Ballard And Tucker Limited

Ballard and Tucker Limited

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 May 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Ballard and Tucker Limited is a dental practice providing general dental treatment and some specialist dental treatment in Biggleswade, Bedfordshire. Treatment is provided on the NHS, but is mostly paid for privately.

The practice is located over two floors of a purpose built building. The main reception is situated downstairs along with three treatment rooms. The other two treatment rooms are situated upstairs. Access to the upstairs area is via an external door and could not be made through the building.

The practice is open from 8.30 am to 5.30 pm Monday to Friday.

Access for urgent treatment outside normal opening hours is by following the instruction displayed on the door, and explained on the answerphone, or by telephoning the NHS 111 service.

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

We received feedback from 29 patients about the services provided, this was mostly positive, and praised the friendly and caring nature of the staff.

Our key findings were:

Summary of findings

- The practice was visibly clean and clutter free.
- Patients were treated with care and compassion; patients with children commented on how comfortable their children felt to attend the practice.
- The practice had medicines in place to deal with medical emergencies that might arise, and had an automated external defibrillator which was regularly checked.
- Treatment options were identified and discussed with patients. Models and picture aids were used to illustrate discussions.
- Staff had a good understanding of how and when to raise a safeguarding concern.
- The practice had policies in place to aid the smooth running of the service, although these had not all been recently reviewed.
- Dentists used nationally recognised guidance to aid in the care and treatment of patients.
- Governance protocols to ensure the continuing improvement of the service were not as robust as they could be. Certain required clinical audit had not been completed such as infection control.
- Some dental care records were not stored securely; patients were unsupervised in areas where they were stored.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.

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

- Ensure care and treatment is provided in a safe way by assessing the risk of the spread of infection by carrying out infection control audits at regular intervals as described in Health Technical Memorandum 01-05 (HTM 01-05).
- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities: for example by the effective use of clinical audit and risk assessment.

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

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

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's staff awareness and training in safeguarding vulnerable adults, child protection, Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005.Ensure all staff are trained to an appropriate level for their role and aware of their responsibilities.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal reference taken and ensuring recruitment checks, including references, are suitably obtained and recorded.
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice carried emergency medicines and equipment in line with national guidance; however certain sizes of airway were missing or not sterile. These were replaced following the inspection.

Staff demonstrated a good understanding of the situations in which they might have to raise a safeguarding concern for a child or vulnerable adult.

Regular servicing and testing of equipment had been carried out to ensure it was safe and effective.

Are services effective?

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

Dentists conducted a thorough assessment of oral health for all patients, and followed nationally recognised guidelines in their care and treatment of patients.

Medical history forms were given to patients to complete and these were checked again at regular intervals to ensure that staff were aware of any changes that might affect treatment.

Dentists demonstrated a clear understanding of the process of obtaining full, valid and educated consent.

Are services caring?

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

Patients commented that they were treated with dignity and respect.

Reception staff were able to describe to us how patients' confidentiality was maintained whilst at the practice.

NHS and private treatment costs were displayed in the waiting area.

Are services responsive to people's needs?

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

The practice set aside daily emergency appointments so that patients with a dental emergency could be seen in a timely manner.

The practice had access to an interpreting service if patients for whom English was not their first language required it.

Arrangements would be made for patients with restricted mobility to be treated in one of the downstairs treatment rooms. Reception staff routinely checked with all new patients whether they were able to manage the stairs.

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 at the end of this report).

Staff felt supported and comfortable to raise concerns with any of the management team.

The practice did not have robust systems in place regarding risks and governance arrangements in the practice.

Clinical audit had not always been completed, and lacked detail and action plans where it had been undertaken.

Ballard and Tucker Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 17 May 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector, the deputy chief inspector in the Primary Medical Services directorate of the CQC and a dental specialist advisor.

Before the inspection we asked the practice for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with 10 members of staff during the inspection.

We informed the local NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them. We also reviewed the information we held about the practice and found there were no areas of concern.

We reviewed policies, procedures and other documents. We received feedback from 29 patients about the dental service.

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

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had limited systems in place to report, investigate and learn from incidents. The practice had a policy regarding reporting incidents which demonstrated the importance of reporting and learning from incidents, but was not following the protocol within the policy. Following our visit the practice implemented a template to ensure that incidents are reported according to their policy.

An accident book detailed three accidents in the year preceding the inspection, two of which described sharps injuries to members of staff. The records of these lacked detail, including the action taken and any steps taken to reduce the chance of re-occurrence.

The practice policy directed staff to report certain incidents to the Health and Safety Executive (in line with the requirements of the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR)). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC).

