Mr. Widarshana Channa Herath

Gnosall Dental

Inspection Report

15 High Street
Gnosall
Staffordshire
ST20 0EX
Tel: 01785822948
Website: Gnosalldental.co.uk

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Overall summary

In response to concerns raised to the CQC we carried out this unannounced inspection on 5 September 2017 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

Gnosall Dental Practice is in Gnosall and provides NHS and private treatment to patients of all ages.

There are steps to gain access to the building therefore level access is not available for people who use wheelchairs and pushchairs. Car parking spaces, including those for patients with disabled badges, are available at the rear of the practice in the shopping centre car park.

The dental team includes one dentist, three dental nurses, one dental hygienist, a secretary and a receptionist. The practice has two 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 did not collect any CQC comment cards as this inspection was unannounced. We spoke with four patients during the inspection. This information gave us a positive view of the practice.

During the inspection we spoke with the principal dentist, one dental nurse, the receptionist and the company secretary. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday 9am to 5pm, Tuesday and Wednesday 8.30am to 5.30pm, Thursday 9am to 5.30pm and Friday 9am to 12pm.

Our key findings were:

- The practice was clean and well maintained.
- Infection control procedures did not all reflect published guidance. For example the practice used bleach to clean work surfaces in treatment rooms and were not disposing of and changing household gloves used in decontamination processes at the required frequency.
- Staff knew how to deal with emergencies but basic life support and emergency medical training was overdue. We were told that this training was booked for September 2017. Not all of the recommended emergency medicines and life-saving equipment was available but this was purchased following this inspection.
- The practice's systems to help them manage risk were not robust. For example the practice had not completed a fire or sharps risk assessment. The practice were not completing an assessment of any premises they visited when they undertook domiciliary visits and had not assessed the individual circumstances to determine which emergency medicines and equipment may be required on these visits.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice's staff recruitment procedures did not ensure that all information as detailed in Schedule three of the Health and Social Care Act was available.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- Staff at the practice told us that they felt involved and supported and worked well as a team.
- The practice asked patients for feedback about the services they provided.
- The practice's complaints policies required updating to provide information to patients of the external bodies that patients are able to complain to if they are not satisfied with the outcome of the investigation completed at the practice.

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 regulations the provider was not meeting are at the end of this report.

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

- Review systems for the recording, investigating and reviewing accidents or significant events which would help to prevent further occurrences and, ensure that improvements are made as a result.
- Review the storage of dental care records to ensure they are stored securely.
- Review its complaint handling procedures and establish an accessible system for identifying, receiving, recording, handling and responding to complaints by service users.
- Review its responsibilities as regards the Control of Substances Hazardous to Health (COSHH) Regulations 2002 and ensure all documentation is up to date and staff understand how to minimise risks associated with the use and handling of these substances.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.

Summary of findings

- Review its responsibilities to the needs of people with a disability, including those with hearing difficulties and the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice were not recording significant events and not all of the accident records detailed information regarding advice or follow up action. There was no evidence to demonstrate that the practice had discussed or recorded any learning from incidents or accidents to help them improve.

Staff were qualified for their roles and they received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns

The practice had not obtained pre-employment information for all staff as detailed in Schedule Three of the Health and Social Care Act.

The practice had not completed infection prevention and control audits during 2017 and staff were not changing the household gloves used during the decontamination process at the required frequency.

At the time of the inspection the practice did not have suitable arrangements for dealing with medical and other emergencies. Not all of the recommended emergency medicines and equipment was available but these were purchased following this inspection.

Are services effective?

No action

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

The dentist assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as efficient, gentle and professional. The dentist discussed treatment with patients so they could give informed consent and recorded this in their records.

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

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

Are services caring?

No action

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

We received feedback about the practice from four people. Patients were positive about all aspects of the service the practice provided. They told us staff were kind

Summary of findings

and caring. They said that they were given detailed 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.

The practice's arrangements to help patients with hearing loss were limited.

The practice website and information leaflet did not give any information to patients who may wish to complain. Information on display in the waiting room was brief and did not provide information for private patients.

Are services well-led?

Requirements notice ✗

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

The practice had some arrangements to ensure the smooth running of the service and improvements were being implemented. These included appraisal systems and the introduction of formally minuted practice meetings to enable the practice team to discuss the quality and safety of the care and treatment provided.

Improvements were required to governance systems. For example not all emergency medicines and equipment was available and these were not being checked at the recommended frequency. Missing items of emergency medicines and equipment were purchased following this inspection.

Apart from fire extinguishers, there was no evidence available to demonstrate that fire safety systems, were being serviced and maintained on a regular basis. There were no records of fire drills completed after 7 June 2016 and those records seen were brief.

