent care stating that urgent appointments were always available on the day that they phoned the practice.

Are services well-led?

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).

There were limited governance arrangements in place to guide the management of the practice. Systems in place to protect patients and staff from risk of harm were not robust. For example the fire policy recorded information which did not relate to the practice. There was no general risk assessment to identify and mitigate any risks to staff or patients attending the practice. The practice had not developed a policy regarding safeguarding vulnerable adults.

Summary of findings

Not all medical equipment was available in line with the resuscitation council guidelines such as a spacer device for inhaled bronchodilators and there was no defibrillator on the premises.

A legionella risk assessment had not been completed at the practice. The practice had not undertaken a record card audit and non-clinical audits were not undertaken regularly to monitor the quality of services.

D Beardmore Dental Surgery

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 15 December 2015. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff records. We spoke with both of the members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments. We received feedback from 27 patients and all feedback received was positive. Patients were extremely satisfied with the service provided by the practice.

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

We were told about the systems in place for reporting and learning from accidents and incidents. An accident reporting book was available but there had been no accidents to report within the previous 24 months.

A significant events file was available. This contained detailed protocols and policies to guide staff on the action to take when reporting a significant event. These policies had been reviewed on an annual basis. Significant event reporting forms were available on file and the practice policy recorded that outcomes and learning outcomes should be recorded on these forms. There was a significant event incident log but there had been no incidents to record. We were told that significant events, incidents and complaints would be discussed at staff meetings as and when they occurred.

We discussed accidents and incidents with the dentist and dental nurse. Both were aware of the type of incidents and accidents that should be reported to the Health and safety executive under the reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR). We saw that a policy was available to guide staff and we were told that there had been no incidents at the practice that required reporting under these regulations.

The principal dentist did not receive alerts from the Medicines and Healthcare products Regulatory Agency. We were told that the principal dentist would register to receive these alerts and disseminate relevant information to staff.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the practice safeguarding lead. Records seen demonstrated that the principal dentist and dental nurse had undertaken safeguarding training. Discussions with both the principal dentist and dental nurse demonstrated that they were aware of the action to take if they suspected abuse of a vulnerable adult or child. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Various guidance documents regarding child protection and the dental team were available. Contact details for reporting child protection issues to external agencies were available. There was no protection of vulnerable adults' policy or contact details. However the dental nurse was aware who to contact and confirmed that policy information would be updated with these details.

We spoke to the dental nurse and the principal dentist about the prevention of needle stick injuries. A sharps box was located in the treatment room. The practice used a system whereby needles were re-sheathed manually following administration of a local anaesthetic to a patient and needle guards were not used; however it was only the dentist who undertook this task. The practice had a policy in place regarding needle stick injuries and this detailed the action to take should a needle stick injury occur. There had been no needle stick injuries at the practice.

We asked about the instruments and equipment which were used during root canal treatment. We were told that root canal treatment was not carried out using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Although the practice was not following the guidance from the British Endodontic Society in relation to the use of the rubber dam, the dentist explained the alternative methods used.

Medical emergencies

Some arrangements were in place to deal with medical emergencies at the practice. There was an oxygen cylinder and other related items such as manual breathing aids. However we noted that there was no documentary evidence to demonstrate that routine checks were made of emergency oxygen to ensure that it was available and in good working order. The principal dentist told us that these checks were completed but records were not kept. There were only two sizes of oropharyngeal airways available which was not in accordance with current guidance (An oropharyngeal airway is a medical device used to help maintain or open a patient's airway). The practice had been advised that an alternative to a spacer device for inhaled bronchodilators could be used. However, the alternative in use was not satisfactory. Following this inspection we received confirmation that the required sizes of oropharyngeal airways had been purchased.

There was also no automated external defibrillator (AED) which is also recommended in the Resuscitation UK

Are services safe?

Guidelines. We were told that the dental practice had a verbal agreement that the AED located at the nearby Morrison's supermarket would be used during any medical emergency at the practice. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The emergency medicines kit was kept in a secure location but was easily available to all staff. Staff were aware of the location of the emergency medicines and equipment. All emergency medicines and oxygen were in date. The expiry dates of medicines were monitored using a monthly check sheet which enabled the staff to replace out of date medicines.

