Bath Dental Practice Ltd

Pulteney Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found this practice was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

We found this practice was not providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

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

Background

Pulteney Dental Practice is a dental practice is a long established a dental practice in the centre of Bath providing NHS and some private dental treatment and caters for both adults and children. The practice has three dental treatment rooms, a reception and waiting area. The practice is accessed by a flight of stairs with no facilities on the ground floor or enabling access for patients with limited mobility. The provider has an arrangement with another dentist locally that has accessible facilities.

The practice has five dentists, four hygienists and two dental nurses who are supported by one receptionist. The practice's opening hours are 9:00am – 5:00pm Monday to Friday. For out of hours service patients are directed to ring 111.

At the time of inspection the provider was the registered manager and was available in the practice three days a week to provide leadership at this location. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. However the practice did have an appointed practice manager but they were not present on the day of inspection.

We carried out an announced comprehensive inspection on 7 December 2015 because we had received information from NHS England regarding concerns about

Summary of findings

the service provided at this practice by the previous dentist and provider. The inspection took place over one day and was carried out by a lead inspector and a specialist dental advisor.

We obtained feedback about the practice from 19 completed Care Quality Commission comment cards and speaking with eight patients during the inspection. The patients we spoke with were complimentary about the service. They told us they found the practice and staff provided good care; were friendly and welcoming and all patients felt they were treated with dignity and respect. Two patients told us they often had to wait for their appointments and were kept informed during the period of waiting.

Our key findings were:

- The patients we spoke with indicated they were treated with kindness and respect by staff. We observed good communication with patients and their families, access to the service and to the dentists, was good. Patients reported good access to the practice with emergency appointments available within 24 -48 hours.
- There were systems to check equipment had been serviced regularly, including the compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- The practice was not meeting the Essential Quality Requirements of the Department of Health guidance, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' national guidance for infection prevention control in dental practices.
- There was no clear designated lead professional for infection prevention and control. The provider had not addressed the environmental shortfalls in meeting the minimum standards.
- The management of sharps was not in accordance with the current EU regulations with respect to safer sharps (Health and Safety Sharp instruments in Healthcare Regulations 2013).
- There were no systems in place to learn and improve from incidents or healthcare alerts.
- There was no evidence of any recent audits being undertaken at the dental practice.
- Appropriate recruitment processes and checks were not undertaken in line with the relevant recruitment regulations and guidance for the protection of patients.

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

- Ensure the practice fully meets the Essential Quality Requirements of the Department of Health guidance, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' as soon as is practically possible.
- Ensure dental sharps are managed in accordance with the current Health and Safety Sharp instruments in Healthcare Regulations 2013 and staff are appropriately trained.
- Provide training and competency assessment for staff about infection prevention and control and ensure all processes adhere to the national guidance HTM 01-05.
- Ensure appropriate systems are in place to meet health and safety regulations including risk assessment and the reporting and management of accident and incident reporting.
- Plan and implement a system of clinical audits as soon as practically possible for infection control, dental X-rays, clinical record keeping and other such audits as expected by the General Dental Council standards and as advised by the Faculty of General Dental Practice .
- Provide clear leadership, management and governance of the practice and assess service delivery to assure the delivery of quality, patient centred treatment and care, supported by learning and innovation, and promote an open and fair culture.
- Ensure patients privacy and dignity is respected at all times.
- Implement a system whereby all accidents and incidents are appropriately reported and managed for the safety of patients and staff.
- Ensure records of identification checks are included in staff recruitment files and use current DBS checks.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.

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 this practice was not providing safe 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).

Systems, processes and practices were not in place to ensure all care and treatment was carried out safely. The practice did not have in place robust arrangements for managing infection prevention and control at the practice. There were deficiencies in identifying, investigating and learning from safety incidents.

There were sufficient numbers of suitably qualified staff working at the practice however we found the practice had not carried out appropriate checks on staff prior to employment at the practice, for example a Disclosure and Barring check. There were systems and practices in place to keep people safe and safeguard them from abuse.

Equipment used in the practice was maintained and serviced appropriately. Potential risks to the service were not always identified and actions taken to minimise risk for the protection of patients from health and safety hazards within the building.