Accident records did not always record details of any advice given or follow up action taken.

The practice had not obtained all of the required pre-employment information for staff.

The dentist was not fully aware of Gillick principles.

Not all of the policies seen had been adapted to meet the needs of the practice.

Summary of findings

The practice team kept complete patient dental care records which were, clearly written or typed. Paper patient dental care records were kept in open shelving behind the reception desk. We noted that these were not securely stored.

The practice had not completed any infection prevention and control audits during 2017, we were not provided with a sharps risk assessment and the practice had not completed a fire risk assessment, although this has now been arranged for October 2017. The practice had not completed a risk assessment of the premises that they were visiting when undertaking domiciliary visits and had not assessed the individual circumstances to determine which emergency medicines and equipment may be required to be taken on these visits.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff spoken with said that they would report all accidents and incidents to the principal dentist.

We were shown accident report forms for 2017. We saw that some of the accidents related to sharps injuries sustained by staff. Advice or details of follow up action were not recorded in sufficient detail on each occasion. We were told that accidents would be discussed during practice meetings but that these had been informal in the past and no minutes were available.

We were told that there had been no incidents at the practice. However, during a conversation it emerged that the practice's computer system had malfunctioned which had resulted in the introduction of a new computer system. The practice had not considered this as a significant event.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were discussed with staff, acted on and stored for future reference.

Reliable safety systems and processes (including safeguarding)

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. Contact details for the local authority responsible for the investigation of safeguarding issues were available to staff in the reception area. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. These included some risk assessments. We saw that the practice risk assessment was completed in November 2015 and was overdue for an annual review but there was no documentary evidence that this had been completed. The practice used safe sharps and were aware of the relevant safety laws when using needles and other sharp dental items. However we saw that sharps bins were stored on the floor in treatment rooms which made them accessible to children. The principal dentist confirmed that these would be moved to a safer location immediately. We asked for but were not provided with a sharps risk assessment. The dentist used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The practice undertook some domiciliary visits to a local nursing home. We were told that during these visits they were involved in fixing and making dentures only. A dental nurse always accompanied the dentist on these visits. The dental nurse acted as a chaperone and was responsible for infection prevention and control procedures. The practice had not completed a risk assessment of the premises that they were visiting and had not assessed the individual circumstances to determine which emergency medicines and equipment may be required to be taken on these visits.

The business continuity plan which described how the practice would deal with events which could disrupt the normal running of the practice was not fully completed. For example contact details for external professionals such as plumber, electrician or burglar alarm company were not recorded on the contact details list.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year. This training was overdue but we were told that this had been booked for September 2017.

Not all of the emergency equipment and medicines were available as described in recognised guidance. For example we saw that emergency medicines such as aspirin were not available at the correct dosage and were not dispersible; midazolam was not available. We identified that oropharyngeal airways, clear face masks for self-inflating bags, single use sterile syringes and needles and spacer devices were not available in the medical emergency equipment kit. Following this inspection we received evidence to demonstrate that these items had been purchased.

The records that staff kept of their checks to make sure emergency medicines and equipment were available,

within their expiry date, and in working order were not effective. These checks were completed on a monthly basis which was not in accordance with the frequency suggested by the resuscitation council guidelines. There was no documentary evidence to demonstrate that oxygen or the defibrillator was checked on a regular basis. Following this inspection the provider forwarded a blank oxygen cylinder check log sheet which we were told would be used in the future to record checks made on the oxygen cylinder. We were not provided with evidence of defibrillator checks nor evidence that the emergency medicine and equipment check list had been updated to include the missing items.

Staff recruitment

We looked at recruitment information held for five staff members. The practice had not obtained all pre-employment information detailed in Schedule three of the Health and Social Care Act. We saw that disclosure and barring service checks had been undertaken and we saw these were available for some staff, some contracts of employment were available, although not all of these had been signed by staff

Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Monitoring health & safety and responding to risks

The practice had some health and safety policies and risk assessments which were up to date and reviewed to help manage potential risk. These covered general workplace and specific dental topics. The practice did not have a fire risk assessment and there was no evidence available to demonstrate that fire extinguishers, smoke alarms and fire alarms had been serviced or maintained. The practice was undertaking fire drills on a monthly basis until June 2016 but these only recorded the date. There was no other information recorded, for example the name of staff in attendance or the time taken to evacuate the premises. We received an email following this inspection which demonstrated that the provider had arranged a fire risk assessment to be completed on 26 October 2017.

