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Mile End Dental Clinic

Inspection Report

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Overall summary

We carried out this announced inspection on 26 April 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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

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

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Mile End Dental Clinic is in Colchester and provides NHS and private treatment to patients of all ages. There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including one space for blue badge holders, are available at the rear of the practice.

The dental team includes eight dentists, eight dental nurses, two dental hygienists, two receptionists, one implant nurse/manager and one practice manager/ dental nurse. The practice has six treatment rooms.

Summary of findings

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

On the day of inspection, we collected 30 CQC comment cards filled in by patients and spoke with one other patient.

During the inspection we spoke with three dentists, one dental nurse, two receptionists, the dental implant nurse manager and the practice manager/dental nurse. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday from 9am to 5.30pm.

Tuesday from 9am to 5.30 pm.

Wednesday from 9am to 7pm.

Thursday from 9 am to 6pm.

Friday from 9am to 5.30pm.

Saturday from 9am to 1.30pm.

Our key findings were:

- We received positive comments from patients about the dental care they received and the staff who delivered it.
- The appointment system met patients' needs and the practice opened late two evenings a week and Saturdays from 9am to 1.30pm. Text appointment reminders were available.
- The practice was clean and well maintained.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice staff dealt with complaints positively and efficiently.
- Risk assessment to identify potential hazards and 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 the provider was not meeting is at the end of this report.

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

- Review the practice's protocols to ensure audits of infection prevention and control are undertaken at regular intervals to improve the quality of the service. Practice should also ensure that, where appropriate, audits have documented learning points and the resulting improvements can be demonstrated.
- Review the practice's protocols for completion of dental care records taking into account the guidance provided by the Faculty of General Dental Practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

We found that this practice was providing safe care in accordance with the relevant regulations. The impact of our concerns with regards sedation and the use of cone beam computed tomography (CBCT) has been reduced due to the registered provider taking urgent action.

The practice had a cone beam computed tomography (CBCT) machine which was serviced annually in line with guidance. When asked, the staff involved in the use of CBCT were not aware of the requirement for monthly tests, quality checks or audits. We were told the visiting clinician was responsible for the testing and audit process. No supporting evidence was provided to corroborate this.

We found that untoward events were not always reported appropriately and learning from them was not shared across the staff team. We found that not all staff had a clear understanding of the process.

We were told there had been a Legionella risk assessment completed in 2011. This was not available during the inspection or thereafter. We were not assured any recommended actions which may have been identified had been actioned and completed, or any recommend prevention methods were appropriate and in place.

There were no records of recent fire equipment servicing or of fixed wire testing. Following the inspection, the practice provided evidence that some of these had been undertaken.

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

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

The practice had suitable arrangements for dealing with medical and other emergencies

Are services effective?

No action

Are services effective?

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 caring and friendly.

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

Summary of findings

The practice provided access to conscious sedation administered intravenously for patients who would benefit. The service was provided by an external anaesthetist who attended the practice when the need arose. When asked, we found the registered provider had no oversight or evidence of the servicing history for the equipment and medicines provided and used by the visiting anaesthetist. They were not fully aware of the medication used by the anaesthetist and how these were transported. When we reviewed some dental care records relating to the use of sedation there was no justification recorded to show why three medicines had been used.

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

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 31 people. Patients were generally positive about all aspects of the service the practice provided. They told us staff were friendly and caring. They said that they were given helpful 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 was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to telephone interpreter services and had arrangements to help patients with sight or hearing loss. Multi-lingual staff were available to support patients.

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.

Summary of findings

We identified a number of shortfalls in the practice's governance arrangements including the oversight of sedation services, cone beam computed tomography (CBCT) and the management of risks. At the time of our inspection the practice staff could not provide confirmation that emergency lighting, fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly tested. After the inspection the practice wrote to us with supporting evidence to show routine safety checks on all fire equipment were completed.

We were told there had been a Legionella risk assessment completed in 2011. This was not available during the inspection or thereafter. We were not assured any recommended actions which may have been identified had been actioned and completed, or any recommend prevention methods were appropriate and in place. The practice had a cone beam computed tomography (CBCT) machine which was serviced annually in line with guidance. There was no oversight by the registered provider and no system in place to ensure validation of equipment, staff training and audits were in line with recommended guidance. The radiation protection file was not easily accessible, staff were not aware of its location and the information stored within was sparse and lacked detail, in particular with regards the CBCT machine.

Following our inspection, the practice confirmed they were taking action to ensure they met current radiation regulations. The registered provider failed to ensure there was a system in place for equipment used by visiting clinicians to ensure this was serviced and maintained.