Are services effective?

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

Patients' needs were assessed and care and treatment was delivered in line with current legislation, the National Institute for Health and Care Excellence (NICE), standards and evidence based guidance. Consent to care and treatment was obtained from patients and recorded appropriately.

There were arrangements in place for working with other health professionals to ensure effective quality of treatment and care for the patient. The practice monitored patients' oral health and undertook full monitoring as outlined in current guidance; with health promotion advice being given to patients. Patients told us treatment options were always explained to them to ensure they could make informed decisions.

The practice maintained appropriate dental care records and patient details were updated regularly. Information was available to patients relating to health promotion including smoking cessation and maintaining good oral health.

Are services caring?

We found this practice was not providing caring services 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).

Feedback from patients indicated staff were friendly, professional, caring and treated patients with dignity. We received feedback from 19 patients via completed Care Quality Commission comment cards and eight patients during the inspection. Patients were complimentary about staff, describing them as friendly, caring, helpful and professional. Patients stated they were involved with their treatment planning and able to make informed decisions.

However during the inspection we observed treatment room doors were open when patients were being treated and conversations could be overheard. These doors opened onto the stair well and people were regularly walking past the doors. For one of the rooms the door was wide open and dental nurses were going in and out during patient treatments to decontaminate their dental instruments while patients were having consultations and treatment.

Summary of findings

Are services responsive to people's needs?

Patients had access to the service which included information available via the practice website. There was a practice leaflet with relevant information for patients. Urgent on the day appointments were available during opening hours. In the event of a dental emergency outside of opening hours details of the '111' out of hours service and local hospital were available for patients' reference.

The practice had made reasonable adjustments to accommodate patients with a disability or impaired mobility.

There were systems in place for patients to make a complaint about the service if required. The practice handled complaints in an open and transparent way and apologised when things went wrong. Information about how to make a complaint was readily available to patients in the reception area and on the organisation's website.

Are services well-led?

We found 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).

There was ineffective leadership locally in the practice and by the provider of the service overall. The practice had ineffective clinical governance and risk management systems. The practice was unable to demonstrate they had a system to ensure all governance arrangements were monitored and documents kept up to date.

The practice had a registered manager in post who is also the provider; however they were only in the practice three days a week. We were told there was a limited leadership structure and staff were not aware of who took responsibility for lead roles. The practice did not operate an audit system to assess and monitor the service and had failed to identify risks associated with infection control issues.

The practice had a limited system for staff communication about practice issues, support and appraisal for staff.

Pulteney Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 7 December 2015. The inspection took place over one day. The inspection was led by a Care Quality Commission (CQC) inspector. They were accompanied by a dentist, specialist advisor.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England and the local Healthwatch, to share what they knew about the practice. We did not receive any information of concern from them regarding this provider.

During our inspection visit, we reviewed policy documents and staff records. We spoke with eight patients, seven members of staff and the service provider. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment.

We observed the dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area. Patients gave positive feedback about their experience at the practice.

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

There was not an effective system in place for reporting and learning from incidents. We were told there had been an incident when sterilised instruments had been left to cool by an open window and had fallen out of the window. The member of staff told us they reported the incident verbally to the provider but had not documented the incident. The provider told they were unaware of the incident. We were shown there was a policy for staff to follow for the reporting of incidents however staff were unaware and the provider had not ensured it was followed. We observed therefore there was no learning from incidents and staff told us they were not sure about the reporting system.

We were told staff meetings were convened for information sharing and to inform the running of the practice, however they were always on days when at least one practitioner was not working in the practice. We saw there had been minutes of the staff meeting s that had been taking place monthly since September 2015. These minutes demonstrated clinical and practice issues were discussed and information shared among those present. We saw and were told the dental hygienists were not invited to the meetings and there was no system in place for sharing of the information discussed with members of staff who were not present.

There were no processes in place for safety alerts to be received and shared with staff in the practice. For example they had not displayed the alert from NHS England relating to the Ebola outbreak.

There had not been any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013) incidents, within the past 12 months. The provider demonstrated a good understanding of RIDDOR regulations and had the appropriate documents available, if such an incident occurred. There was an accident book and file which were kept in the provider's office and accessed by staff as needed.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. These included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. This information was available in the staff room and surgeries. Staff spoken with were aware of the policy and contact numbers.

