Mr. Roddy Casey

Aylestone House Dental Practice

Inspection Report

345 Aylestone Road
Leicester
LE2 8TA
Tel: 0116 2832701
Website:www.aylestonehouse.co.uk

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Overall summary

We carried out this announced inspection on 3 December 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 not 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

Aylestone House Dental Practice is located in a suburb of Leicester and provides NHS and (mostly) private treatment to adults and children. At the time of inspection, the practice was not accepting any new NHS patients.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including for blue badge holders, are available in the practice's car park at the rear of the premises.

Summary of findings

The dental team includes three dentists, three dental nurses, three trainee dental nurses and a practice manager. The practice has three treatment rooms; all are on the ground floor.

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 21 CQC comment cards filled in by patients.

During the inspection we spoke with the principal dentist, two dental nurses and two trainee dental nurses. We looked at practice policies and procedures, patient feedback and other records about how the service is managed.

The practice is open: Monday from 08:15am to 6:30pm, Tuesday from 08:15am to 5:30pm, Wednesday from 08:15am to 5pm, Thursday from 08:15am to 5:30pm and Friday from 08:15am to 2:30pm.

Our key findings were:

- The practice appeared clean and well maintained.
- The provider had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies, although one staff member had not updated their training within the previous 12 months. Appropriate medicines and life-saving equipment were available; the spare oxygen cylinder was not fit for purpose and a medicine that required cool storage was not managed according to guidance.
- The practice had some systems to help them manage risk to patients and staff. We found areas that required review such as implementing a process for significant/ untoward incident reporting.
- The provider had safeguarding processes and we noted that most staff had completed training in safeguarding vulnerable adults and children. We were unable to view a certificate for one of the dental nurses.
- The provider did not have a policy or procedure to support the appointment of new staff. They had not completed all essential recruitment checks at the point of staff appointment. We were informed that a new policy was being implemented after our visit.
- Not all clinical staff provided patients' care and treatment in line with current guidelines. Dental record keeping did not follow best practice guidance.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Staff were providing preventive care and supporting patients to ensure better oral health.
- The appointment system took account of patients' needs.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and patients for feedback about the services they provided. The last patient survey was undertaken in 2015 however.
- The provider dealt with complaints positively and efficiently.
- Governance arrangements required strengthening including audit activity. We were informed that audit activity would be improved following our visit.

We identified regulations the provider was not complying with. They must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.

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:

- Introduce protocols regarding the prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Review the practice's protocols for domiciliary visits taking into account the 2009 guidelines published by British Society for Disability and Oral Health in the document "Guidelines for the Delivery of a Domiciliary Oral Healthcare Service".
- Review stocks of medicines and equipment and the practice's system for identifying, disposing and replenishing of out-of-date stock.

Summary of findings

- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with 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 had some systems and processes to provide safe care and treatment. We found areas that required significant review to ensure that risks were appropriately managed. For example, the completion of risk assessments where DBS checks were accepted from staff' previous employers and when domiciliary visits were made to patients in their home.

Whilst there were records of accident reports and evidence that issues were discussed in practice meetings, the practice had not implemented suitable formal processes for reporting, investigating and learning when things went wrong.

We saw evidence that most staff received training in safeguarding people, although not all certificates were available for our review. Policy required review to ensure that most up to date and current information regarding staff's safeguarding training was held.

Staff were qualified for their roles. The practice did not have a recruitment policy or procedure documentation to help them employ suitable staff. The practice did not demonstrate that they had completed all essential recruitment checks at the point of staff appointment. We were told that a policy was being implemented after our visit.

The practice had not ensured that all facilities and equipment were safe or that all equipment was maintained according to manufacturers' instructions. Gas safety testing and fixed wiring testing was overdue for completion at the time of inspection. Action was taken by the provider after the inspection.

The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice had mostly suitable arrangements for dealing with medical and other emergencies. The spare oxygen cylinder required replacement and the fridge's temperature required monitoring to ensure medicines were stored correctly.

Are services effective?

Requirements notice 

We found that this practice was not providing effective 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).

Patients described the treatment they received as excellent, professional and thorough.

Summary of findings

We found that that not all clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. Detail in record keeping required improvement in a sample of patient records that we looked at. This included information regarding oral risk assessments, patients' treatment options and consent.

