

Meridian Clinics Limited

Malcolm Patrick Association

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 15 September 2015 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 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

Malcolm Patrick Association is a dental practice situated in Hall Green, Birmingham. The provider is one of three dentists who co-own this practice and are all individually registered with the Care Quality Commission. During this visit we inspected one of these dentists (the provider). This report will make many references to the practice but we are actually only referring to Dr Notta's roles and responsibilities within the practice from herein.

The dental practice is a detached property situated on a busy road. Plant equipment is stored in the basement. The ground floor includes a reception area, waiting room, two treatment rooms, staff changing room, staff room, store room and stock cupboard. The first floor has three treatment rooms, a spare room, panoramic X-ray area, intra oral X-ray area, dark room (for developing X-rays) and an office.

The practice benefits from having five parking bays to the front of the premises and 12 bays at the back.

The practice offers care and treatment on a private basis only.

The practice has one dental nurse and shares one receptionist with two other providers located in the same premises. They work in one of the treatment rooms on the first floor. Opening hours are Monday to Thursday 8:30am to 5pm.

The provider is the registered manager. A registered manager is a person who is registered with the Care

Summary of findings

Quality Commission to manage the service. 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.

19 patients provided feedback about this service. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. All information we received from these patients was very complimentary. Patients were positive about their experience and they commented that they were treated with care, respect and dignity.

Our key findings were:

- The practice carried out oral health assessments and planned treatment in line with current best practice guidance, for example, from the Faculty of General Dental Practice (FGDP).
- Patients were very complimentary about the practice and told us they were treated with respect and kindness. Staff ensured there was sufficient time to explain fully the care and treatment they provided in a way patients understood. Patients commented they felt involved in their treatment and that it was fully explained to them.
- Patients were able to make emergency and routine appointments when needed.
- The practice had a complaints system in place.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- There was no robust audit system in place to monitor the quality of services provided.
- There was no established system to assess and manage risks to patients, including health and safety and the management of medical emergencies.

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

- Ensure they establish an effective system to assess, monitor and improve the quality of services provided.
- Ensure they establish an effective system to assess, monitor and mitigate the risks to the health and safety of patients, staff and visitors.

You can see full details of the regulations not being met at the end of this report.

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

- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice (FGDP) regarding clinical examinations and record keeping.
- Consider reviewing storage arrangements in the treatment room so the work surfaces are less cluttered and easier to clean.
- Maintain clear records of adverse incidents within an incident log book.

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.

Staff told us they felt confident about reporting accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice had systems in place to manage risks to patients, safeguarding, medical emergencies, whistleblowing, recruitment and complaints.

Staff members were suitably qualified for their roles. The practice had a recruitment policy which gave details of relevant checks which were in place to ensure patient safety.

Patients' medical histories were obtained before any treatment took place. Staff were trained to deal with medical emergencies. However, not all emergency equipment and medicines were in date and in accordance with the BNF and Resuscitation Council UK guidelines.

Are services effective?

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

Patients' dental care records provided information about their current dental needs and past treatment. The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained. However, improvements were required in some areas, for example, recording the justification for taking X-rays.

Dentists had a general awareness about the importance of gaining patients' consent and the relevance of the Mental Capacity Act 2005.

The practice followed guidelines on best practice when delivering dental care. These included the FGDP and the National Institute for Health and Care Excellence (NICE). The dentist was aware of 'The Delivering Better Oral Health Toolkit' (DBOH) with regards to prevention of oral disease.

Staff were supported to deliver effective care through training and supervisions. They were supported to meet the requirements of their professional registration.

Are services caring?

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

Patient feedback stated that they had very positive experiences of dental care provided at the practice. Staff behaved in a respectful, appropriate and kind manner. Patients commented that they felt involved in their treatment and that it was fully explained to them.

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

Summary of findings

There was a complaints policy in place.

The practice had made reasonable adjustments to accommodate patients with limited mobility.

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).

The culture of the practice encouraged candour, openness and honesty. There was a clearly defined management structure in place and staff felt supported and appreciated in their own roles.

There were limited systems in place to assess and monitor and improve the quality of the service; and to assess, monitor and mitigate the risks to patients, staff and visitors. Stock control systems were required to ensure robust disposal and replacement of out of date medicines.