We found the practice staff were completing infection prevention and control audits annually not bi-annually as recommended. We discussed examples of what constituted a significant event or untoward event during the inspection and we found not all staff were aware of this. Staff were not aware of any reported events or any learning process in place within the practice. Staff were not aware of any policies in relation to the reporting of significant events, or of other guidance on how to manage different types of incidents. Following the inspection, the practice staff provided evidence of significant event analysis reports.

No action

Are services safe?

Our findings

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.

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

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

The practice had a staff recruitment policy and procedure to help them employ suitable staff and also had checks in place for agency and locum staff. These reflected the relevant legislation. We looked at six staff recruitment records. We noted there were no records to show they had obtained photographic proof of staff's identity in the recruitment records we reviewed. We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice did not have effective systems in place to ensure facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. During our inspection we found there were no records of fire equipment servicing or fixed wire testing. Following our inspection, the practice provided evidence to confirm testing had been undertaken with fixed wire testing completed in September 2016. We were told the fire brigade inspected the practice in 2016. The report was not available during the inspection and we were told this would be reviewed and followed up. After the inspection the practice staff wrote to us with the report and supporting evidence to show routine safety checks on all fire equipment was completed. Within the staff meetings minutes, we saw evidence of regular bi annual fire drills.

We found a malfunction had occurred with the fire monitoring panel and due to this it had been switched off. Urgent action was taken to address this, and the staff ensured the engineers were called to service the panel.

The practice had a cone beam computed tomography (CBCT) machine which was serviced annually in line with guidance. We were told staff had completed training in 2014 when the machine was installed and further training certificates were seen after the inspection.

We found not all appropriate safeguards were in place for patients and staff. For example, there were no recommended warning lights or signage on the room where this equipment was located on the day of inspection. We were told this had been taken into consideration, although not reflected in the local rules. When asked, the staff involved in the use of CBCT they were not aware of the requirement for monthly tests, quality checks or audits. The justification for CBCT was included with scan and we were shown the criteria for its use. We were told the visiting clinician was responsible for the testing and audit process. No supporting evidence was provided to corroborate this.

We asked to see a policy with regards the use of the CBCT machine and we were told there was not a formal policy as this was covered as part of the induction process.

The radiation protection file was not easily accessible, staff were not aware of its location and the information stored within was sparse and lacked detail, in particular with regards the CBCT machine. We found some information in the practice manager's office to confirm there were arrangements to ensure the safety of the intra oral X-ray equipment. We discussed this with the practice

No action

Are services safe?

management team. Following our inspection, the practice confirmed they were taking action to ensure they met current radiation regulations and had the required information in their radiation protection files.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year following current guidance and legislation. Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

We held discussions with practice management team regarding the necessity to hold adequate checks and records and to ensure staff were suitably trained. Following our inspection, the practice staff provided evidence to show that the required processes had been in place with regard to staff training and checks and records.

Risks to patients

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

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken and was updated annually.

The practice provided access to conscious sedation administered intravenously for patients who would benefit. The service was provided by an external anaesthetist who attended the practice when the need arose. When asked, we found the registered manager had no oversight or evidence of the servicing history for the equipment and medicines provided and used by the visiting anaesthetist. They were not fully aware of the medication used by the anaesthetist and how these were transported. When we reviewed some dental care records relating to the use of sedation there was no justification recorded to show why three medicines had been used. The dental care records we reviewed included regular checks of pulse, blood pressure, breathing rates and the oxygen saturation of the blood throughout the sedation procedure. There were no records to confirm that supporting staff were suitably trained in relation to sedation on the day of inspection. These were later sent as supporting evidence.

We held discussions with practice management team regarding the necessity to hold adequate checks and records and to ensure staff were suitably trained in both sedation and the use of CBCT. The practice took immediate action and following our inspection the practice agreed to stop all CBCT and sedation services until the practice systems had been strengthened.

The registered 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, and the effectiveness of the vaccination was checked. We noted that one member of staff was recorded as a non-responder and the management were unaware if a risk assessment was in place. The risk assessment was later sent to the inspector.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. We found that the practice could not demonstrate that immediate life support or equivalent training had been completed by all those staff that supported the sedation process. Following our inspection, we were provided with a certificate to confirm that one dental nurse had completed an advanced first aider course. The practice provided certification of other training received by clinicians following the inspection.

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.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team. There was no risk assessment in place for when the dental hygienists worked 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. The practice had an infection prevention and control policy and procedures.

No action

Are services safe?

They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. Staff completed infection prevention and control training and received updates as required.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance.

