Sharma Family Ltd

Irby Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 February 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 not 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

The practice is situated in Irby village, Wirral. The practice has two dentists, two dental hygienist/therapists, two qualified dental nurses, one of which acts as a receptionist and practice manager also. The practice provides primary dental services to private patients only. The practice is open:

Monday, Tuesday, Thursday 8.30am – 5pm

Wednesday 9am - 5pm

Friday 8.30am – 4pm

The principal dentist is the registered manager. 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.

We received feedback from 25 patients about the service. The 23 CQC comment cards seen and two patients spoken to reflected positive comments about the staff and the services provided. Patients commented that the practice appeared clean and tidy and they found the staff very caring, friendly and professional. They had trust and confidence in the dental treatments and said

Summary of findings

explanations from clinical staff were clear and understandable. Urgent or emergency appointments were available within 48 hours and appointments usually ran on time.

Our key findings were:

- The practice recorded and analysed accidents and complaints and would cascade learning to staff when they occurred. However there had been no recorded complaints or significant events recorded in the last 12 months.
- Staff had received safeguarding training and knew the process to follow to raise any concerns.
- There was a limited number of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies, however emergency medicines and emergency equipment was not suitable.
- Improvements were needed to infection prevention and control procedures.
- Patients received explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and their confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice staff worked as a team; however they lacked support for undertaking their roles and with professional development.
- The practice took into account any patient comments and used these to help them improve, however no formal system for obtaining feedback from patients was in place.
- The practice did not have a structured plan in place to audit quality and safety of services provided. The policies and procedures were not localised to the practice or updated in line with current legislation and guidance.

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

- Ensure fire safety training, fire risk assessments and regular fire drills take place.
- Ensure they comply with relevant patient safety alerts and recall notices issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS).
- Ensure infection prevention and control policies and procedures are implemented that follow the Department of Health's Code of practice about infection prevention and control of healthcare associated infections (Health and Social care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and related guidance) and the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)
- Ensure audits of various aspects of the service, such as radiography, infection control and dental care records are undertaken at regular intervals to help improve the quality of the service. The practice should also ensure all audits have documented learning points and the resulting improvements can be demonstrated.
- Ensure a system is implemented by which patient views are obtained and analysed and used to help improve services.
- Ensure that their audit and governance systems are implemented and remain effective.

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 consider:

- Reviewing the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'.
- Assessing the risks to patients and implementing preventative measures when undertaking root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Reviewing at appropriate intervals the training, learning and development needs of individual staff members and establish an effective process for the on-going assessment, supervision, training and development of all staff.
- Reviewing the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Summary of findings

- Reviewing the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Reviewing the practice's recruitment policy and procedures to ensure appropriate Disclosure and Barring Service (DBS) checks, character references for new staff and proof of identification are requested and recorded suitably and maintain accurate, complete and detailed records relating to employment of staff.
- Implementation of a paper records storage system that meets health and safety and fire regulations in accordance with the Department of Health's code of practice for records management (NHS Code of Practice 2006) and other relevant guidance about information security and governance.
- Implementation of a comprehensive business continuity plan and make it readily available to all staff.
- Reviewing staffing requirements to ensure adequate numbers of suitably qualified and skilled staff work at the practice to meet the needs of patients and ensure suitable cover is available in times of staff absence.
- Reviewing the need for suitably trained first aiders to be present at all times during the practice open hours.
- Reviewing the support mechanisms for staff to ensure they are supported professionally and in training and development and are able to access supervision and support for their role.
- Publishing a practice information leaflet to inform patients of the services offered, costs, staffing and the complaints procedure. Publicise information for patients on how to access emergency dental care out of normal practice working hours.

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 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 at the end of this report).

The practice had a system in place to record accidents and complaints and staff were aware of their responsibilities to report incidents under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) – this regulates the statutory obligation to report deaths, injuries, diseases and dangerous occurrences, including near misses that take place in the work place or in connection with work). We saw that accidents were recorded and procedures were in place for recording and analysing significant events, However there had been no significant events reported in the last year. Safety alerts were received by the practice however there was no evidence of action taken in response to safety alerts.