Malcolm Patrick Association

Detailed findings

Background to this inspection

We inspected Malcolm Patrick Association on 15 September 2015. The inspection team consisted of a CQC inspector and a specialist dental advisor.

Prior to the inspection we reviewed information we held about the provider.

During the inspection we toured the premises, spoke with the provider and their dental nurse and receptionist. We also spoke with one of the other providers (but they will be inspected separately). To assess the quality of care provided we looked at practice policies and protocols and other records related to the management of the service.

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 their objectives and a record of any complaints received in the last 12 months.

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 clear guidance for staff about how to report accidents. We saw an accident log book at the practice. The provider understood the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reports had been made in the last 12 months.

We were told that adverse incidents were discussed with staff informally to provide opportunities for shared learning. However, the practice did not maintain clear records of adverse incidents. We discussed this with the provider and they informed us that an incident book was introduced the day after the inspection.

There were no systems in place to ensure that all staff members were aware and responsive to national patient safety and medicines alerts. The provider told us they would sign up to receive updated alerts from the MHRA (Medicines and Healthcare Products Regulatory Agency).

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for safeguarding teams. The provider was the safeguarding lead professional in the practice and we saw evidence they had completed safeguarding training in child protection in August 2015. However, the certificate did not state the level of training that the dentist had undertaken. The provider sent us evidence after the inspection and this showed they had completed Level Three (enhanced) safeguarding training for vulnerable adults in November 2015.

There had not been any safeguarding referrals to the local safeguarding team; however staff were confident about when to do so. Staff we spoke with told us they were confident about raising any concerns with the provider (safeguarding lead professional).

The practice had safety systems in place to help ensure the safety of staff and patients in the event of a sharps injury (needles and sharp instruments).

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. A rubber dam kit was not available in the treatment room. We were told the dentist referred most patients who required endodontic treatment to another dentist. However, the dentist was not using a rubber dam on the few occasions when they did carry out this treatment. We were told alternative actions were used to reduce the risk to patients where rubber dam was not being used.

We saw that patient records were accurate, complete, legible, up to date and stored securely to keep people safe and safeguard them from abuse.

The practice had clear processes to make sure they did not make avoidable mistakes such as extracting the wrong tooth. The nurse told us they and the dentist always checked and re-checked the treatment plan and tooth charting.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had access to emergency resuscitation kits, oxygen and emergency medicines.

There was no system for effectively checking current stock and expiry dates. As a result, we noticed that one of the emergency medicines was out of date (expired in April 2015). This was brought to the attention of the provider and they immediately ordered new stock – the provider contacted us the day after the inspection and produced evidence that new stock had been delivered. They assured us that they would be holding a staff meeting regarding this and they would introduce a more thorough checking system to avoid another incident like this. We were also told they were currently conducting monthly checks on the oxygen cylinders – this was discussed with the provider and we were told they would be changing to weekly checks.

The practice policy and equipment for managing medical emergencies were mostly in line with the Resuscitation Council UK guidelines, except for the absence of a portable suction device. Medicines to deal with medical emergencies were as stated in the British National Formulary (BNF).

Are services safe?

There was an Automated External defibrillator (AED) present. An AED 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. Staff received annual training in the management of medical emergencies and were aware of the location of the emergency equipment and drugs which were stored in a secure area.

Staff recruitment

The provider had two employees (a dental nurse and receptionist). Both of these staff members had been employees at this practice for almost 40 years.

The provider had not actively employed new staff since they took on this role. The practice had a policy for the safe recruitment of staff. This included obtaining professional registration certificates, qualifications, indemnity information, employment contracts and the immunisation status. The practice had a risk assessment in place with regard to the Disclosure and Barring Service (DBS) checks for staff. DBS checks 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.

Monitoring health & safety and responding to risks

We saw evidence of a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice. Staff we spoke with were aware of the health and safety policy. We saw the health and safety poster displayed in the staff room.

We were told that fire alarms were tested every month but this was not recorded. There was no evidence that fire drills took place. Fire extinguishers were present and were last serviced in March 2015. We did not see any evidence of fire safety training.

We saw some risk assessments to manage risk to patients and staff but not all were up to date and/or complete. For example, we saw a risk assessment for handling sharp instruments which was complete. There was a partially completed fire risk assessment in that there was no grading of risks identified and no remedial actions taken. A Legionella risk assessment was undertaken in 2011.