The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentist and dental hygienist when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedure to keep patients safe. This had been reviewed on an annual basis. The practice was using bleach to clean surfaces in dental treatment rooms at the end of each day. Practice staff should consider using a proprietary detergent for cleaning down working surfaces rather than domestic bleach; bleach can be harmful to the skin, eyes and the nasal and throat passages when used for this purpose. We also noted that the practice did not have a cover for their computer keyboard. This presents a cross infection risk; HTM01-05 recommends the use of keyboard covers or easy clean waterproof keyboards.

Staff completed infection prevention and control training every year.

The practice had arrangements for transporting, cleaning, checking, sterilising and storing instruments. We noted that the household gloves used for manual cleaning of dental instruments were not changed on a regular basis in line with HTM01-05. This was discussed with the principal dentist on the day of inspection who confirmed that systems would be put in place to ensure these gloves were changed on at least a weekly basis. Records showed equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance.

The practice had previously carried out infection prevention and control audits twice a year. We were shown the audits for May and October 2016 which demonstrated that the practice was meeting the required standards. We were not shown any infection prevention and control audits for 2017. The practice did not have a blood and bodily fluids spillage kit. We received confirmation following this inspection that a kit had been purchased.

The practice had limited procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. On the day of inspection staff were unable to produce evidence that the temperature of water was checked and logged. We were told that these were not kept on the premises. Following this inspection the provider forwarded a sample of hot and cold water temperature records including those for January, March, April and May 2017. Not all of these records had been signed by the person who completed the information.

No action

Are services safe?

An external company completed cleaning at the practice. The practice was clean when we inspected and patients confirmed this was usual. We discussed the correct storage of cleaning equipment with the principal dentist during the inspection as currently these were being incorrectly stored.

We discussed the storage of clinical waste including amalgam. We noted that the clinical waste bin was not locked. We were told that clinical waste was not locked during the day when the practice was open. We discussed the need to ensure clinical waste was securely stored at all times.

We noted that waste amalgam capsules were stored in an unmarked pot. Following this inspection the provider informed us that their waste collection company did not require dedicated amalgam capsule storage containers, however the provider provided evidence that a storage container had been purchased.

Equipment and medicines

We saw servicing documentation for the equipment used. Staff carried out checks in line with the manufacturers' recommendations. Portable electrical appliances were being checked by an external professional on an annual basis.

Medicines that require refrigeration should be stored at between 2 and 8 degrees Celsius. Staff were not checking and recording the temperature of the fridge on a daily basis as recommended. Following this inspection we were told that a new daily fridge temperature log had been introduced at the practice and we were forwarded a blank copy of this document.

The practice had suitable systems for prescribing, dispensing and storing medicines.

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

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They had the required information in their radiation protection file. We saw evidence that the dentist graded and reported on the X-rays they took but the justification for taking the X-ray was not always recorded. We were told that the practice carried out X-ray audits following current guidance and legislation but we were told that these were not kept on the premises. following this inspection the provider forwarded a copy of the June 2017 X-ray audit this had been reported on and action plan completed.

Clinical staff completed continuous professional development in respect of dental radiography.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed dental care records containing information about the patients' current dental needs, past treatment and medical histories. The principal dentist was in the process of developing new templates to record information on the new computer system. The dentist assessed patients' treatment needs in line with recognised guidance.

We saw that the practice audited patients' dental care records to check that the dentist recorded the necessary information. These were reported on and action plans completed.

Health promotion & prevention

The practice believed in preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist 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 for each child.

The dentist told us they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

Staffing

We were not shown evidence to demonstrate that staff new to the practice had a period of induction based on a structured induction programme. Following this inspection the provider forwarded a copy of a brief standardised induction checklist that would be used for any new staff employed at the practice.

We confirmed clinical staff completed the continuous professional development (CPD) required for their registration with the General Dental Council. CPD logs were available which recorded details of training completed by clinical staff. We saw evidence to demonstrate that staff had completed training, for example regarding information governance, infection control and safeguarding. The emergency resuscitation and basic life support training was last completed in May 2016 and was therefore overdue but we were told that this had been booked for September 2017.

Staff told us they had appraisal meetings booked for the week of our inspection. The secretary undertook an appraisal meeting with a member of staff during this inspection. The secretary told us that a formal appraisal system had only recently been introduced. Information regarding appraisal was to be included on the practice's computer system to enable staff to see their individual appraisal and training records.