Infection prevention and control policies and procedures were in place, however these were generalised and not localised to the practice. There was no evidence of the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and the Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance. Regular infection prevention and control audits did not take place. Staff training in infection control was basic and not updated regularly. We found sterilised instruments had not been dated with a processed or expiry date.

The dental X-ray units were suitably sited and used by trained staff. Local rules were not displayed where X-rays were carried out as required by the Ionising Radiations Regulations 1999. The radiation protection file did not contain details of the radiological protection advisor, local rules or a radiological risk assessment. However during the course of the inspection the practice provided us with evidence of these.

We found that emergency medicines and equipment in use at the practice was not complete and therefore not fit for use. The practice responded and we saw evidence that they had immediately ordered an appropriate emergency medicines kit, oxygen, an automated external defibrillator and other equipment to support emergency situations.

There was limited numbers of suitably qualified staff working at the practice. In the case of absence staff covered each other and as a consequence full cover for reception and dental nurse duties was not provided.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

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

Patients received an assessment of their dental needs including recording and assessing their medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained. The practice kept dental records of oral health assessments; treatment carried out and monitored any changes in the patients' oral health. The practice promoted good oral health and provided regular oral health advice and guidance to patients.

Summary of findings

Generally National Institute for Health and Care Excellence (NICE), national best practice and clinical guidelines were considered in the delivery of dental care and treatment for patients. The treatment provided for patients was effective and focussed on the needs of the individual. Patients were referred to other services in a timely manner.Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration with regards to their continuing professional development (CPD).

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patients spoke highly of the care and treatment given. We found that treatment was clearly explained and patients were provided with information regarding their treatment and oral health. Patients who were nervous or anxious about attending the dentist were cared for with compassion that helped them feel more at ease.

Are services responsive to people's needs?

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

The practice was aware of the needs of their patients and took these into account in how the practice was run. Patients had access to convenient appointments at the practice and emergency/urgent appointments were available within 48 hours. There were good dental facilities in the practice and there was adequate maintained dental equipment to meet patients' needs. Appointment times were convenient and met the needs of patients. The practice was accessible and accommodated patients with a disability or lack of mobility. Treatment rooms and a disabled accessible toilet were located on the ground floor.

There was a complaints system in place however no formal complaints had been logged in the last 12 months.

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).

There was a leadership structure evident. Staff felt supported by the manager and could speak to the dentists for advice. Training took place on an ad hoc basis however there was no evidence of a training and development plan in place and clinical support and supervision for staff was not accessible.

Staff attended documented meetings and had discussions on an informal basis. However meetings were not based on good governance and lacked information exchange such as learning from significant events, complaints and audits.

There was a lack of patient and staff feedback mechanism. No patient or staff surveys were undertaken.

The practice had poor governance and risk management structures in place. There was no clinical audit program in place. Some basic environmental risk assessments had been undertaken; however fire and radiological risk assessments were not in place. The practice arranged to have these undertaken following our visit.

Irby Dental Surgery

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.

The inspection took place on 9 February 2016 and was conducted by a CQC inspector and a dental specialist advisor.

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included any complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed information we held about the practice and found there were no areas of concern. During the inspection we spoke with a dentist, dental nurse and the receptionist /practice manager. We reviewed policies, procedures and other documents. We reviewed 23 CQC comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice and spoke to two patients on the day of inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to report accidents, health and safety events and complaints. We found that there had not been any significant clinical events reported in the last two years however staff were aware of how to report accidents and incidents. The dentist we spoke with had a basic understanding of their responsibilities under the Duty of Candour.

We were told that patient safety alerts were received by the practice and disseminated to relevant staff. However there was no evidence to demonstrate these had been actioned. We found that in the case of the safe use of window blinds this had not been actioned and no risk assessment was in place to demonstrate the practice had considered the risks associated with their window blinds.