The practice received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to one of the dental partners who disseminated relevant alerts to the staff at practice meetings, or by speaking to them individually.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place regarding safeguarding vulnerable adults and child protection; these were available in the governance folder for staff to reference, although they were not dated so we could not be assured that they were up to date and relevant.

Staff had a good understanding of how to raise a safeguarding concern, and in what circumstances they may need to do so. Contact details for the relevant authorities were available behind the reception desk and all staff (with the exception of reception staff) had undertaken training in safeguarding.

The practice had an up to date Employers' liability insurance certificate due to expire in January 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We asked the dentists about the safety systems employed during root canal treatment. The British Endodontic Society recommends the use of rubber dam for root canal treatment. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment; it prevents the patient from inhaling or swallowing debris or small instruments.

We found that dentists did not always use a rubber dam during root canal treatment. In addition we found that even when a rubber dam was not fitted a fluid was used to disinfect the root canals that could burn the soft tissues of the mouth.

Clinicians told us that in the event of rubber dam not being used they would use cotton wool to isolate the tooth, and high speed suction to mitigate the risks.

Medical emergencies

The practice carried emergency equipment and medicines to deal with any medical emergencies that may arise. The emergency medicines were checked and found to be present in accordance with the British National Formulary (BNF) guidelines. All the emergency medicines were in date.

The Resuscitation Council UK listed emergency equipment that they recommend dental practices carried. The practice had equipment in line with this guidance with the exception of the oro-pharyngeal airways. The practice did not have one of each of the five sizes of airway, and those that they did have were not always sterile, and not dated with a use by date. Following the inspection we received information that these had been replaced.

The practice had an automated external defibrillator (an AED is a portable electronic device that automatically diagnosed life threatening irregularities of the heart and delivered an electrical shock to attempt to restore a normal heart rhythm).

The practice had two oxygen cylinders, one in the upstairs area and one downstairs, these were checked regularly.

Are services safe?

We found that the emergency equipment was not kept all together, certain pieces of equipment were upstairs, others downstairs in different places. In the event of a medical emergency it is important that all medical equipment was kept in one place so that it could be retrieved with ease. We received assurances from the practice that this would be the case going forward.

All staff had undertaken medical emergencies training in April 2015, and it was booked again for June 2016.

Staff recruitment

We looked at the staff recruitment files for five permanent staff members and two temporary staff to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant, and where necessary a Disclosure and Barring Service (DBS) check was in place. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice did not have a staff recruitment policy in place, and there was no consistent checklist of documents required for new staff.

We found that the practice had DBS checks in place for all clinical staff, although the reception staff had not had this check performed. We asked the practice manager regarding DBS checks and she explained that reception staff were not required to chaperone in the treatment rooms, however no formal risk assessment was in place.

None of the recruitment files we saw contained any record of references having been sought or obtained, although in some cases staff told us that references were received by phone and not recorded. We raised this with the practice who made arrangements to make a record of any verbal references received.

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice.

A health and safety policy was available for staff to reference in hard copy form. Although it was not dated recent amendments had been made to the policy. This included information on accidents and incidents, fire safety and substances hazardous to health. The policy had been signed by staff, but mostly a few years ago.

The practice had limited measures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Practices are required to keep a detailed record of all the substances at use in the practice which may pose a risk to health, although the practice had a detailed policy in this regard, there were very limited risk assessments for individual substances.

The practice described the systems in place in event of a fire, and discussed how the system was checked to ensure it functioned effectively. The practice completed fire checks every week. An external contractor visited the practice annually to service the alarm system, check the appropriateness of the fire control measures, and check the extinguishers. Staff were able to identify the external muster point, and a mock evacuation was carried out in April 2016.

General practice risk assessments had been carried out in December 2015 including manual handling, electricity, pressure vessels and first aiders.

During our visit we were concerned by the staffing levels in the upstairs practice. A clinician was working with a dental nurse in a treatment room in this area, but there was no direct access to any other staff without going outside and next door into the main building, equally patients could access sensitive information and chemicals in this area unchecked.

In the event of a medical emergency this could mean a delay in help arriving. This risk was mitigated by the fact that an alert could be sent over the computer system (although not audibly) to draw attention to the need for extra staff. In addition we were told that there was usually a supplementary member of staff in this area when patients were being seen. If oral surgery was being carried out the emergency medicines and equipment was re-sited upstairs so that it could be obtained quickly if needed.

Immediately following our visit the practice implemented a policy but which there would always be a member of staff working at the upstairs reception. In addition sensitive information was locked away, and chemicals moved to

prevent them being accessed by patients and visitors. In addition an audible alarm was added to the computer system so help could be sought with greater ease and certainty.