The practice held received training to maintain their competence in dealing with medical emergencies on an annual basis and we saw that this training was up to date.

We saw that a first aid kit was available which contained some equipment for use in treating minor injuries. However this was not being monitored to ensure equipment was within its expiry date and one item seen was out of date. The principal dentist and the dental nurse had completed first aid training.

Staff recruitment

This dental practice is owned and run by Mr Beardmore (the dentist) and his wife who is the dental nurse. We looked at the recruitment file for the dental nurse and saw that she was employed at the practice in 2008 which was prior to regulation by the Care Quality Commission (CQC). The recruitment file did not contain all of the information that would now be required under the Health and Social Care Act. (Dental practices were required to register with the CQC under the Health and Social Care Act in 2011). We were told that the practice would not be employing any further staff and as such did not have need for a recruitment policy.

We saw details to demonstrate that staff were registered with the General Dental Council (GDC) and information regarding immunisation status. We saw that Disclosure and Barring Service checks (DBS) had been completed. However the DBS check for the dental nurse related to a job for another employer. These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Some systems were in place to ensure that the service was uninterrupted during times of annual or unexpected leave. This dental practice was open for one and one half days per week. Cover arrangements included asking patients who required urgent treatment to visit an alternative local practice. Appointments would not be booked at the practice at times of known annual leave as the practice would be closed.

Monitoring health & safety and responding to risks

The practice had some systems, processes and policies in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy was in place which was reviewed on an annual basis and a health and safety at work poster was on display in the reception area. There was one fire extinguisher at the practice but no documentary or other evidence that this had been serviced. The principal dentist told us that this was a new fire extinguisher and therefore did not need servicing but was unable to provide evidence of when this extinguisher was purchased.

We were told that fire safety checks were not undertaken as there was no fire alarm system at the practice. There were no emergency lights but a smoke detector was in place. There were no records to demonstrate that regular checks were undertaken to ensure the smoke detector was in good working order. We looked at the fire policy and saw that this requested weekly fire alarm checks to be undertaken. The fire policy had therefore not been adapted to meet the needs of the practice. We were shown a copy of the practice's fire risk assessment. This required that electrical equipment should have regularly maintenance carried out by a competent person. We were told that there had been no five year fixed wiring checks undertaken.

We discussed risk assessments with the principal dentist who was aware of any risks inherent at the practice but said that as only one member of staff was employed at the practice they were not required to record health and safety risk assessments. The practice did not have any documentary evidence to demonstrate that they had assessed, monitored and mitigated any risks relating to health, safety and welfare of service users and staff.

Are services safe?

We saw that a control of substances hazardous to health (COSHH) file was available. We were told that the practice did not use many chemicals and therefore there were very few COSHH assessments available.

Infection control

On the day of inspection the dental treatment room, reception/waiting area and toilets were visibly clean, tidy and clutter free. Patient feedback reported that the practice was always clean and tidy. Environmental cleaning was carried out by the principal dentist and the dental nurse, who worked in accordance with the national colour coding scheme.

Personal protective equipment (PPE) such as disposable gloves and aprons was available for staff and patient use as appropriate. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

We discussed infection prevention and control and we saw that various infection prevention and control policies were available including a hand hygiene policy. However, we noted a number of issues that compromised good infection control in the environment:

- The infection prevention and control policy was dated 2009 and there was no evidence of review or update. The practice were not carrying out six monthly infection prevention and control audits which was not in accordance with current guidance.
- There were no foot operated bins available to reduce the risk of cross infection and a cleaning mop was being stored in a patient toilet. This was not stored correctly to ensure that it air dried quickly
- Sharps boxes did not have the date of assembly recorded on them. This helps to ensure that sharps waste is collected by waste contractors within the required timescales.

Staff had received appropriate training in infection prevention and control, although annual update training had not been completed and the last training was completed in September 2014.