Not all staff had a thorough understanding of the Mental Capacity Act 2005 and how it might impact on patients' ability to consent. Following our visit, we were told that the Act would be discussed amongst staff in a practice meeting.

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

Staff completed training relevant to their roles; there was scope to improve monitoring systems regarding completion of staff training to ensure the provider had oversight.

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 21 people. Patients were positive about all aspects of the service the practice provided. They told us staff were well trained, efficient and welcoming.

They said that they were given helpful, informative 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 took account of patients' needs. Patients could get an appointment quickly if in pain.

Staff considered some patients' different needs. This included level access at the rear of the premises and accessible toilet with a handrail. The practice did not have access to interpreter services at the time of our inspection and had not considered whether a hearing loop might be beneficial for their patients.

The practice took patients' views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Summary of findings

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 principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included most policies, protocols and procedures that were accessible to all members of staff. Not all policies required had been implemented such as recruitment and incident reporting. We noted that policy would benefit from review.

There were some clear and effective processes for managing risks, issues and performance. We found that some risks had not been identified such as gas safety and five yearly fixed wiring testing.

The practice had systems to monitor clinical and non-clinical areas of their work to help them improve and learn. We found that audits did not always drive improvement. We were informed that audits of radiography, record keeping and infection and prevention control would be improved after our inspection.

The practice welcomed feedback from patients and staff. The practice had not undertaken a staff survey since 2015.

Requirements notice 

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

The practice had some clear systems to keep patients safe; we also noted areas that required review.

Staff showed awareness of their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances.

We saw evidence that most staff had received up to date safeguarding training. One of the dentist's certificates did not state the level of training completed and certificates were not available for the principal dentist and one of the dental nurses. We were told that the principal dentist and dental nurse had completed training in early 2018 but had not obtained their certificates. A certificate for the dentist was provided after our visit.

The principal dentist was the lead for safeguarding concerns. Whilst external contact information for safeguarding teams was held in policy and procedure documentation, this was not posted or displayed for staff elsewhere. Staff were unsure when contact details were last checked to ensure they were up to date. We were told that the practice manager was responsible for this and they were on a period of leave from work. We noted that the original date of the safeguarding policy was in July 2012; whilst it was noted that it had been subject to review since then, there was scope for policy provision to include other considerations such as awareness of modern slavery. Following our visit, we were informed that a laminated flow chart containing contact numbers had been displayed in the staff area.

Staff told us they could put electronic notes on patient records to identify any vulnerable patients e.g. children with child protection plans, adults with safeguarding concerns or other people who require other support such as with mobility or communication.

The practice had a whistleblowing policy. We reviewed two policy documents which included an older version of the policy that required removal from file to avoid confusion.

Staff felt confident they could raise concerns without fear of recrimination; not all were clear on the correct external reporting channels. Staff were aware however where to locate policies.

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.

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

The practice did not have a recruitment policy or procedure to help them employ suitable staff. We looked at four staff recruitment records to ensure they met with legal requirements. Whilst staff had DBS checks held on record, we noted that two of these had been ported from staff' previous employers. One check was undertaken in 2011 and was provided when the staff member started work in 2017. A risk assessment had not been undertaken to ascertain if a new DBS check required completion. References were not held for a member of staff who started work in April 2013. Another staff member did not have photographic identity held on their file. One of the dentists did not have an up to date GDC registration certificate held on their file.

Following our inspection, we were informed that the provider was applying for a new DBS check for the staff member whose last check had been undertaken in 2011. We were also advised that a recruitment policy was being implemented.

We checked that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice had not ensured that all facilities and equipment were safe or that all equipment was maintained according to manufacturers' instructions. For example, the gas safety inspection was due as the certificate held on record was dated March 2017. The practice could not locate the five yearly electrical fixed wiring certificate. Following our inspection, the gas safety check was completed and we were sent supporting evidence to confirm this. The fixed wiring testing was carried out after our visit and the practice told us that action was required on one of the fuse boxes which would be completed in January 2019.

Are services safe?

Records showed that risks presented by fire had been addressed, although we noted that the practice did not have nominated fire marshals. We looked at a health and safety risk assessment dated May 2018 which had been carried out by an external agent. This recommended that emergency lighting was tested monthly. We were not provided with records to confirm this was taking place. The assessment also included recommendations regarding asbestos management. The principal dentist told us that this would be actioned when premises modifications took place in the reception area.