The practice had a sharps policy in place which detailed the importance of not re-sheathing needles, and that dentist should dispose of all sharps at the point of use. Information on how to respond to a sharps injury was available to staff and included contact details for the nearest occupational health department.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy in place which had not been recently reviewed. This detailed aspects of infection control including decontamination, manual cleaning, disinfection of impressions and hand hygiene. Decontamination is the process by which contaminated re-usable instruments are washed, rinsed, inspected, sterilised and packaged ready for use again.

The practice had two dedicated decontamination rooms, one downstairs and one upstairs. We observed the process being completed in both decontamination rooms.

The practice used ultrasonic baths to clean instruments (a dedicated piece of dental equipment which cleaned instruments by passing ultrasonic waves through a liquid in which the instruments were immersed). Following this instruments were manually cleaned and then inspected.

Inspection of instruments was necessary to confirm the removal of all visible debris, and check for any defect in the instruments. HTM 01-05 recommends that this is carried out with the aid of an illuminated magnifier. Although the downstairs decontamination facility had this equipment, the upstairs facility did not. We were informed that this broke several weeks earlier and they were awaiting a replacement. Following the inspection this was purchased.

Each decontamination room had an autoclave for sterilising dental instruments, and after sterilising, instruments were pouched and a use by date written on the pouch.

Staff showed us records of the checks undertaken to ensure that the decontamination process was effective. This included weekly and quarterly tests on the ultrasonic baths, and testing of the autoclaves to ensure that the appropriate temperature and pressure are reached for effective sterilisation. However the autoclave in the downstairs decontamination room required another daily check because it was a vacuum type autoclave, this was not being carried out. We raised this with the practice principal who took immediate steps to ensure that the process met required standards.

The practice had systems in place for the segregation, storage and disposal of clinical waste. The practice had a contract for removal of waste from the premises, however the clinical bin was overflowing and not locked or secured during the day (although it was secured at night). We raised this with the principal dentist who took immediate steps to ensure that all clinical waste was stored securely prior to its collection, and arranged an increase in the frequency of collections to prevent such a situation arising again.

There were systems in place to protect staff, patients and visitors from the risk of water lines becoming contaminated with Legionella bacteria. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. An external assessment was carried out, which detailed measures to be taken to reduce the risk. This included checking water temperatures in the building on a monthly basis, disinfecting and flushing the dental water lines. We saw records to indicate this was being carried out as described.

All clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact). Evidence of this was retained in the staff recruitment files.

Equipment and medicines

We saw that the practice had equipment to enable them to carry out a range of dental procedures.

We saw that regular servicing and testing had been carried out on the autoclaves and compressors within the previous year, in line with the manufacturer's instructions.

Are services safe?

We found a medicine used to treat diabetics was being kept at room temperature. At room temperature the medicine was valid for 18 months from when it was issued to the practice. In order for it to be valid to the expiry date it would need to have been refrigerated. The practice had not amended the expiry date to account for the fact that it was not refrigerated. Immediately following the inspection a new medicine was purchased and the expiry date appropriately amended.

The practice kept antibiotics on the premises to dispense if required, these were stored appropriately. Prescriptions were stamped individually, and pads were kept locked away.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

The practice had decommissioned two intra-oral X-ray machines at the time of our visit (an intra-oral X-ray machine took X-rays of one or a few teeth at a time), and new ones had arrived to be fitted. The practice was also waiting to install a new dental panoramic tomograph machine which can take a single X-ray involving both jaws.

The practice kept a radiation protection file which demonstrated that all of the X-ray machines had undergone critical examination testing in the last year (to confirm that they are working within normal parameters). The file also listed the responsible persons for X-ray safety in line with the requirements of IRR 1999.

Evidence was seen that staff were up to date with required training in radiography as detailed by IR(ME)R. Clinical audits were carried out on X-ray quality, most recently on 2 March 2016. A sample of X-rays from all the clinicians were graded on quality and an overall score given. The process would have been more effective if it were operator specific as it would highlight and discrepancies between operators.

We saw evidence that dentists recorded a justification for taking an X-ray in the dental care records, as well as documenting the quality grade, and reporting on the image.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with three dentists and we saw patient care records to illustrate our discussions.

Medical history forms were given to patients to be completed at every check-up appointment. These were then scanned onto the computer system and checked verbally with the patients at every visit. In this way clinicians could be assured of being made aware of changes to medical history which might affect treatment.