It was assumed by staff the provider was the lead person for safeguarding but this was not clearly identified. All staff spoken with told us they had undertaken safeguarding training in the last 12 months, and were able to describe what might be signs of abuse or neglect. However while some certificates were available in a variety of folders there was no overall training matrix to ensure documentary evidence was available to corroborate training had been completed. Staff told us if they had any concerns they would discuss them with the dentist with whom they were working and the provider.

Staff were aware of the practice policy in relation to raising concerns about another member of staff's performance (a process sometimes referred to as 'whistleblowing'). Staff told us they would feel able to raise concerns with the provider.

We were shown the practice had carried out a range of risk assessments in August 2015 but not all risks had been identified or steps taken to address them. The provider told us they would be addressed in their long term plans for environmental alterations to the premises. The provider showed us the plans but there were no clear timeframes when these plans would be implemented. The provider had been talking with us about them for 12 months but had not yet taken any action to implement them. We saw a number of policy documents were not signed or dated for accountability purposes, were downloaded from websites but not personalised to the practice or out of date and did not always reflect most recent guidance.

The treatment of sharps and sharps waste was not in accordance with the current Health and Safety Sharp instruments in Healthcare Regulations 2013 legislation with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. We found there was no protocol in place to reduce the risks from unintentional inoculation of infected material from needles and other sharp instruments used in dental practice in accordance with the EU directive.

There were no measures in place with respect to the use of safer syringes or any awareness by the staff such systems

should be in place. The practice did not have a needle stick injury procedure available for staff. Although a dental nurse we spoke with demonstrated an understanding of managing a sharps injury which included the Occupational Health requirements in the legislation and where to go to obtain blood tests and remedial treatment following a contaminated sharps injury. Sharps containers were assembled and labelled correctly.

The practice followed some national guidelines about patient safety. For example, the practice used a rubber dam for root canal treatments. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Medical emergencies

The practice held emergency medicines, in line with guidance issued by the British National Formulary, for dealing with common medical emergencies in a dental practice. These medicines were all in date. The practice had an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). Oxygen and other related items, such as manual breathing aids, were also available. The emergency medicines and equipment were stored in a central location known to all staff.

Records showed weekly checks were carried out to ensure the equipment and emergency medicines were safe to use. Staff had attended their annual training in emergency resuscitation and basic life support as a team within the last 12 months. The dental team practiced specific medical emergency scenarios to support them to respond quickly to medical emergencies and to practise using equipment.

There were no members of staff who were trained in first aid and the equipment in the first aid box went out of date in 2013. The provider and staff were unaware of this.

There was a business continuity policy and disaster recovery document that indicated what the practice would do in the event of situations such as a temporary or prolonged power cut and loss of the practice premises.

Staff recruitment

The practice staffing consisted of five dentists, four hygienists two dental nurses and one receptionist from an agency.

The practice recruitment policy and procedure outlining how staff were to be recruited for the safety of patients did not reflect the requirements as outlined in Schedule 3 Regulation 19 of the Health and Social Care Act 2014. We review 2 staff records and found the recruitment checks completed for each person were variable. Neither of the staff files contained all the required recruitment information as specified in the relevant regulations.

In the two staff files seen one contained an old Disclosure and Barring Service (DBS) certificate dated June 2013 and which had been obtained from a previous employer and was not portable. In the second file there was no DBS certificate or record of a DBS number following a check. The staff files seen did not have all the required documents to demonstrate safe recruitment practices had been undertaken and completed. On the day of inspection the practice had an agency receptionist working with them who had no means of identification and the practice had not checked their identity when they arrived for work. In discussion with the provider who requested agency staff we ascertained none of the recruitment check information was sought from the agency prior to employing agency staff either receptionist or dental nurse.

We were told and saw documentary evidence all qualified clinical staff were registered with the General Dental Council (GDC). We spoke with the newly recruited staff who told us they had received an induction but for one of them it had not adequately covered key information they needed to know for their role.