The practice had suitable arrangements to ensure the safety of the X-ray equipment and had the required information in their radiation protection file. Three yearly full surveys were undertaken; we were not provided with supporting documentation for annual mechanical and electrical tests for X-ray equipment on the day of our visit. This documentation was located and forwarded to us afterwards.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. The practice carried out radiography audits every year. We found that radiograph audits required strengthening. The latest audit related to only one of the dentists and a small sample was chosen for review.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety. We identified areas that required review.

The practice had health and safety policies, procedures and risk assessments; although we found that some assessments required completion.

The 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. We found that the effectiveness of the vaccination was not always checked however. Our review of documentation showed that two of the dental nurses did not have their immunity levels recorded. We noted that the practice's infection control policy stated that this would be held by the practice.

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. The risk assessment did not specifically address the risks to staff whose immunity levels to Hepatitis B were not known / recorded.

The practice had current employer's liability insurance.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year. One of the dental nurses had last completed the training in June 2017 as they were unable to attend the most recent training in August 2018. This required update.

Emergency equipment and medicines were available as described in recognised guidance. Glucagon was stored in a refrigerator, however its temperature was not monitored to ensure that it was stored at the required temperature. We also found that the spare oxygen cylinder required removal as it was out of date as well as items contained in the first aid kit, as these had passed their expiry dates for safe usage. Staff had kept records of their checks of emergency medicines and equipment.

A dental nurse worked with the dentists when they treated patients in line with GDC Standards for the Dental Team.

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. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health and Social Care.

Staff completed infection prevention and control training and received updates as required.

The practice had suitable arrangements for cleaning, checking, sterilising and storing instruments in line with HTM 01-05. We noted that boxes used to transport instruments did not have secure lids. This presented a risk of injury from the contents if dropped whilst being carried through the practice.

The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance.

Are services safe?

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Recommendations included training and management issues. We did not view evidence to confirm that these had been actioned and completed. Records of water testing and dental unit water line management were in place.

We saw cleaning schedules for the premises. The practice was visibly clean when we inspected.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We did note that the locked bin outside required securing; we found that the key was attached to the waste bin. Following our inspection, we were advised that the bin had been secured to a wall with a padlock.

The practice carried out infection prevention and control audits twice a year. We looked at the last two audits dated in April and October 2018. We noted that there was scope to improve the completion of audits as they were brief and lacked detail. An annual Infection Prevention Control statement regarding compliance had not been completed. Following our visit, we were advised that a new audit tool would be used in future.

Information to deliver safe care and treatment

Staff had most of the information they needed to deliver safe care and treatment to patients.

The dentist we spoke with was not aware of sepsis guidance.

Dental care records we saw were legible and were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

Patient referrals to other service providers contained information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The provider 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 NHS prescriptions securely as described in current guidance. We found that the practice had not implemented a procedure for recording individual prescription numbers until they were issued. This meant that the provider might not be able to identify if a prescription was taken inappropriately. Following our visit, we were informed that controls had been implemented to enable effective monitoring.

We spoke with the dentist about their awareness of current guidance in relation to prescribing medicines. We saw some examples involving recent patient attendances for emergency appointments; their treatment of the patient to avoid having to prescribe antibiotics reflected the understanding and awareness of the dentists in this area. The dentist told us they would prescribe a course of antibiotics for seven days rather than the recommended five.

Track record on safety and Lessons learned and improvements

There were risk assessments in relation to safety issues. We noted exceptions in relation to staff whose Hepatitis B status was not known. Risk assessments had not been completed in advance of domiciliary visits undertaken to assess any medical risks posed by the patients' medical history and the suitability of a patient's home to carry out treatment.

The provider demonstrated that they had a positive safety record in relation to some issues. For example, there was a process for the reporting of accidents. Accident reports we viewed did not always indicate what action had been taken in response to the event. However, staff told us that issues were discussed and were reviewed in team meetings. For example, we were informed that a staff injury with a matrix band resulted in the purchase of a safer type. There was scope to improve the recording of preventative action taken and staff learning when accidents occurred.

We were not provided with a policy for reporting significant events / untoward incidents although we located a reporting form in documentation. Staff told us that they were not aware of any significant events or untoward incidents. Our review of practice meeting minutes, accident reports and complaints identified a number of incidents that could have been reported and investigated as such.

Are services safe?