The practice did not have an effective process to mitigate risks associated with the Control of Substances Hazardous

to Health (COSHH) 2002. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. In dental practices, this includes blood spillage procedures and waste disposal procedures. We reviewed a brief assessment guide but it was not comprehensive. Within this guide, hazards were identified but no procedures were named on safe handling.

Infection control

There was an infection control policy in place to keep patients and staff safe. However, the policy was generic and not specific to the practice. For example, there was no named infection control lead person on the policy. It had not been updated since 2012 so would not be in accordance with the HTM 01-05 infection control guidance which was published in 2013.

The practice mostly followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 – Decontamination in primary care dental practices (HTM 01-05)'. However some improvements were required.

We observed the treatment room to be visibly clean and hygienic. However, the work surfaces were cluttered. This was due to lack of storage space and the lack of a separate decontamination room. We spoke with the provider who had already identified this and told us they were considering converting one of the rooms into a decontamination room. There were no formal plans in place but they were hoping to implement this within the next six months.

There was a small tear in the dental chair in the treatment room which would make effective cleaning difficult. This was brought to the attention of the provider and they informed us that this would be rectified. We contacted the provider subsequent to the inspection to follow this up. They sent us photographs and an invoice which showed that the chair had been re-upholstered. Drawers were clean and free from clutter.

Clear zoning demarking clean from dirty areas was apparent in the treatment room. Hand washing facilities were available including liquid soap, gels and paper towels

Are services safe?

in the treatment room and toilet. Bare below the elbow working was observed by staff members. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. Feedback received from patients confirmed that the practice was always clean.

We observed the decontamination process and found they met mandatory standards. These are the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments and subsequently packaging and storing clean instruments.

The practice had systems in place for daily quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were interrupted.

Staff received annual training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We saw that there was a system for environmental cleaning and colour coded equipment was used. There were hand washing facilities in the treatment room and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

We observed waste was generally separated into safe containers for disposal and we were told this was regularly collected by a registered waste carrier. The practice was unable to produce any documentation of this on the day of our inspection. However, they did contact us subsequent to our visit with details of a current contract. Sharps bins were appropriately located and not overfilled.

The practice had carried out the self-assessment audit relating to the Department of Health's guidance on decontamination in dental services (HTM 01-05). This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. This audit was carried out in-house by the practice in April 2015 but it had not been completed (34% complete). Without a complete audit, the practice could not be sure that they were fulfilling the requirements of HTM 01-05.

Records showed a risk assessment process for Legionella had not been carried out since 2011. This previous risk

assessment recommended it should be repeated in 2013 but this had not been done. (Legionella is a term for particular bacteria which can contaminate water systems in buildings.) This meant that the risks of Legionella bacteria developing in water systems within the premises had not been identified. The practice was not undertaking regular assessment of the water quality to check that Legionella was not developing. They did have a policy of running the water lines in the treatment rooms at the beginning of each session and between patients.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. This was displayed on the wall in the treatment room for quick reference.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, autoclaves and the dental chair. We saw evidence of validation of the autoclave.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. The prescriptions for prescribing private medicines were stored securely. None of the records we viewed had required medicines to be prescribed but we were told that prescription details were recorded.

Portable appliance testing (PAT) was completed in July 2014. PAT confirms that electrical appliances are routinely checked for safety.

Radiography (X-rays)

The practice had a radiation protection file. Records we viewed demonstrated that the X-ray equipment was appropriately maintained. Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these. However, one of the machines was clearly marked 'out of use' as it had not been maintained. This would serve as a reminder to all staff to prevent the accidental use of the machine. The provider informed us that they were not planning to undertake any maintenance work on the machine and would dispose of it accordingly in future.

Are services safe?

A Radiation Protection Advisor and a Radiation Protection Supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available for staff to reference if needed.

An X-ray audit had been carried out within the last 12 months. X-ray audits should regularly be undertaken to ensure that the quality is monitored and X-rays are justified in line with Faculty of General Practice (FGDP) guidelines.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date comprehensive dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the FGDP. The dentist used NICE (National Institute for Health and Care Excellence) guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. This was documented.

We talked to the provider regarding oral health assessments and treatment and corroborated what they told us by looking at patients' care records. These included details of the condition of the gums and any signs of mouth cancer. Medical history checks were updated by each patient every time they attended for treatment and recorded in their dental care record.