Monitoring health & safety and responding to risks

Potential risks to the service were not always anticipated and planned for in advance to ensure patient and staff safety. We saw there was a health and safety policy in place. Fire extinguishers were serviced annually. The practice did not have any fire alarms but smoke detectors which we were told were checked regularly, however there was no documentary evidence to support this. There was no fire risk assessment for the practice. Staff told us they had not received fire training, as stated in the fire policy and there was no evidence fire drills or fire evacuations were held at regular intervals and recorded to mitigate risks to patients and staff.

There were limited arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to

control substances which are hazardous to health. The provider told us there was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified, however it could not be found in the practice or on the computer systems. COSHH products were securely stored. There was no clearly identified person with responsibility for maintaining the file and disseminating information about how to minimise the risks associated with any new products, to staff before they were used. This demonstrated a lack of systems to monitor health and safety and mitigate risks associated with hazardous substances.

Infection control

The practice had an infection control policy which was out of date and staff were unaware of its contents to minimise cross infection risks. None of the staff was clear about who was the named lead person for infection prevention and control it was assumed it was the provider but there was no lead nurse.

There were not effective systems in place to reduce the risk and spread of infection within the practice. We found there were deficiencies which demonstrated HTM 01 05 Essential Quality Requirements for infection control were not being met. (National guidance for infection prevention control in dental practices - Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05). The practice had an out of date (2009) copy of this guidance document.

All staff members spoken with told us they were aware of the guidance document HTM 01-05. However they were not aware the decontamination processes they were following were not fully in line with the guidance. For example they were not aware it was poor practice to be decontaminating instruments in a surgery where treatment was taking place. We were also told sterilised instruments that were cooling were left uncovered by an open window which led onto the street. Therefore the instruments were incorrectly stored thus desterilising them through aerosol contamination.

The practice did not have a decontamination room and all decontamination from the three surgeries was undertaken in one surgery. The hygienist working is this surgery continued to treat patients within the aerosol area while instruments were being scrubbed clean and sterilised. Additionally there was no written policy or protocol to direct staff not to decontaminate instruments while a patient was being treated. None of this meets the essential requirements of HTM 01-05. In discussion with two members of staff we were told they had to decontaminate when patients were being treated as they did not have enough instruments in each surgery. Staff spoken with told us they had never run out of instruments but had been very low and borrowed from other surgeries.

In discussion with staff members we were told there were no recorded daily checklists for preparing the surgeries or closing them down. The staff members we spoke with were able to describe the correct process however it was not possible to evidence this was followed for the safety of patients. There were no records the practice was testing the quality of the water in the dental unit water lines. This does not meet the requirements of HTM 01-05. We reviewed records of the checks and tests carried out on the autoclaves and the records were in line with current national guidance.

A legionella risk assessment for the practice had not been completed as required by HTM 01-05. [Legionella is a bacterium found in the environment which can contaminate water systems in buildings].

We were told no audit of the infection control processes had been completed in accordance with HTM 01 05 guidelines. Regular audit recommended by HTM 01-05 to monitor the quality of the systems and processes in relation to infection control. We found although staff told us they had received recent update training in infection control they were either not fully conversant with the essential requirements of HTM01-05, or felt unable to challenge poor practice and implement their learning and their awareness of the essential standards.

It was noted the waiting area and reception were generally visibly clean. However we observed the chairs in the waiting room while clean were cloth covered and did not comply with the code of practice and HTM 01-05. It was also observed the dental chair in one surgery had three tears in the covering fabric providing a potential for cross infection. Also in one surgery the washable flooring was cracked in the clinical area and part of the surgery was carpeted. This does not meet with HTM01-05.

Are services safe?

There were sufficient stocks of personal protective equipment such as gloves, face masks and aprons and staff observed and spoken with demonstrated they used this equipment appropriately for the patient's or their own protection.

The practice abided by the current Department of Health guidelines regarding the segregation and storage of dental waste. The treatment of sharps waste was in accordance with current guidelines. We saw that sharps containers were correctly labelled and in good condition. Practice staff understood the policy regarding needle-stick injuries and staff files reflected that they had all received inoculations against Hepatitis B. The practice used an appropriate contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

We observed the cleaning cupboard was cluttered and dirty.