There was a system for receiving safety alerts; we were told that these were actioned by the principal dentist. They told us that a file was held containing alert records. We were not able to locate where the information was held.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The practice systems for keeping dental practitioners up to date with current evidence-based practice required review.

We looked in detail at a sample of 12 patient records. We found that not all clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. Further detail was required in dental record keeping overall, with the exception of one of the dentists records that we looked at.

One of the dentists undertook home visits to treat patients who were unable to attend the practice. This included visits to sheltered accommodation. We were informed that the visits took place around twice monthly. We found that the provider had not taken into account guidelines as set out by the British Society for Disability and Oral Health when providing dental care in in people's residence. The dentist had not undertaken risk assessments in advance of visits made. For example, the dentist attended patients' residences alone without assistance from another member of the team. We were not provided with information to show that the patient, environment they were visiting and whether any emergency medicines were required were subject to a pre-assessment. We did however note that the treatments carried out were of lower risk and comprised of screening, dentures or occasional very loose tooth extraction.

The practice offered dental implants. These were placed by one of the dentists at the practice who had undergone appropriate post-graduate training in this speciality. The provision of dental implants was mostly in accordance with national guidance. We noted that post-operative antibiotics were prescribed following treatment. The provider referred to evidence based research published in 2013 for the prescribing of antibiotics. Whilst the research supported effectiveness for pre-operative antibiotics prescribing, the findings showed the benefits for post-operative antibiotic prescribing were unclear. We informed the provider to review anti-microbial prescribing guidance issued after this date.

Staff had access to technology in the practice, for example an intra-oral camera 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. We noted that some of the dentists' record keeping required further detail to support the delivery of care in line with the toolkit.

The dentists 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 dentist told us they would where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

The practice provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns in supporting patients to live healthier lives. The dentist referred patients to the Smoke Free App or advised them to contact their GP or local pharmacy. Literature was held in the waiting room for patients regarding smoking cessation.

We looked at outcomes for patients with gum disease. This involved patient preventative advice and the taking of plaque and gum bleeding scores. We looked at a sample of patients' records for three dentists and found varying quality of detail in information recorded. Whilst we saw evidence that Basic Periodontal Examination (BPE) was carried out, those with a score of three or four did not always have detailed pocket charting recorded. Information available in the records did not support that patients with more severe gum disease were recalled at recommended intervals to review their compliance and to reinforce any home care preventative advice given.

Consent to care and treatment

We looked at how the practice obtained consent to care and treatment and whether this was in line with legislation and guidance.

The practice team told us they understood the importance of obtaining 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. Whilst one of the dentist's notes in patient records contained more detail, we found there was insufficient detail in other dentists. notes to adequately describe the consent process. This included for example, advantages and disadvantages of treatments,

Are services effective?

(for example, treatment is effective)

risks and benefits and reasonable expectations of outcomes of each care and treatment option. Following our inspection, the provider informed us that a template had been implemented which would help ensure that recording of consent was included in patient records.

Patients confirmed in some of the CQC comment cards that their dentist listened to them and gave them clear information about their treatment. One patient commented that there was excellent communication and explanation of procedures.

The practice's consent policy included information about the Mental Capacity Act 2005 (MCA). The dentist we spoke with did not fully understand their responsibilities under the Act when treating adults who might not be able to make informed decisions. Following our visit, we were informed that the MCA would be discussed amongst staff in a practice meeting.

The policy also referred to Gillick competence, by which a child under the age of 16 years of age may give consent for themselves. The staff showed awareness 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

We found that dental care records contained information about patients' medical histories and past treatment. We did not find that their current needs were always recorded. For example, risk assessments for caries, oral cancer and periodontal condition. This was recorded in one of the dentist's notes in patient records, but not routinely in respect of the other dentists. The lack of detail did not provide assurance that patients' treatment needs were always assessed in line with recognised guidance.

We saw the practice audited patients' dental care records; the last audit was undertaken in September 2018. Audit required strengthening as it had not identified issues that we found on the date of inspection.

Effective staffing

The practice employed trainee dental nurses who were supported by staff within the practice. We saw that staff had acquired specialist skills. For example, one of the dentists had undertaken post graduate study in root canal treatment, another dentist was appropriately trained to place implants and one of the dental nurses had also undertaken a course in implants to provide support. Another dental nurse was trained as an oral health educator when they commenced working at the practice; they had not utilised these skills to date in their current role.