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

We were told there had been a Legionella risk assessment completed in 2011. This was not available during the inspection or thereafter. We were not assured any recommended actions which may have been identified had been actioned and completed, or any recommend prevention methods were appropriate and in place. We found the practice had submitted water samples to a professional Legionella testing organisation on 15 August 2017. A certificate confirmed no Legionella was present in the practice water at that time.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual.

We noted that whilst the clinical waste bin was secured to the building, the bin itself was open with clinical waste bags on view and accessible. We discussed this with the practice management team who confirmed the lock was broken and that prior to the inspection they had taken action to request the bin be replaced.

We found the practice were not undertaking infection prevention and control audits twice a year. The latest two audits were completed in February 2017 and April 2018.

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 and were kept securely and complied with data protection requirements.

When we reviewed some dental care records relating to the use of sedation we found there was no justification recorded to show why three medicines had been used. 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

The practice protected staff and patients with guidance available for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002.

Copies of manufacturers' product safety data sheets were held for all materials and the practice were in the process of completing risk assessments for all of these. This information was stored in a designated COSHH file.

Lessons learned and improvements

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).

We discussed examples of what constituted a significant event or untoward event during the inspection and we found not all staff were aware of this. They were not aware of any reported events or any learning process in place within the practice. They also were not aware of any policies in relation to the reporting of significant events, or of other guidance on how to manage different types of incidents.

The practice had signed up to receive national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). These

No action

Are services safe?

were monitored by the practice manager who actioned them if necessary. There was scope to ensure any actions taken from alerts relevant to the practice were recorded and reviewed

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.

The provider took into account guidelines as set out by the British Society for Disability and Oral Health when providing private dental care in domiciliary settings such as care homes or in people's residence.

The practice offered dental implants. These were placed by the principal dentist and one of the dentists at the practice who had undergone appropriate post-graduate training in this area. The provision of dental implants was in accordance with national guidance.The practice had access to CBCT and intra-oral cameras to enhance the delivery of care.

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 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 information and leaflets to help patients with their oral health. There was a display in the waiting rooms on National Stop Snoring Week 2018, a health promotion campaign advising people of the health issues associated with snoring.

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.

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

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

Consent to care and treatment

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

The practice team understood the importance of obtaining and recording patients' consent to treatment. The 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's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to the legal precedent called the Gillick competence by which a child under the age of 16 years of age can consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance. When we reviewed some dental care records relating to the use of sedation there was no justification recorded to show why three medicines had been used.

We saw that the practice had previously audited patients' dental care records to check that the dentists recorded the necessary information. We saw an audit undertaken in 2015 and this audit had been redone and reviewed in August 2017.

The practice provided access to conscious sedation administered intravenously for patients who would benefit.

Are services effective?

(for example, treatment is effective)

The service was provided by an external anaesthetist who attended the practice when the need arose. The dental care records we reviewed included regular checks of pulse, blood pressure, breathing rates and oxygen saturation of the blood throughout the sedation procedure. There were no records to confirm that supporting staff were suitably trained on the day of the inspection. These were later sent as supporting evidence.

We held discussions with the practice management team regarding the necessity to hold adequate records and to ensure staff were suitably trained if the service was to continue being provided. The practice took immediate action and following our inspection to ensure the practice systems had been strengthened.

Effective staffing

Staff new to the practice had a period of induction based on a structured induction programme. We looked at two recent induction programmes for new staff and noted that these were neither signed nor dated by either the new member of staff or the individual overseeing their induction.

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. 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 bacterial infections.

The practice also had systems and processes for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were caring and welcoming. We saw that staff treated patients respectfully and were friendly towards patients at the reception desk and over the telephone. One CQC comment card expressed concerns that they had been asked in the past to sign blank forms. We discussed this with the management team who agreed to review this process.

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 and televised health information displays were available for patients to read.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it. A radio was playing in both the downstairs and upstairs waiting rooms; we noted private conversations could still be overheard. Staff password protected patients' electronic dental care records and backed these up to secure storage.

Paper records were stored away from patients, there were no means of securing this or the practice office area to prevent access from unauthorised persons. We discussed this with the practice management team and following our inspection the practice provided evidence that security in these areas had been improved. The practice also confirmed any members of staff or the cleaning team who had access to this area would be required to sign a practice confidentiality agreement.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of therequirements under the Equality Act.

- Interpretation services were available for patients who did not speak English. Patients were also told about multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

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

The practice's website provided patients with information about the range of treatments available at the practice. The dentists described to us the methods they used to help patients understand treatment options discussed. These included for example photographs and X-ray images.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Staff were clear on the importance of emotional support needed by patients when delivering care. For example, where patients were nervous and requested a specific dentist this was discussed to ensure that all appointments were scheduled to accommodate this.

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

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made reasonable adjustments for patients with disabilities. These included step free access and an accessible toilet.