Reliable safety systems and processes (including safeguarding)

The principal dentist had a lead role in safeguarding to provide support and advice to staff and to oversee safeguarding procedures within the practice, however they were not present all the time and no deputy had been nominated. The practice had a policy and procedures in place for the protection of vulnerable adults and children. There were guidance flow charts of what to do in the event of concerns regarding child and vulnerable adult abuse, however these weren't localised to the practice. Staff were able to demonstrate that they understood the different forms of abuse and how to raise concerns. Training records showed that most of the staff had received safeguarding training for both vulnerable adults and children to level two. One of the dentists informed us they had undertaken this training however were unable to demonstrate this on the day of inspection.

Dental care records were electronic and contained a medical history that was obtained and updated prior to the commencement of dental treatment and at regular intervals of care. The clinical records we saw contained sufficient detail to demonstrate what treatment had been prescribed or completed, what was due to be carried out next and details of possible alternatives.

Computers were password protected and data regularly backed up to secure storage. Screens at reception were not overlooked which ensured patients' confidential information could not be viewed at reception. However some historic paper records were not stored safely.

We discussed with the dentist and practice staff, the use of rubber dams. A rubber dam is a thin rubber sheet, used in dentistry to isolate the operative site from the rest of the mouth and protect the patient's airway. We found that a rubber dam was not used routinely in root canal treatments. It was not clear or documented in the dental records we reviewed as to whether a rubber dam or alternative precautions were taken in order to protect the patient's airway during the treatment. There were no risk assessments documented.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff received basic life support training annually. Staff we spoke with were able to describe how they would deal with medical emergencies.

The emergency medicines, equipment and oxygen system were not fit for purpose. Emergency medicines stocked were not in line with the Resuscitation Council UK and British National Formulary guidelines, and some of the medicines were out of date. Equipment was passed the expiry date and there was no suitable oxygen tubing in place. The practice did not have an automated external defibrillator (AED) as part of their equipment. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). AEDs are recommended as standard equipment for use in the event of a medical emergency by the Resuscitation Council UK.

The practice immediately rectified the concerns and we saw evidence later in the inspection to demonstrate that suitable emergency medicines and equipment including an AED had been ordered and would be delivered urgently.

Staff recruitment

The practice had recruitment procedures in place; however these were not local to the practice. Staff records we reviewed demonstrated that all clinical staff had undertaken a Disclosure and Barring Service (DBS) however

Are services safe?

we noted that two of these had been undertaken for another provider. DBS checks are not transferrable. Clinical staff had evidence of registration with their professional body the General Dental Council (GDC) and appropriate indemnity insurance. The GDC is the organisation which regulates dentists and dental care professionals in the United Kingdom. We found that staff recruitment files generally contained the information required relating to workers.

There were limited numbers of suitably qualified and skilled staff working at the practice. There was only one full time dental nurse and a part time dental nurse/receptionist employed at the practice. This meant that the dental hygienists/therapists were not suitably assisted or chaperoned and when a dental nurse was absent there was insufficient cover to ensure that the dentist operated with assistance at all times.

Monitoring health & safety and responding to risks

A health and safety policy, COSHH assessments, Legionella risk assessments and basic general environmental risk assessments were in place. However there was no fire risk assessment. Fire safety training and fire evacuation drills had not taken place for some time or on a regular basis. The nominated first aider was the principal dentist who was part time. We did not see evidence that they had been suitably trained in first aid and they were not present at the practice all of the time.

We saw records to demonstrate that fire detection and fire fighting equipment such as fire alarms and fire extinguishers were regularly tested.

The practice did not have a business continuity plan in place that staff were aware of. There were contact details for service contractors and other relevant persons.