We were informed that staff new to the practice had a period of induction based on a structured programme. We saw evidence of this for some staff; we were not provided with the documentation for the most recently recruited dentist who started work in the practice in November 2017. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff employed by the practice discussed their training needs at annual appraisals. We found that some were overdue for completion. For example, records produced showed that one of the dental nurses had last had an appraisal in January 2016 and another had one completed in February 2017. Records for the practice manager showed that an appraisal was last completed in April 2016. One of the dental nurses had recently had an appraisal in November 2018, however. The irregular completion of appraisals impacted upon the ability of the practice to address the training requirements of staff. We noted that the practice manager had been absent since August 2018.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The practice 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 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.

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 well trained, efficient and welcoming.

We saw that staff treated patients respectfully and appropriately and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding. Nervous patients told us that staff had allayed their dental fears.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity. We identified an area for improvement as one of the treatment rooms at the rear of the practice was visible to the outside; this meant that a patient could be observed by anyone accessing the large rear car park. The provider took immediate action and told us after the inspection that they had temporarily covered the window whilst they waited for a permanent solution.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and the separate waiting area provided some privacy when reception staff were dealing with patients. If a patient asked for more privacy, staff could 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.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

We asked staff about how they helped patients be involved in decisions about their care and how they complied with the requirements under the Equality Act/Accessible Information Standard. (A requirement to make sure that patients and their carers can access and understand the information they are given.)

- Staff were not aware of interpreter services for patients who did not speak or understand English. We were informed that these patients would be advised to bring a family member with them to assist. This could present a risk of miscommunications / misunderstandings between staff and patients. We were informed that the practice manager spoke Polish.
- The practice did not have access to information in different formats/texts to aid communications.

Patients confirmed that staff gave them information to help them make informed choices about their treatment. Patients also said that staff listened to them, did not rush them and discussed options for treatment with them.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, models, software, X-ray images, screens, and an intra-oral camera. These were used to help the patient/relative better understand the diagnosis and treatment.

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 some patient needs and preferences.

Staff told us they understood the emotional support needed by patients when delivering care. We were told that longer appointments could be allocated for those who were anxious or nervous and appointments could be spread over two separate times if this suited the needs of the patient. Information for nervous or anxious patients was provided on the provider's website. We were provided with an example where staff assisted a patient who was blind and guided them into the dental chair.

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

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment. Patients with mobility problems and those who used wheelchairs could gain level access to one of the surgeries by accessing it at the rear of the premises. Information regarding this access was included on the practice's website.

The practice had made some other reasonable adjustments for patients with disabilities. These included an accessible toilet with a hand rail. A call bell was not fitted in the toilet facility but this was directly in front of the reception area, so staff could be alerted of any problems encountered. The practice did not have a hearing loop or magnifying glass/reading glasses at reception. Staff were not aware if a disability access audit had been completed.

Staff sent a text message 78 hours in advance to patients to remind them to attend for their booked appointment. We were told that telephone call reminders were occasionally made if a long appointment was booked or if a patient was new to the practice. The practice did not have a procedure for contacting patients by landline telephone or letter if they did not have a mobile telephone.

Timely access to services

Patients could 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 information leaflet.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients told us that they had enough time during their appointment and did not feel rushed. Appointments appeared to run smoothly on the day of the inspection and patients were not kept unduly waiting.

The staff took part in an emergency on-call arrangement with some other local practices for their privately registered patients. NHS patients were advised to telephone NHS 111.

The practice's answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily and were not often 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 policy providing guidance to staff on how to handle a complaint. The practice information leaflet and website page explained how to make a complaint.

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

The complaint leads aimed to settle complaints in-house and patients would be invited to speak with them in person, if appropriate. 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 within the previous 12 months.

These showed the practice responded to concerns appropriately. Our review of practice meeting minutes showed that patients' complaints and comments were discussed. We noted some outcomes in records we reviewed; these demonstrated that learning was shared amongst staff to improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The dentists had the capacity and skills to deliver high-quality, sustainable care; however, we found that improvements were also required in the service. Following our visit, the practice demonstrated a proactive approach to rectify shortfalls we identified.

The principal dentist was aware about issues and priorities relating to the quality and future of services. The principal dentist had plans for refurbishment of part of the premises including the reception area.