Dental care records showed assessment of the periodontal tissues (the gums and soft tissues of the mouth) had been undertaken. These had been recorded using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to patients' gums. Higher figures would trigger further investigation and treatment.

Comprehensive screening was carried out on patients including checks of the soft tissues of the face and neck, as well as those inside the mouth and an assessment of the jaw joints.

Dentists demonstrated a thorough understanding of the national guidelines available to aid diagnosis and treatment. This included the National Institute of Health and Care Excellence (NICE) guidelines pertaining to wisdom teeth extractions, recall intervals and antibiotic prescribing for patients at risk of infective endocarditis (a serious complication that may arise after invasive dental treatments in patients who are susceptible to it). Also the Faculty of General Dental Practitioners' guidance on when X-rays were required and necessary. We found that this guidance was being followed by the dentists.

Dental care records we were shown indicated that accurate and detailed notes of the discussions and treatment carried out were being recorded.

Health promotion & prevention

Medical history forms completed by patients asked for information regarding nicotine use. Dental care records indicated that diet and lifestyle advice was being given to patients. Clinicians we spoke with were aware of the local availability of smoking cessation services and how to refer patients to that service. The practice also had free toothpaste samples available for patients.

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

The practice had four general dentists, a specialist oral surgeon, an orthodontist and (at the time of our visit) a locum orthodontist. They employed three part time dental hygienists, three qualified dental nurses, two trainee dental nurses, two receptionists and a practice manager.

The practice demonstrated appropriate staffing levels, and skill mix to deliver the treatments offered to the patients.

Prior to our visit we checked the registration of the clinical staff with the General Dental Council (GDC) and found that they were all appropriately registered with no conditions on their practice. The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians orthodontic therapists and dental technicians.

The practice did not offer direct access to the dental hygienists, patients saw a dentist first who would detail a course of treatment for the dental hygienists complete.

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC).

Working with other services

The practice made referrals to other dentists and dental services in the local area. Referrals would be made when the practice was not able to offer a particular service or if the patient required more specialised treatment.

If an urgent referral was made to the hospital; for example, in the event of a suspected cancer, the letter was faxed, and then immediately followed up with a phone call to ensure that the referral had been received.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We spoke with clinicians regarding how they obtained full, valid and educated consent for treatment. Dentists explained that they always indicated all the options for treatment as well as the risks and benefits of each treatment option. The practice had access to picture books and used diagrams to explain treatment options in detail. They also had the benefit of a dental laboratory close by, and could borrow examples of dental work to show patients.

Patients were provided with a written treatment plan, and encouraged to take it away and consider it before signing it. Clinicians described how they asked patients to explain their treatment choices so that the dentists could be assured that patients had a thorough understanding of the options. Dental care records showed these discussions had taken place with patients.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment; however staff did not seem confident of the application of this in practise.

Similarly staff demonstrated an understanding of the situation in which a child under the age of 16 could legally consent for themselves, but would benefit from further training in this area to clarify application of this. Gillick competence relies on the assessment of a child's understanding of the procedure and the consequences of having/not having the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed patients to the practice being treated in a friendly and courteous manner. Feedback we received from patients commented how the staff were caring and polite and were able to put children at ease.

Staff we spoke with explained how patients' confidentiality was maintained in the practice. Computers were positioned below the level of the counter top at the reception desk, thereby obscuring them from the view of patients at the desk.

If a patients wanted to speak in privacy staff described how they would take them to an unused surgery so that they could speak without being overheard.

In the next door practice area we witnessed patients being treated with the door open, conversations between patients and clinicians could be overheard. We raised this with the principal dentist who said that the door would normally be shut, and immediate steps were taken to ensure it would be.

Involvement in decisions about care and treatment

Dental care records shown to us gave a detailed description of discussions held between the clinician and patients regarding the treatments options available to them, and their risks and benefits. Patients were given a written treatment plan detailing the costs of treatment.

NHS and private price lists were on display in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

We examined the appointments book and found that adequate time had been allocated per patient for discussion and treatment.

The practice was open from 8.30 am to 5.30 pm Monday to Friday. The practice had a trial period where they opened on a Saturday but they found there was not sufficient uptake of this service by their patient population to continue.

Emergency appointments were set aside daily, and staff would endeavour to see emergency patients within 24hrs of contacting the service.

Tackling inequity and promoting equality

Staff we spoke with expressed that all patients were welcomed and treated according to their individual needs.

Due to the practice being situated over two floors receptionist would routinely ask new patients about their ability to manage stairs. If they were not happy with the stairs the practice would arrange an appointment at a time where a downstairs treatment room could be utilised.