The practice did not have a separate decontamination room for instrument processing. Decontamination of dental instruments took place in the treatment room, when the treatment room was not in use by patients. We saw that there were two sinks; one for hand washing and one for cleaning instruments. On the day of our inspection, the decontamination process was demonstrated to us. The dental nurse manually scrubbed the instruments before visually inspecting them with a magnifying glass to ensure all visible debris had been removed. They were then placed in an autoclave. We noted a number of shortfalls in the decontamination process:

- The practice was using a wire brush to clean dental instruments. This was removed during the inspection. Use of wire brushes during the decontamination process may cause corrosion of dental instruments by removing their protective layer.
- Washing up liquid was being used to clean dental instruments. Detergents specifically formulated for cleaning instruments were not being used. Following this inspection we received confirmation that correct cleaning detergents were now being used.

When instruments had been sterilised they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. Records were not kept to monitor expiry dates. However we were told that due to the low number of instruments used there was a daily check completed but this was not recorded.

Maintenance of dental water lines took place to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). We were told about the methods used which were in line with current HTM 01 05 guidelines. However, a Legionella risk assessment had not been carried out at the practice.

Equipment and medicines

We saw records to demonstrate that some equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the steriliser had been serviced in December 2015. The practice had an ultra-sonic bath used in the process of decontaminating used dental instruments. The service interval had lapsed and the equipment was not being used until a service had been completed.

Are services safe?

We saw records to confirm that the batch numbers and expiry dates for local anaesthetics were recorded in a book when these medicines were administered. These medicines were stored safely for the protection of patients.

We saw that the principal dentist had undertaken visual checks of portable electrical appliances (PAT) at the practice and had placed stickers to demonstrate this on portable electrical equipment.

Radiography (X-rays)

We were shown a radiation protection file which did not contain all information in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).This file contained the names of the Radiation Protection Advisor (RPA) and the Radiation Protection Supervisor. We were told that the RPA had changed recently and we were given the details of the new RPA. However, we saw that action had not been taken to address issues identified in the risk assessment completed by the previous RPA. For example they had recommended warning lights outside the dental treatment room to demonstrate when the X-ray was in use but these were not available.

Included in the file were the critical examination packs for the X-ray set for 2011. However there was no copy of the local rules, acceptance test for the installation of the X-ray, no evidence that the Health and Safety Executive had been notified and no current maintenance logs after 2011 (these should be undertaken every three years). Following this inspection we received email confirmation that X-ray equipment was last serviced on 7 December 2015 by the new RPA.

There was one X-ray unit at the practice. We saw that the treatment room door did not display notices conforming to legal requirements to inform patients that X-ray machines were located in the room. The principal dentist confirmed that this would be actioned. Following this inspection we received email confirmation that a sign was now in place.

A sample of dental care records where X-rays had been taken showed that when dental X-rays were taken the justification was not recorded. A book was used to record quality grades for an ongoing audit of radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Discussions with the principal dentist showed they were aware of the National Institute for Health and Care Excellence (NICE) guidelines. We discussed recall arrangements with the principal dentist and identified that the majority of patients were seen on a six-monthly basis at their request. However, those patients with complete sets of dentures were seen on an annual basis.

The principal dentist described to us how they carried out their assessment of a patient. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. This was followed by an examination covering the condition of a patient's teeth, gums (using the basic periodontal examination (BPE)) and soft tissues and any signs of mouth cancer. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need).We were told that patients were made aware of their oral health and if necessary any treatment options explained in detail.

We reviewed patient dental care records and saw that there was no written evidence of treatment plans given to patients following discussion of treatment options available. There was no written evidence that preventative dental information was given in order to improve the outcome for the patient. For example there was no written information to demonstrate that dietary advice or details of smoking cessation were given. The principal dentist told us that a written estimate was sent to patients by post for any complex treatments to be undertaken. Patients were therefore given time to think about the treatment options available to them. One of the four sets of dental care records that we looked at had a copy of a treatment plan with costs recorded but this had not been signed by the patient. There was no evidence of treatment information in the other records reviewed.

The practice had not completed a record keeping audit to ensure relevant information was recorded in patients' records on each occasion.