Working with other services

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included 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 urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist 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. Mental capacity assessment forms were available for use at the practice if required. We discussed Gillick competence with the dentist who was not aware of the need to consider this when treating young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

No action

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were friendly, helpful and efficient and we were told that there was a lovely atmosphere at the practice. We saw that staff treated patients with dignity and respect and were friendly towards patients at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding and made you feel at ease.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided some privacy when reception staff were dealing with patients. The receptionist told us about the methods they used to maintain privacy when the waiting room was busy. 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 personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. However we saw that some paper copies of dental care records were kept on open fronted shelving behind the reception desk. These were not securely stored to maintain confidentiality of information.

Music was played in the reception and treatment rooms and drinking water was available for patients in the waiting area.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. The principal dentist described the conversations they had with patients to satisfy themselves they understood their treatment options. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. We were told that they were always given lots of information and when a decision had been made they were given a treatment plan.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort. One patient told us that they had telephoned the practice that morning as they were suffering with tooth pain. They were given an appointment the same afternoon.

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments for gum disease and more complex treatment such as veneers and implants.

Each treatment room had a screen so the dentist could show patients photographs and X-ray images when they discussed treatment options.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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

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. One patient we spoke with confirmed that they had telephoned the practice that morning and been given an emergency appointment. 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.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment. For example staff described an example of a patient who found it unsettling to wait in the waiting room before an appointment. The team kept this in mind to make sure the dentist could see them as soon as possible after they arrived. Appointments were arranged to ensure that the patient received the first or last appointment of the day or an appointment during lunchtime.

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

Promoting equality

The practice was located in a converted cottage. One treatment room was available on the ground floor and one on the first floor of the building. Access to the practice was via steps and the patient toilet was located on the first floor of the building. The dentist mainly worked in the first floor treatment room and the hygienist on the ground floor. However, we were told that where patients were unable to access the first floor, the dentist would see patients in the ground floor treatment room. An access audit was completed in 2004, the audit identified issues for action, for example notifying patients that there was no ground floor toilet.

The practice did not provide a hearing loop. Staff told us that the majority of patients had been visiting the practice for many years and staff made alternative arrangements to communicate with patients who were hard of hearing.

Staff said that the majority of patients who attended this practice could speak and understand English. We were told that translation services had not been required, however contact details could be found if required. A sign in the waiting area informed patients that if they required information translating into braille, large print or if they required the use of an interpreter they should inform the receptionist.

Access to the service

The practice displayed its opening hours in the premises and on their website.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and kept two 30 minute appointment slots free for same day appointments. They took part in an emergency on-call arrangement with two other local practices. The information leaflet advised patients to call the practice number if they needed emergency dental treatment during the working day and when the practice was not open. The practice's answerphone provided emergency telephone contact numbers. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a number of complaints policies providing guidance to staff on how to handle a complaint. These had not been adapted to meet the needs of the practice. Neither the practice information leaflet nor the website explained how to make a complaint. The principal dentist was responsible for dealing with complaints and we were told that staff would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

The receptionist told us they aimed to settle complaints in-house and invited patients to speak with the principal dentist in person to discuss these. Information was available for NHS patients about organisations they could contact if not satisfied with the way the practice dealt with

No action

Are services responsive to people's needs?

(for example, to feedback?)

their concerns. This practice also sees private patients and those who pay for their treatment via a dental plan. There was no information on display for these patients about organisation they could contact if they were not satisfied with the way the practice dealt with their concerns.

We were told that the practice hadn't received any complaints.

Requirements notice

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management, clinical leadership and day to day running of the practice. Staff knew the management arrangements and their roles and responsibilities, although we were told that the principal dentist held the majority of lead roles at the practice.

We noted that improvements were required to governance systems. For example the practice were not checking and recording emergency medicines and equipment at the recommended frequency and not all equipment and medicines were available. Following this inspection the missing items of emergency medicine and equipment were purchased.

We were shown some of the practice's policies, procedures and risk assessments which helped to support the management of the service and to protect patients and staff. We spoke with staff about policies and procedures. Staff were not aware of all of the policies available. We were told that the policies were not usually available to them at the practice but the principal dentist was always available to provide advice and support.

Some of these policies and procedures had not been adapted to meet the needs of the practice.

We were told that there was no fire risk assessment, sharps risk assessment and the practice risk assessment had not been reviewed or updated since 2015. Following this inspection we were told that a fire risk assessment would be completed by an external professional in October 2017.

A legionella risk assessment had been completed. We asked for records to demonstrate that the practice were monitoring hot and cold water temperatures as recommended. Following this inspection we were sent copies of some records for 2016 and the records for January, March, April and May 2017. Not all of these records had been signed by the person recording the information.