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the compressor, autoclaves, X-ray equipment and fire extinguishers. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out as evidenced by stickers on plugs. However there was no supporting documentation to demonstrate regular checks by a competent person to ensure the on going safety of appliances.

The practice had policies and procedures regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The dentists used the on-line British National Formulary to keep up to date about medicines. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored safely and staff kept a detailed record of stock in each treatment room.

Prescriptions pads were stored securely and details were recorded in patients dental care records of all prescriptions issued.

Radiography (X-rays)

Radiography equipment was available in all of the five treatment rooms.

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The practice had a copy of local rules for each surgery. There was a radiation protection file however it had not been maintained in line with these regulations. The file did not include the critical examination packs for all X-ray sets used in the practice. There was no evidence in it of acceptance testing for new installation of X ray sets and the three-yearly maintenance logs were not available.

We saw evidence for one member of staff who had completed radiation training but there was no evidence to demonstrate other members of staff were trained and safe to use the x-ray equipment.

We reviewed of dental care records where X-rays had been taken. These records showed dental X-rays were justified, quality assured and reported upon. The practice had not carried out an audit of their X-ray performance within the last three years in accordance with national radiological guidelines

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The practice had policies and procedures in place for assessing and treating patients using the basic periodontal examination (BPE). We found the dentists regularly assessed patient's gum health and soft tissues which included the lips, tongue and palate. Patients attending the practice for a consultation received an assessment of their dental health after providing a medical history covering health conditions, current medicines being taken and whether they had any allergies.

Patients' dental recall intervals were determined by the dentist using a risk based approach based around current National Institute for Health and Care Excellence (NICE) guidelines. The NICE dental recall clinical guideline helps clinicians assign recall intervals between oral health reviews which are appropriate to the needs of individual patients.

Patients requiring specialised treatment such as conscious sedation were referred to other dental specialists or the local hospital. The practice then monitored patients after being referred back to the practice to ensure they received a satisfactory outcome and all necessary post procedure care.

We reviewed completed comment cards that had been supplied to the practice by the Care Quality Commission (CQC), 19 patients provided feedback about the service. All of the comments were positive about the service they had received. Patients commented the service was efficient, staff were friendly and helpful and the dentists were excellent and very professional. We also spoke with eight patients during the inspection who corroborated these views.

Health promotion & prevention

The waiting room and reception area at the practice contained a wide range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. This included information about how to maintain good oral hygiene both for children and adults and the impact of diet, tobacco and alcohol consumption on oral health. Patients were advised of the importance to have regular dental check-ups as part of maintaining good oral health.

Staffing

The practice had five dentists, four hygienists, two dental nurses and a receptionist.

All staff were trained appropriately and registered with their professional body. They maintained their skill levels by means of continuing professional development (CPD); this is a compulsory requirement of registration with the General Dental Council (GDC) as a dental professional. We examined staff files and they showed details of the number of hours undertaken and training certificates obtained for each member of staff.

We saw the practice induction process for new staff included all aspects of health and safety and included fire safety, medical emergencies, infection control and decontamination procedures. The staff we spoke with confirmed some, but not all of this had been covered when they commenced work in the practice but there was no documentary evidence to confirm this.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. This included referral for specialist treatments such as conscious sedation and patients who required orthodontic treatment.

Consent to care and treatment

We discussed the practices policy regarding consent to care and treatment with staff. We saw evidence patients were presented with treatment options and consent forms which were signed by the patient. The dentists we spoke with were also aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge.

We saw in patient records and advice sheets the practice were aware of the need to obtain consent from patients and this included information regarding those who lacked capacity to make decisions. However staff had not yet received Mental Capacity Act 2005 (MCA) training. The MCA

Are services effective?

(for example, treatment is effective)

provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them. The clinical staff had limited understanding of the meaning of the term mental capacity and were not able to describe to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patient's privacy, dignity and providing compassionate care and treatment. During our inspection, we observed patients attending in person or calling the practice by telephone were greeted warmly and spoken to politely and in a caring manner.

Staff confirmed that should a confidential matter arise the patient would be seen in a treatment room away from reception.