Health promotion & prevention

The reception and waiting room at the practice did not have any literature for patients regarding how to reduce the risk of poor dental health.

Adults and children attending the practice were advised during their consultation of steps to maintain healthy teeth. Free samples of toothpaste were available for patients. We were told that patient's gum health assessments were discussed with them and recorded in their dental care records, and where no improvement in these scores was noted, advice was given regarding flossing, tooth brushing and the use of other dental devices to maintain good oral hygiene. Tooth brushing techniques were explained in a way they understood and we were told that dietary, smoking and alcohol advice was also given to them. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. However, the sample of dental care records we observed demonstrated that dentists had not recorded details of oral health advice given to patients regarding diet and smoking.

Staffing

Practice staff included the principal dentist and a dental nurse. Continuing professional development (CPD) requirements were discussed. CPD is a compulsory requirement of registration as a dental professional. We saw training certificates and CPD logs which demonstrated training undertaken for the dental nurse. Training included cardio pulmonary resuscitation (CPR), disinfection and decontamination, legal and ethical issues, child protection and adult safeguarding and radiography and radiation.

We saw some training records for the principal dentist. We saw that the last training undertaken regarding radiography was completed in 2013. We did not see evidence of any training regarding mental capacity.

Records showed professional registration with the GDC was up to date for all relevant staff. We were told that there was no formal documented appraisal system in place but regular discussions were held regarding working practice and systems in place at the practice.

Working with other services

The practice had suitable arrangements in place for making referrals to other dental professionals when they were unable to provide the necessary treatment themselves. For example those patients who required specialist oral surgery were referred to a local hospital. The practice kept

Are services effective?

(for example, treatment is effective)

a copy of all referral letters; however patients did not get a copy of the letter. There was no system to check that referrals had been received apart from discussions with patients at their next six monthly appointment at the practice.

Consent to care and treatment

Patients we spoke with told us that they were provided with sufficient information during their consultation to help them make an informed decision about any particular treatment. The principal dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient. Patient dental care records demonstrated that verbal consent was obtained prior to any treatment. A treatment plan which had not been signed by the patient was available in one patient's dental care records reviewed. There was no evidence of treatment plans in the other three records seen. We were told that treatment plans were given to patients or sent to them in the post. There were no records to demonstrate that consent was reviewed or audited at the practice.

We discussed the Mental Capacity Act 2005 (MCA) with the principal dentist. We were told that the practice did not have any patients who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. Staff had not completed training regarding the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had a reception with adjoining waiting area and one treatment room on the first floor. We spent time in the waiting area and observed patients being greeted at the practice. We noted that all staff had a good relationship with patients, were caring, respectful and showed empathy. The reception desk was located next to the waiting area. We were told that appointments were booked so that patients were seen by the dentist as soon as they entered the practice and they were not kept waiting. This helped to ensure that confidential discussions could be held at the reception area without being overheard by other patients.

We saw that treatment room doors were closed at all times when patients were with the dentist. Conversations between patients and dentists could not be heard from outside the room which protected patients' privacy. Feedback from patients confirmed that they were treated with respect and privacy; dignity was always maintained.

The practice did not have a computer and all patients' information including clinical records were stored in locked storage cabinets.

Feedback received from patients was positive. We were told that the dentist had a lovely manner and made patients feel relaxed. The principal dentist told us that they took their time with patients who were anxious about receiving dental treatment. Step by step explanations were given and staff involved patients in general conversations to try and relax them. We were told that if required patients would be referred to another practice to receive sedation but this had not been necessary to date.

Involvement in decisions about care and treatment

Patients to the service were provided with a verbal estimate of costs before treatment started. Costs of private treatment were not on display within the practice. The principal dentist did not wish to put details of costs on display but discussed other methods for ensuring this information was available to patients such as discussing costs with patients over the phone but these were subject to change dependent upon the dental examination. We saw a letter in one set of patient care records informing the patient of their treatment options and costs. This had not been signed by the patient. Other records seen did not contain any written information regarding treatment options or costs. We were told that treatment plans including details of costs would be sent to patients in the post. Patients we spoke with confirmed that treatment options were always explained to them, and they were given ample opportunity to ask questions about their treatment. Patient said that they had all of the information they needed to be able to make a decision about treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We looked at the appointment schedules and found that adequate time slots were given for appointments of varying complexity of treatment. Feedback from patients was positive. We were told that the dentist took their time to explain treatments in detail and also made time to exchange polite conversation which patients said made them feel relaxed and at ease.