Text appointment reminders were sent and staff told us that they telephoned some vulnerable patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs. The practice displayed its opening hours in the premises, and included it in their practice 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 111 out of hour's service.

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

Listening and learning from concerns and complaints

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

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

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

The practice manager told us the practice 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 since August 2017. 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 principal dentist had overall responsibility for the management and clinical leadership of the practice.

They were supported by a practice manager and a dental implant manager who were responsible for the day-to-day running of the practice. Staff told us the principal dentist and practice manager were approachable and listened to them.

Vision and strategy

The practice planned its services to meet the needs of the practice population. This included any on-going refurbishment works and enhancing the technology provision already in place.

Culture

Staff told us they enjoyed their job and felt supported, respected and valued in their work.

Staff reported they felt able to raise concerns with the principal dentist and practice manager. We were given examples of the practice processes in place to act on staff member's behaviour and performance if it was inconsistent with the practice policies.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour. Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

We identified a number of shortfalls in the practice's governance arrangements including the oversight of sedation services, cone beam computed tomography (CBCT) and the management of known risks.

At the time of our inspection the practice staff could not provide confirmation that emergency lighting, fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly tested. We were told the fire brigade inspected the practice in 2016. The report was not available during the inspection and we were told this would be reviewed and followed up. After the inspection the practice wrote to us with supporting evidence to show routine safety checks on all fire equipment were completed.

We were told there had been a Legionella risk assessment completed in 2011. This was not available during the inspection or thereafter. We were not assured any recommended actions which may have been identified had been actioned and completed, or any recommend prevention methods were appropriate and in place. We found the practice had submitted water samples to a professional Legionella testing organisation on 15 August 2017. A certificate confirmed no Legionella was present in the practice water at that time.

The practice had a cone beam computed tomography (CBCT) machine which was serviced annually in line with guidance. We were told staff had completed training in 2014 when the machine was installed. After the inspection the practice wrote to us with updated training certificates. We found not all appropriate safeguards were in place for patients and staff. For example, there were no recommended warning lights or signage on the room where this equipment was located on the day of inspection. We were told this had been taken into consideration, although not reflected in the local rules. When asked, the staff involved in the use of CBCT were not aware of the requirement for monthly tests, quality checks or audits. We were told the visiting clinician was responsible for the testing and audit process. No supporting evidence was provided to corroborate this. We asked to see a policy with regards the use of the CBCT machine and we were told there was not a formal policy as this was covered as part of the induction process.

The radiation protection file was not easily accessible, staff were not aware of its location and the information stored within was sparse and lacked detail, in particular with regards the CBCT machine. We found some information in the practice manager's office to confirm there were arrangements to ensure the safety of the intra oral X-ray equipment. We discussed this with the practice management team. Following our inspection, the practice confirmed they were taking action to ensure they met current radiation regulations and had the required information in their radiation protection files.

The practice provided access to conscious sedation administered intravenously for patients who would benefit.

Are services well-led?

The service was provided by an external anaesthetist who attended the practice when the need arose. When asked, we found the registered manager had no oversight or evidence of the servicing history for the equipment and medicines provided and used by the visiting anaesthetist. They were not fully aware of the medication used by the anaesthetist and how these were transported. When we reviewed some dental care records relating to the use of sedation there was no justification recorded to show why three medicines had been used. There were no records to confirm that supporting staff were suitably trained on the day of inspection. These were later sent as supporting evidence.

We found the practice staff were not undertaking infection prevention and control audits twice a year.

We discussed examples of what constituted a significant event or untoward event during the inspection and we found not all staff were aware of this. Staff were not aware of any reporting events or any learning process in place within the practice. Staff were not aware of any policies in relation to the reporting of significant events, or of other guidance on how to manage different types of incidents. Following the inspection, the practice staff provided evidence of significant event analysis reports.

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, a suggestion box, social media and verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from patients the practice had acted on. For example the practice displayed a 'you said we did' report in the upstairs waiting area in response to patient feedback.

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.

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.

Continuous improvement and innovation

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

The whole staff team had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

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

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 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 registered provider did not have oversight on the requirment for tests, quality checks or operator training for the cone beam computed tomography (CBCT) machine. · The register provider had failed to ensure staff had an understanding of what constituted an untoward event and how this should be reported and shared. · The registered provider had failed to identify equipment used for sedation was serviced and maintained appropriately. · The registered provider did not have a system to identify training needs for staff, in particular the use of CBCT equipment and dental sedation. · We were not assured any recommended actions which may have been identified in the 2011 Legionella risk assessment had been actioned and completed, or any recommend prevention methods were appropriate and in place. Regulation 17 (1)