Infection control

The practice was visibly clean, tidy and uncluttered. The treatment rooms had units and work surfaces that promoted good infection prevention and control. There was an overarching infection control policy and procedure in place. This was basic in detail and not localised to the practice. The policy and procedures did not reflect or refer to current Department of Health's guidance, Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) and the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

General cleaning was undertaken by a cleaner and a cleaning schedule was in place. Responsibility for cleaning the clinical areas in between patient treatments was identified as a role for the dental nurse and they were able to describe how they undertook this.

There was a lead dental nurse for infection control and decontamination in the practice who had received a basic level of training in infection prevention and control. We found that the practice had undertaken an infection control audit in 2013 however there was no evidence of action planning or re-audits to demonstrate compliance with relevant legislation.

We found that there were adequate supplies of liquid soaps and paper hand towels throughout the premises. However one of the treatment rooms did not have a functioning liquid soap dispenser. Posters describing proper hand washing techniques were displayed. There was a policy and procedure for dealing with inoculation /sharps injuries however this was not displayed in appropriate areas where there is a risk of such an injury taking place. Sharps bins were properly located and not overfilled. However some of the sharps boxes were not signed and dated. The practice did not use a safer sharps system in accordance with Health and Safety (sharp instruments in healthcare) Regulations 2013 even though a system was available. A clinical waste contract was in place. Clinical waste was stored securely until collection.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room that was in line with best practice published guidance. Access to this room was not restricted to authorised personnel only. The decontamination room had defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye/face wear.

We found that instruments were being cleaned and sterilised in line with published guidance. On the day of our inspection, the dental nurse demonstrated the decontamination process to us and used the correct

procedures. The practice cleaned their instruments manually. Instruments were then rinsed and examined using an illuminated magnifying glass to enable closer inspection of instruments after cleaning. Instruments were then sterilised in a validated autoclave. At the end of the sterilising procedure the instruments were packaged and sealed, however there was no indication on the packaging of the processed and expiry date in accordance with the recommendations of the Department of Health.

The equipment used for cleaning and sterilising was checked, maintained and serviced in line with the manufacturer's instructions. Daily, weekly and monthly records were kept of decontamination cycles to ensure that equipment was functioning properly. Records showed that the equipment was in good working order and being effectively maintained. There was only one steriliser at the practice and no documented risk assessment or continuity plan in the case of malfunction of the equipment.

Staff were well presented and wore clean uniforms. We saw and were told by patients that they wore personal protective equipment when treating patients. We saw documented evidence that clinical staff had received inoculations against Hepatitis B. People who are likely to come into contact with blood products and are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

The practice had a legionella risk assessment and conducted regularly cleaning of the dental unit waterlines (DUWL) and temperature tests on the sentinel taps in the hot and cold water supplies. A Legionella risk assessment is a report by a competent person giving details as to how to control the risk of the legionella bacterium spreading through water and other systems in the work place.

Equipment and medicines

We found that equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments, the X-ray sets and equipment in the treatment room. There were records of service and maintenance histories for equipment tested.

We found that portable appliance testing (PAT) had been completed in 2011. PAT is the name of a process which electrical appliances are routinely checked for safety. The Health and Safety Executive recommends PAT testing is carried out at regular intervals dependant on the type of electrical item, however this ranges from annually to every three years. The practice sent us evidence to show that a PAT test had been booked.

Emergency medical equipment was not monitored regularly to ensure it was in working order. There were no records of checks carried out. Emergency medicines were not checked to ensure they did not go beyond their expiry date.

Radiography (X-rays)

We noted that local rules were not displayed in areas where X-rays were carried out. Local rules, Health and Safety Executive (HSE) notification, radiation risk assessments and the radiation protection advisor (RPA) contract were not evident in the radiation protection file. A radiation protection advisor must be appointed for a dental practice to provide advice on complying with legal obligations under the Ionising Radiation Regulations (IRR99) and Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 including the periodic examination and testing of all radiation equipment, the risk assessments, contingency plans, staff training and quality assurance programme. These constitute the local rules.

The practice responded immediately and we saw evidence of the RPA contract, HSE notification and local rules later during the inspection.

The maintenance logs for the X-Ray units were within the current recommended interval of 3 years.