Patients we spoke with said that they found it easy to get a routine appointment when the practice was open and were generally seen at their appointment time. When the dentist and dental nurse were treating patients the telephone answer machine was used to take messages. The feedback we received from patient comment cards was positive. Patients described their care as excellent; we were told that the dentist and all staff were professional, thorough and offered flexibility for appointments to meet peoples' needs.

Tackling inequity and promoting equality

The practice was located on the first floor of a converted residential property. The dental treatment room was accessed by stairs which would prove difficult for patients with mobility difficulties. There was no disabled toilet facility at this practice. There was no hearing loop at the practice. We were told that currently there were no patients who had severe hearing difficulties and who would need special support or equipment.

Staff told us that all patients registered at the practice were able to speak English and there was currently no need for an interpretation service. Staff confirmed that an interpretation service was available if required.

We saw that an equality and diversity policy had been developed but no formal equality and diversity training had been undertaken.

Access to the service

The practice was open on a Tuesday from 8.40 am to 5.40 pm and a Wednesday from 8.40am to 12.40pm. The routine opening hours were available on the practice leaflet, although we saw that this required updating as it contained out of date information. When treatment was urgent, patients would be seen on the same day. Appointments could be made in person or by telephone. One patient we spoke with confirmed that they had been seen for urgent treatment when the practice was closed and the dentist had opened the practice for them.

Feedback received demonstrated that patients had satisfactory access to the service and did not have difficulty getting through to the practice on the telephone.

Concerns & complaints

Information for patients about how to complain was not on display in the reception/waiting area. We saw that a complaints policy was available which had been reviewed on an annual basis. This gave details of who to speak to within the practice and the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example the General Dental Council and Dental Complaints Service for complaints about private treatment. The practice leaflet did not give any information to patients regarding how to make a complaint.

We were told that the practice had not received any formal written complaints. However if complaints were received they would be discussed, logged and learning outcomes recorded.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements in place such as various policies and procedures. However systems to ensure risks were identified and managed appropriately were not robust. For example, there was no legionella risk assessment, infection prevention and control assessments were not undertaken on a six monthly basis and no general risk assessments had been undertaken at the practice. The fire policy had not been adapted to the practice.

A very limited amount of clinical audits had been undertaken; we saw that radiography quality assurance grades were recorded but we were told that there had been no record card audit.

Leadership, openness and transparency

The principal dentist was in charge of the day to day running of the service. The dental nurse was the only other staff member employed at the practice, the individual responsibilities of staff members was clear. The principal dentist was responsible for all clinical areas and administrative tasks were the responsibility of the dental nurse.

We were told that regular practice meetings were held but these were informal. Any issues were discussed as and when they occurred including accidents, complaints or any changes in working practice. The dental nurse told us that she was confident that any issues raised would be listened to and acted upon.

Learning and improvement

Staff kept continuous professional development (CPD) logs to demonstrate training undertaken. We saw that copies of training certificates which demonstrated that staff were up to date with their training. CPD must be completed for continued registration with the General Dental Council (GDC).

We were told that informal discussions were held daily regarding the day ahead, changes at the practice or any information of note. As well as this informal monthly meetings were held, although minutes of these meetings were not available. Following this inspection we received confirmation that minutes of practice meetings were now kept.

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The practice did not have effective systems in place to; • Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. This should include systems to maintain and monitor emergency equipment and fire systems including risk assessments. Where appropriate X-ray signage must be in place. Assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. Ensure that a legionella risk assessment is undertaken by a competent person and any actions identified are undertaken. • Ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000 This includes undertaking necessary action to address issues identified in the Radiation Protection Adviser's risk assessment; and reviewing the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray. Regulation 17 (1)(2)(a)(b)