There was some evidence of compliance with the IRMER regulations for taking X-rays. We saw evidence of X-ray reports and quality assurance scores in the records. However, the dentist was not routinely documenting the justification for taking X-rays. Records showed treatment options were discussed with patients.

Health promotion & prevention

The medical history form patients completed included questions about smoking but not about alcohol consumption. We were told that the practice made the decision to remove the question about alcohol consumption as several patients commented they found it too personal. However, this is an essential part of the patient's social history and an important factor to consider when assessing a patient's risk of developing oral disease.

The practice could demonstrate that they were delivering preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). For example, the practice recalled patients, as appropriate, to receive fluoride applications to their teeth. We were told that dietary advice was also provided.

We saw evidence of health promotion leaflets in the practice but these were not kept in the waiting room. Staff told us these would be given to patients by the dentist for any specific oral health conditions that were relevant to that patient. Examples were information leaflets on extractions, tooth decay and gum disease.

Staffing

We saw that the practice had an induction policy for new employees to familiarise themselves with the way the practice ran. There had not been any new employees since the provider took over this practice. Staff told us they had good access to ongoing training to support their skill level. Records showed professional registration with the GDC was up to date for all clinical staff and we saw evidence of ongoing continuous professional development. We saw some evidence that the clinical staff had completed mandatory training, for example, in basic life support and safeguarding. Records showed staff had completed this in the last 12 months but the CPD log at the practice was not complete for all staff members. Some information was given to us after the inspection, for example, evidence that the provider had completed safeguarding training. We were told that the provider paid for staff to complete their core CPD topics.

The provider monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that the dentist and nurse planned their holidays in advance so they were away from the practice at the same time. In the event of staff absences due to illness, we were told they had access to temporary staff in the form of flexible part-time staff (employed by the other two providers within the same practice). They also had access to an agency in case they required a locum dental nurse.

The dental nurse was supervised and supported on a day to day basis by the provider. Staff told us the provider was readily available to speak to at all times for support and advice. Staff had not received any formal appraisals or reviews of their professional development in the last 12 months. However, staff told us they were encouraged to develop their skills and discussed their professional development informally. One staff member informed us they were keen on adding to their skills and were hoping to enrol on courses which would enable them to carry out extended duties.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. The practice completed detailed referral letters to ensure the specialist service had all the relevant information required.

Consent to care and treatment

Patients were given appropriate verbal information to support them to make decisions about the treatment they received. Written treatment plans for routine dental

treatment were provided upon request. We were told that patients were routinely given written information for more complex dental treatment, such as implants or orthodontic work.

Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act (MCA) 2005). There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

19 patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. The information received from patients was overwhelmingly positive. Patients were satisfied with their experience and they commented that they were treated with care, respect and dignity. Many of the patients had been treated at this practice for decades. Patients were very complimentary about all aspects of their dental experience here.

Staff told us that they always interacted with them in a respectful, appropriate and kind manner. During the day we saw and heard staff supporting patients in person and on the telephone. In each case the staff were very friendly, respectful and approachable. Staff told us that many of them had known the patients for decades and had built strong professional relationships over the years.

Staff we spoke with were aware of the importance of providing patients with privacy. Staff said if a patient wished to speak in private an empty room would be found to speak with them. We observed privacy and

confidentiality were maintained for patients who used the service on the day of inspection. Patients' dental care records were kept securely in a cabinet behind the reception area.

We were told that the practice managed anxious patients using various methods. For example, they would book longer appointments so there was extra time to support patients' needs and ample time to speak with the staff. The practice booked appointments for discussions only (without any treatment) if the patient requested; this would help to build trust and confidence between the patient and staff.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Patients were also informed of the range of treatments available.

Examination and treatment fees were displayed on the wall in the treatment room but not in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties had access to the practice via a ramp. There were toilet facilities on the ground floor but these were without disabled access. The provider predominantly worked in the treatment room on the first floor. However, the practice arranged for patients to be seen on the ground floor by swapping treatment rooms when required.

We found the practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointment slots to accommodate urgent appointments. We were told that the provider re-opened the practice one evening to treat a patient who needed urgent dental treatment. We were also told that some patients (those who had extensive or invasive dental treatment) could contact the provider on their mobile telephone in the event of an emergency. We observed that appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Patient feedback confirmed that the practice was providing a service that met their needs. For example, patients felt they had sufficient time during their appointment and didn't feel rushed. The practice offered patients a choice of treatment options to enable them to receive care and treatment appropriate to their needs. However, the practice was not undertaking their own patient survey and there was no suggestion box available. Staff told us patients made suggestions verbally which could be acted on but there was no system in place to record this.