Leaders at all levels were visible and approachable. They worked closely with staff and others.

Vision and strategy If applicable

The practice had business plans to achieve priorities. The practice planned its services to meet the needs of the practice population.

Culture

Staff stated they felt respected and supported. They were proud to work in the practice.

Openness, honesty and transparency were demonstrated when responding to complaints. For example, an apology and explanation was issued to a patient who had cancelled their appointment but the cancellation notice had not been received at the time by the practice.

Whilst we identified a number of untoward incidents, the practice had not recorded them as such. The practice did not have an incident reporting policy and staff did not know about incident reporting. A lack of formalised approach presented a risk that the practice may not always undertake robust action or identify any patterns of adverse events.

The provider was aware of the requirements of the Duty of Candour.

Staff could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. During the practice manager's absence, dental nurses were supporting the principal dentist in the delivery of the service. Staff knew the management arrangements and their roles and responsibilities.

There were responsibilities, roles and systems of accountability to support governance and management. We found that there was scope for greater management oversight to ensure staff training was monitored for completion and that the most appropriate level was completed for safeguarding training.

The provider had a system of clinical governance in place which included most policies, protocols and procedures that were accessible to all members of staff. Not all required policies had been implemented such as recruitment and incident reporting. We noted that some policies would benefit from review such as the safeguarding policy.

There were some clear and effective processes for managing risks, issues and performance. We found that some risks had not been identified expeditiously such as gas safety and five yearly fixed wiring testing. The dentist had not completed a risk assessment prior to undertaking home visits to patients and did not demonstrate that they had a clear understanding of the Mental Capacity Act.

Appropriate and accurate information

The practice did not demonstrate that it had always acted on appropriate and accurate information. For example, the practice did not demonstrate that it complied with its own policy in relation to infection prevention and control and ensuring that all staff immunity information was held on record.

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 had involved patients, staff and external partners to support quality sustainable services. We were informed that the most recent patient survey was undertaken in July 2015; the practice may benefit from issuing a new survey to obtain patients' views.

Are services well-led?

The practice used 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 extended its opening hours over lunchtime on a Friday and its reception staff availability between lunchtime on a Monday and Thursday.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. We were informed that a radiology protocol was displayed in one of the surgeries.

Continuous improvement and innovation

There were systems and processes for learning; we found they required strengthening and greater oversight.

The practice did not have quality assurance processes to encourage learning and continuous improvement. Audits undertaken included dental care records, radiographs and infection prevention and control. The practice could not be assured that audits were always effective; they had not identified issues we had found on the day of inspection. Following our visit, we were told that audit would be strengthened.

Staff directly employed by the practice had annual appraisals, although some were overdue for completion. We saw evidence of some completed appraisals in the staff folders.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. We noted that one of the dental nurses had not attended the most recent training however.

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 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users must-** **a) be appropriate** **b) meet their needs, and** **c) reflect their preferences** • Patients' dental assessments were not completed in accordance with nationally recognised evidence-based guidance. • Patients' dental assessments did not include information regarding the consent process. • Not all staff had a clear understanding of the Mental Capacity Act 2005 and how this might impact on treatment decisions.

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 Aylestone House Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **There were limited systems or processes established to enable the registered person to assess, monitor and improve the quality and safety of services provided. In particular:** **· Formalised procedures were not in place for significant event/untoward incident reporting. Staff were not aware of incident reporting.**

This section is primarily information for the provider

Requirement notices

· There were limited systems for monitoring and improving quality. For example, radiography audit had not resulted in learning and improvement to the service.

· Policy required implementation. For example, recruitment policy and incident reporting.

· There were limited processes to improve quality; staff had not received up to date annual appraisals.

There were limited systems or processes established 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 had not ensured that information was held for each staff member as specified in Schedule 3. In particular: proof of identity including a recent photograph and satisfactory evidence of conduct in previous employment.

· The provider had not implemented a robust system for the review and action of patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

· Risk assessments had not been implemented in relation to safety issues including:

- Not holding staff immunity status for Hepatitis B.

- Accepting ported DBS checks from staff' previous employers.

- Not assessing the patient environment prior to undertaking home visits to patients.

· The provider had not ensured that all recommendations had been completed in relation to the legionella risk assessment.

· The provider had not identified at the time of inspection that gas safety or the fixed wiring was overdue for testing.