Patients told us they felt their privacy was respected during consultations and treatments. However we observed doors to two treatment rooms were open to public areas when patients were being treated. One of these was only open on one occasion. The other treatment room door was open to the stair well and people were regularly walking past the doors. For one of the rooms the door was wide open and dental nurses were going in and out during patient treatments to decontaminate their dental instruments and while patient's were having consultations. So conversations could be overheard from these rooms and patients observed having treatment.

A data protection and confidentiality policy was in place. This policy covered disclosure of, and the secure handling of patient information. We observed the interaction between staff and patients and found confidentiality was being maintained. We saw patient records, both paper and electronic were held securely.

We reviewed completed comment cards that had been supplied to the practice by the Care Quality Commission (CQC), 19 people provided feedback about the service. All of the comments were positive about the service they had received. Patients commented the service was efficient, staff were friendly and helpful and the dentists were excellent.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected. Staff described to us how they involved patients relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Dental care records we looked at reflected this.

Patients were given a copy of their treatment plan and associated costs. This gave patients clear information about the different elements of their treatment and the costs relating to them. They were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was open from 9:00am – 5:00pm Monday to Friday. Staff told us the appointment times were reflective of patients' needs. Patients who provided feedback were satisfied with the opening times.

The practice provided patients with information about the services they offered on the practice website and in the waiting room. The services provided include preventative advice and treatment and routine and restorative dental care together with oral health promotion and orthodontic treatments**.**

Patients we spoke with told us they had flexibility and choice to arrange appointments in line with other commitments. We observed the practice arranged appointments for family members at consecutive appointment times for their convenience.

Patients booked in with the receptionist on arrival who kept patients informed if there were any delays to appointment times.

Tackling inequity and promoting equality

Staff told us the patient population was quite diverse. The receptionist told us they took account of the varying needs of patients and made reasonable adjustments to ensure all patients had equal access to the service. Staff told us they had access to translation services via an online translation service and this included providing information in other languages if required.

The practice was only accessible via a flight of stairs. They provider told us they had an arrangement with another practice locally for patients with mobility issues who could not access their practice. Staff we spoke with told us for patients who were shaky using the stairs or required some assistance for their safety they would always walk with them on the stairs. The provider told us they had not had a Disability access assessment done in accordance with the Disability Discrimination Acts (DDA) of 1995.

Access to the service

The practice had a comprehensive website with information about their services, treatments, opening times and contact details. Opening times were displayed on the website as well as on the practice door. There was a patient leaflet with detailed information for patients outlining treatment costs and services.

Staff told us patients were seen as soon as possible for urgent care during practice opening hours and this was normally within 24 hours. Appointments were available each day to accommodate this. CQC comment cards reflected patients felt they had good access to routine and urgent dental care. There were clear instructions in the practice and via the practice's answer machine for patients requiring urgent dental care when the practice was closed.

If patients required an appointment outside of normal opening times they were advised to call the NHS 111 service. The details of the service were on the practice answer machine message and contact numbers were also displayed on the practice website and by the entrance to the practice.

The practice supported patients to attend their forthcoming appointment by having a reminder system in place. This included telephoning and texting patients as a reminder. Patients we spoke with told us this was very helpful.

Concerns & complaints

The practice had a complaints procedure that explained to patients the process to follow, the timescales involved for investigation and the person responsible for handling the issue. It also included the details of other external organisations that a complainant could contact should they remain dissatisfied with the outcome of their complaint or feel that their concerns were not treated fairly. Details of how to raise complaints were included in the practice leaflet given to all new patients and accessible in the reception area. Staff we spoke with were aware of the procedure to follow if they received a complaint.

There had been no complaints recorded in the past year.

Are services well-led?

Our findings

Governance arrangements

The registered manager with the CQC was also the provider. We saw and evidenced there was an overall lack of clear systems and process to effectively lead and manage the practice.

There was a variety of policies, policy statements and other documents the practice used to govern activity. For example, the fire policy, the equality and diversity policy statement as well as the complaint policy. We looked at a number of these documents and saw several were not dated so it was not clear when they were written or when they came into use. Other policies seen were dated but not signed for accountability purposes and did not contain current best practice guidance for the safety of patients. The practice was unable to demonstrate they had a system to help ensure all governance documents were kept up to date.