Evidence was not available to demonstrate that fire safety systems were being serviced and maintained on a regular basis. We saw evidence of fire extinguisher maintenance but there were no records regarding service and maintenance of smoke alarms, emergency lighting or the fire alarm. The principal dentist had completed monthly fire and smoke tests until 20 July 2017. There were no records of fire drills completed after 7 June 2016. Those records seen did not record details of the staff present or how long it had taken to evacuate the building or any action or learning from the drill.

The practice had not obtained all of the required pre-employment information for staff as detailed in Schedule three of the Health and Social Care Act.

We discussion information governance arrangements and staff were aware of the importance of these in protecting patients' personal information. Evidence was available to demonstrate that staff had completed information governance training. The practice maintained some computerised and some paper patient dental care records. Paper records were stored in open fronted shelving in the reception area. These were not securely stored to maintain confidentiality.

Leadership, openness and transparency

The practice had a policy regarding duty of candour and staff spoken with were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the principal dentist encouraged them to raise any issues and they felt confident they could do this. They told us the principal dentist was approachable, would listen to their concerns and act appropriately.

Staff spoken with told us that they all worked as a team and dealt with issues professionally.

The practice had previously held informal meetings where staff could raise any concerns and discuss clinical and non-clinical updates. The secretary had recently introduced formal minuted meetings and staff told us that they were able to add items to the agenda for discussion at these meeting. Following this inspection we were forwarded the agenda for the meeting held in May 2017.We were told that as well as the formal meetings, discussions were held during lunchtime and immediate discussions were arranged to share urgent information

Learning and improvement

The practice had some quality assurance processes to encourage learning and continuous improvement. We were shown the audit of dental care records for October 2016,

Requirements notice ✖

Are services well-led?

X-rays for June 2017, waste for October 2016 and hand hygiene for October 2016. They had clear records of the results of these audits and the resulting action plans and improvements. However the infection prevention and control audits we were shown were for May and October 2016. We were not shown any audits for 2017.

We looked at the records of accidents at the practice within the last 12 months. These did not always record details of any advice given or follow up action taken. We were told that there had been no significant events at the practice. However during discussion we were told about a computer failure which resulted in a new computer system being introduced. This had not been considered or recorded as an event. There was no evidence of discussions held or any learning recorded from incidents or accidents to help them improve.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. An appraisal system had recently been introduced and the secretary would be responsible for completing appraisal of all staff, apart from the principal dentist. We were told that the appraisal system would include discussions regarding learning needs, general wellbeing and any issues or concerns.

Staff told us they completed mandatory training, including medical emergencies and basic life support, each year. We noted that this training was overdue and had been arranged for September 2017. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice provided support and encouragement for them to do so.

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

The practice used patient surveys and verbal comments to obtain patients' views about the service. A copy of the practice's patient satisfaction survey was available in the leaflet stand in the waiting area for patients to complete, although this was not clearly visible to patients. Staff we spoke with had not been updated with the results of any satisfaction surveys. The secretary confirmed that these would now be discussed during practice meetings. Following this inspection we were forwarded a copy of the analysis of patient feedback for 2017. This recorded the results of the satisfaction surveys in a graph. We saw that 15 surveys had been completed and positive feedback received.

NHS Friends and Family Test (FFT) forms were available in the waiting room for patients to complete. These would be handed to the receptionist who would pass these on to the principal dentist for forwarding to NHSE. The FFT is a national programme to allow patients to provide feedback on NHS services they have used.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to ensure that the regulated activities at Gnosall Dental Practice were compliant with the requirements of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: The provider was unable to provide evidence that they had completed recent audits regarding infection prevention and control. There was no sharps or fire risk assessment and the practice risk assessment had not been reviewed on an annual basis. The provider had not completed a risk assessment of the premises they were attending when they undertook domiciliary visits and had not assessed the individual circumstances to determine which emergency medicines and equipment may be required to be taken on these visits. There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: There was no evidence that staff had completed fire drills within the last 12 months. Fire precautions monitoring checks had not been completed and recorded since July 2017 and there was no evidence of routine maintenance and servicing of some fire safety equipment.

This section is primarily information for the provider

Requirement notices

Sharps bins were located on the floor and easily accessible to patients including children.

Household gloves used during the decontamination process were not changed at the frequency recommended, the practice did not have a keyboard cover in dental treatment rooms as recommended in HTM01-05

Clinical waste bins were not locked during the day to provide secure storage.

The checks made on emergency medical equipment were not completed at the frequency suggested in the Resuscitation Council Guidelines and not all of the emergency equipment was included in these checks.

There was additional evidence of poor governance. In particular:

There was no evidence in each staff recruitment file of proof of identification, criminal records bureau check, evidence of good conduct in previous employment or the vaccination status of staff.

There was no documentary evidence of staff induction for newly employed staff