Tackling inequity and promoting equality

The practice did not have equality and diversity or disability policies to support staff in understanding and

meeting the needs of patients. However, the practice appeared to recognise the needs of different groups in the planning of its services. We were told that visually impaired patients were given the choice of being treated in a ground floor or first floor treatment room. The practice did have some patients who had a hearing impairment. The practice did not have a hearing induction loop but we were told they spent more time communicating with these patients, using visual prompts where necessary.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

Staff told us that they had very few patients who were not able to converse confidently in English. Consequently, they informed us that they did not have access to an interpreting service but communicated with patients via the patient's relatives or carers.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met their needs.

Where treatment was urgent, patients would be seen within 24 hours or sooner if possible. The practice had clear instructions for patients requiring urgent dental care when the practice was closed. These instructions were displayed on posters in the reception areas and on the telephone answering machine.

Concerns & complaints

The practice had an effective system in place for handling complaints. Information for patients about how to complain was available in the reception area. The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. The policy included details of external organisations that patients could contact if they were not satisfied with the provider's response to a complaint.

No complaints had been received in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

The practice had limited governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments in place to manage those risks, for example, sharp instruments. Other risk assessments were lacking in detail or were out of date, for example, the fire risk assessment was 80% complete. There was no effective approach for identifying where quality and/or safety were being compromised. As a result of this, we identified that the glucagon (a medicine used in the management of medical emergencies) was out of date.

There was no regular audit process in place to monitor the quality of care provided. It is considered good practice to undertake regular audits of patient dental care records and oral health assessments. The lack of auditing of clinical records suggested the provider could not be sure that they were conducting a full and proper clinical examination in line with NICE and FGDP guidelines. The practice had undertaken the self-assessment audit relating to infection control. However, there was no action plan. A key part of any audit is comparing actual performance with the set standard. The results should then be used to develop an action plan, specifying what needs to be done, how it will be done, who is going to do it and by when.

There was an effective management structure in place to ensure that responsibilities of staff were clear. The provider was in charge of the day to day running of the practice. Staff we spoke with told us that they felt supported and were clear about their roles and responsibilities. The provider worked at this practice four days per week. In their absence, staff commented that the other dentists within the practice were always approachable and helpful.

Care and treatment records were kept securely and we found them to be complete, legible and accurate.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice.

Staff told us that there was an open culture within the practice and they were encouraged and confident to raise

any issues at any time. All staff were aware of whom to raise any issue with and told us the senior staff members were approachable, would listen to their concerns and act appropriately.

The practice did not have a bullying and harassment policy or a whistleblowing policy describing staff rights in respect of raising concerns about their place of work under whistleblowing legislation. However, staff we spoke with knew their responsibilities and told us they were confident about raising concerns if needed.

We saw evidence of regular practice meetings (approximately on a monthly basis). Minutes were recorded in a small memo book although they were rather brief and lacking in detail. Minutes were available for 2015 but not for 2014 as we were told they were not stored at the practice. In addition to these staff meetings, we were told the practice had social meetings to build rapport and have informal discussions.

Learning and improvement

We did not see any evidence that staff had annual appraisals where their performance and any suggestions could be discussed. However, staff told us they had informal discussions about this with the team. Staff told us they had access to training and this was monitored to ensure essential training was completed; this included medical emergency and safeguarding training. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC).

The practice had no audit system in place to encourage continuous improvement and learning. These should include completed clinical audits such as medical records and infection control.

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

Patient and staff feedback confirmed they felt engaged and involved at the practice. Staff we spoke with told us their views were sought and listened to. One example of this was when the practice was recently redecorated; staff told us they were invited to express their views.

Are services well-led?

The practice did not undertake their own patient satisfaction survey or have a suggestion box. Staff mentioned that compliments and complaints from patients were made verbally and passed on to the provider to act on if necessary.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>The practice did not have effective systems in place to:-</p> <ul style="list-style-type: none">• Assess, monitor and improve the quality of the services provided• Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors <p>Regulation 17(1)(2)(a)(b)</p>