We asked the provider about the fire safety of the practice and were told no fire risk assessment of the building had been completed. We identified you had smoke detectors, however there were no records to demonstrate these were regularly tested to ensure they were in working order for the safety of patients and staff.

We observed there was no risk assessment for the management of sharps or compliance with the latest EU directive of 2013. This demonstrated there were no systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Leadership, openness and transparency

There was ineffective leadership locally in the practice and by the provider of services overall. There was a limited system of clinical governance in place to underpin the quality of clinical care provided by the practice however it was not being managed effectively.

Staff showed little awareness of current guidelines with respect to infection control, and the importance of clinical audit in monitoring the quality of care provided. The provider told us they were aware of a number of gaps in the governance of the practice but had not yet been able to recruit a practice manager and had been concentrating on clinical issues.

We heard from staff there were practice meetings and saw minutes had been recorded of the meetings in which clinical and practice issues were discussed. However there was no clear pathway for ensuring practice staff who were not present at the meeting received the information discussed for the safety of patients.

There were no clearly defined leadership roles within the practice and staff assumed the provider took the lead role in all required areas. However the provider told us they are only in the practice three days a week and no arrangements had been made for others to take the lead roles when he was not available.

We were shown the practice had a number of policies which included guidance about confidentiality, record keeping, incident reporting and consent to treatment. Staff we spoke with knew where to find these policies if required.

Staff told us they enjoyed their work and working at the practice but were aware of the lack of a practice manager and the large amount of work the provider had to address. In discussion with the provider during the inspection and immediately afterwards they told us they placed a high priority on maintaining standards of care through the provision of a skilled clinical team, robust administrative support and the maintenance and renewal of the practice premises to reflect best practice guidance. They were committed to maintaining a quality of service provision in the practice and implementing new research and guidance. The provider showed us plans for environmental changes to address some of the shortfalls identified but did not have a time frame for them to be implemented.

Management lead through learning and improvement

All clinical staff told us they were up to date with their continuing professional development (CPD) requirements; however there was limited documentary evidence to corroborate their comments. Staff told us they were supported in their learning through the on going provision of training in the practice. Staff told us they had been provided with the mandatory training in infection control

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and dealing with emergencies in dental practice. One member of staff told us how they had been supported by the provider to update their knowledge and skills in relation to their role.

We found there was no programme of clinical and non-clinical audits taking place at the practice. Normally this would include important areas such as infection prevention control, clinical record keeping, and X-ray quality. While staff were aware of how to undertake an audit due to the lack of leadership and clearly defined roles staff did not have a sense of responsibility to work with the provider to ensure standards of service were monitored and any identified shortfalls addressed.

The practice demonstrated they had recently commenced a system of appraisal for staff working in the practice. We were shown appraisal documents for two staff which demonstrated support and areas for development.

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

The practice carried out patient satisfaction surveys on an on-going basis. Results were analysed monthly. We reviewed the results of recently completed forms and they were very positive.

Staff we spoke with confirmed their views were sought about practice developments through the staff meetings. They also said the provider was approachable and they could go to them if they had suggestions for improvement to the service.

During our feedback to the provider at the end of the inspection he told us he would be taking action to address the issues and concerns identified in the inspection for safety and well-being of patients and staff.

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 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: 10(2) the provider must ensure the privacy, dignity and respect of all service users. The provider must ensure treatment room doors are closed during patient consultations and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: 19(2)(3)(a) Schedule 3 - People who use services and others were not protected against the risks associated with recruitment processes The provider must evidence they employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role and to enable them to provide the regulated activity.

This section is primarily information for the provider

Enforcement actions

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: 12(2)(h) The provider was not: assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

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: Regulation 17(1)(2)(a)(b)(c)(d)(e)(f). Systems and processes were not established or operated effectively to ensure compliance with the requirements in this Part (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 20014). The provider did not have systems and processes in place to enable the: assessment, monitoring and improvement of the quality and safety of the services provided in the carrying on of the regulated activity. Experiences and risks for service users were not assessed, monitored and mitigated in relation to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider must evaluate and improve their performance in respect of the processing of the information referred to in sub-paragraphs (a) to (e).