The dental care records we saw showed that dental X-rays were not always justified and reported on every time as recommended by the Faculty of General Dental Practice of the Royal College of Surgeons of England. Audits of the quality of radiographs were not undertaken on a regular basis.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The clinical staff were familiar with, and used current professional guidance for dentistry. Patients attending the practice for a consultation received an assessment of their dental health which began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence, and were told by patients, that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and looking for the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Details of the treatment were also documented and included any administered local anaesthetic.

The dentist and patients we spoke with told us that each patient's diagnosis was discussed with them and treatment options were explained. Preventative dental advice and information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures. Where appropriate, referrals to dental hygienists/therapists were made and dental fluoride treatments were prescribed. The patient's notes were updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Patients were referred appropriately and in a timely manner for example in the case of suspected oral cancers and for specialised orthodontic treatments.

We reviewed 23 comment cards and spoke to two patients on the day of inspection. Feedback we received reflected that patients were satisfied with the assessments, explanations and the quality of the treatment.

Health promotion & prevention

The prevention of dental disease was part of the practice's philosophy. To facilitate this philosophy, the practice used the services of dental hygienists/therapists who worked under the prescription of the dentist. They provided a variety of treatments including simple scaling and polishing of teeth to more complex gum treatments for patients suffering from the more aggressive forms of gum disease. They would also provide tailored preventative advice and treatments as necessary.

The waiting room and reception area at the practice contained some 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. The sample of dental care records we observed demonstrated that dentists had given oral health advice to patients. Oral health products such as tooth brushes, inter dental cleaning aids and fluoridated tooth paste were for sale and available at the reception desk.

Staffing

The practice had two dentists, two dental hygienist/ therapists, two qualified dental nurses, one of which also acted as the receptionist and practice manager. We found that the hygienists/therapists worked alone and not with an assistant dental nurse. In the absence of a dental nurse the remaining nurse would act as a chaperone to the dentist and also as receptionist. This was not suitable as it meant that the dentists would on occasions work unassisted. We were told that staff from a sister practice could help out in the case of urgent need, however we found that this did not routinely occur.

Dental staff were trained and registered with their professional body. Clinical staff maintained their continuing professional development (CPD) to maintain their skill levels and had undertaken various role related courses. CPD is a compulsory requirement of registration as a general dental professional and this activity contributes to their professional development.

The practice provided limited access to other update training and training courses. We did not see a training plan or details of what training had been undertaken by which staff except for staffs CPD records. Staff had undertaken annual cardiopulmonary resuscitation training and safeguarding vulnerable adults and children. There was no evidence of staff having been trained in fire safety.

Basic staff appraisals had taken place. Staff told us they would also have informal discussions with the dentists and manager about their performance and any training /development needs.

Are services effective?

(for example, treatment is effective)

Working with other services

The dentist explained how they worked with other services. They were able to refer patients to a range of specialists in secondary and tertiary care services if the treatment required was not provided by the practice.

Consent to care and treatment

Staff we spoke with on the day of our visit demonstrated an understanding of patient consent issues. The dentist understood the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan.

We saw that patients were presented with treatment options. Staff explained how they would obtain consent from a patient who suffered with any mental impairment which might mean that were unable to fully understand the implications of their treatment. They explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area gave privacy and confidentiality was maintained. Treatment rooms were situated away from the main waiting area and we saw that doors were able to be closed at all times when patients were with the dentist and hygienists. Conversations between patients and dentists could not be heard from outside the rooms which protected patients' privacy.

Patients reported they felt that practice staff were kind, helpful and caring and they were treated with dignity and respect at all times. Comments also told us that staff always listened to concerns and provided patients with good advice to make appropriate choices in their treatment.

Staff were clear about the importance of emotional support needed when delivering care to patients who were very nervous or fearful of dental treatment. This was supported by patients' comments reviewed which told us that they were well cared for when they were nervous or anxious and this helped make the experience better for them.