We discussed with staff how they could assist patients for whom English was not their first language. The practice said this was not a frequent concern, but they could access an interpreting service through NHS England if a patient required it.

The practice had some information on individual treatments available for patients to read on their website. Clinicians we spoke with said they would steer patients towards reading this information away from the surgery environment, and contact the practice again with any further questions.

Access to the service

The practice had a Disability Discrimination Act audit which was completed on 11 December 2015, this recognised that the downstairs reception and treatment areas were accessible by wheelchair. It was also recognised that an external doorbell to alert reception that a patient required assistance with the doors would be a beneficial addition.

Information on how patients could be seen outside normal working hours was displayed on the front door of the practice and described on the answerphone. For NHS patients this involved utilising the NHS 111 service. For private patients the practice took part in a rota with other local practices to provide cover, and the mobile phone number was given.

Concerns & complaints

The practice displayed its complaints policy on the wall of the waiting area for patients to reference. This detailed the way in which complaints to the service would be handled. If the complaint was not handled satisfactorily by the service, details were given of how to escalate the complaint beyond the practice. This included the Patient Advice and Liaison Service for NHS patients and the Dental Complaints Service for private patients.

The practice had not received any formal complaints; therefore it was not possible to see if they had been handled according to their policy.

Are services well-led?

Our findings

Governance arrangements

The practice had a principal dentist, dental partner, and had recently appointed a practice manager. The practice manager was in the process of reorganising and overhauling the governance arrangements for the practice.

The practice did not have adequately robust systems in place to recognise risks to staff, patients and visitors to the service; although they responded in a timely way when these risks were pointed out.

We saw a range of policies and procedures to assist in the smooth running of the practice; this included cross infection, health and safety and staff concerns. These were frequently undated or dated several years previously. Therefore their relevance could not be assured.

Monthly staff meetings were carried out for all staff. These had an open agenda; therefore staff were able to request any topic, which became a point for discussion. Minutes of the staff meetings were available for staff to reference if they had not been able to attend.

Systems in place to monitor the safety and effectiveness of the service were not sufficiently robust; clinical audit processes had not been followed, pre-recruitment checks did not include a record of references having been sought and oversight of the mandatory training requirements of staff was not being carried out.

We found that in the unmanned reception of the secondary part of the building historic dental care records were being stored insecurely. This meant that patients waiting in that area could access those records in the cupboards. We also noted that patients could access a kitchen that contained hazardous substances, and an office which contained files, some of which contained sensitive information. Following our visit we received evidence that hazardous substances had been removed, and confidential information had been locked away.

Leadership, openness and transparency

Despite recent changes to the management structure at the practice staff described the practice team as a family, and reported that they felt comfortable to raise concerns and suggestions with any member of the management team. We recognised that following these recent changes plans had been put into place to address the shortfalls in the governance procedures.

The practice had a policy in place regarding staff concerns. This encouraged staff to report concerns about the actions or behaviours of a colleague without fear of retribution. This had been signed by all staff, but mostly in 2010.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training, however their approach was not always robust.

An audit of X-ray quality had been completed in March 2016, however this was largely ineffective. An action plan had not been generated to address shortfalls, and the audit was not operator specific, and therefore could not identify any discrepancies between the quality of X-rays taken by different clinicians.

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health states that infection control audits should be carried out every six months. The last audit we were shown was dated November 2010 although following the inspection an audit was completed.

Clinical staff working at the practice said they were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. However all staff kept their logs of CPD individually and the principal dentist did not have access to these, so did not maintain oversight of the CPD and mandatory training carried out by the staff. Following our inspection the practice introduced a system by which all staff CPD was monitored by the practice manager to ensure they were up to date with the requirements of the GDC.

Staff told us that appraisals took place annually and were due again in July 2016; however records of previous appraisals had not been kept.

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

The practice sought feedback from patients by various means. They had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide

Are services well-led?

feedback on the services provided. The FFT comment box being used specifically to gather regular feedback from the NHS patients, and to satisfy the requirements of NHS England.

In addition they carried out patient satisfaction surveys on the general dental services, and separately on the oral surgery services. Although we were not shown any outcomes for the surveys.

Staff were encouraged to give feedback and had ample opportunity to do so either formally or informally.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not effectively assess the risk of the spread of infection by completing regular infection control audits. **Regulation 12 (1)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not operate effective systems and processes to assess and monitor the service. Certain clinical audit was not being completed. Risks to the health and safety of people using the service were not identified or assessed. Risks relating to pre-employment checks on staff had not been identified and appropriate action taken. Substances hazardous to health had not been appropriately risk assessed. **Regulation 17 (1)**