Involvement in decisions about care and treatment

The dentists explained that patients were given time to think about the treatment options presented to them and made it clear that a patient could withdraw consent at any time. Patients told us that they received a good explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan.

Patients' comments told us that the staff were professional and care and treatments were always explained in a language they could understand. Information was given to patients enabling them to make informed decisions about care and treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

The practice did not have a practice information leaflet to detail the range of services offered to patients and which included information in relation to the complaints procedure. The practice provided private dental care. Treatment costs were displayed. The practice's website included information for patients about services and costs.

Each patient contact was recorded in the patient's dental care record. New patients completed a medical history and dental questionnaire. This enabled the practice to gather important information about their previous dental, medical and relevant social/lifestyles history. They also aimed to capture the patient's expectations in relation to their needs and concerns which helped direct dentists to provide the most effective form of care and treatment.

Tackling inequity and promoting equality

The practice had good facilities and was accessible on the ground floor to patients with reduced mobility and those using wheelchairs. Treatment rooms and a disabled accessible toilet were located on the ground floor. Translation services were available for those patients whose first language was not English.

Access to the service

Appointment times and availability met the needs of patients. Patients were able to book in person or by telephone. SMS text messages were sent to patients to remind them of their appointments. Patients were able to get an urgent appointment either on the same day or within 48 hours. The arrangements for obtaining emergency dental advice outside of normal working hours were detailed on the telephone answerphone message but not on the website or door of the practice. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment.

Patients we spoke with and comments we received told us that there were no concerns regarding waiting times and that appointments usually ran on time. Patients commented that they had sufficient time during their appointment for discussions about their care and treatment and for planned treatments to take place.

Concerns & complaints

The practice had a complaint policy and procedure however this was not localised to the practice. It did include the details of 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. Staff we spoke with were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that there had been no formal documented complaints received in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

The practice lacked robust governance arrangements for monitoring and improving the services provided for patients.

The practice did not have a program of clinical audits and did not undertake audits on a regular basis. We saw an infection control audit that had been undertaken in 2013 however this had not been repeated at recommended intervals of six monthly.

There were general environmental and COSHH risk assessments in place; however there was no formal fire risk assessment and fire safety training did not take place annually.

There was a range of policies and procedures in use at the practice. However these were not dated and were not localised to the practice. As a consequence some of the policies, for example the infection prevention and control one, did not reflect relevant national guidelines (HTM 01-05) or were updated to reflect any changes in legislation. Staff were aware of the policies and procedures however there was no indication that they had read and understood them. Policies and procedures were not audited for their effectiveness.

Leadership, openness and transparency

The principal dentist was the leader of the practice however they were not always present or accessible to staff for support. Staff lacked access to suitable supervision and support in order to undertake their role effectively. Staff told us that they could speak with the dentist, manager or other staff if they had any concerns.

Staff were aware of whom to raise any issues with and told us that the dentists and other staff would listen to their concerns.

The practice did not display a statement of purpose. Staff articulated the values of the practice to provide patients with treatment that was in their best interests and provide appropriate oral health advice.

Management lead through learning and improvement

The dentists and dental nurse kept themselves up to date professionally. The dental professionals were registered with the General Dental Council (GDC). The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the UK. Staff told us the practice supported them to maintain their continuous professional development. Appraisals had taken place however these were basic in detail and did not action any personal development needs such as role specific training and core training for the practice.

The practice staff attended training days and sessions. These included basic life support and safeguarding. Although they were able to maintain their own CPD, core mandatory training and an effective practice training plan was not in place.

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

The practice staff told us that patients could give feedback at any time they visited. However there were no formal systems in place such as satisfaction surveys, in order to obtain feedback from patients. There was a complaints policy in place however this was not publicised.

The practice held quarterly documented meetings however these were basic in detail and governance issues did not feature as regular agenda items.

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 **Patients were at risk of unsafe care and treatment because the provider did not have suitable systems in place to assess, manage and mitigate the risks associated with healthcare infection, prevention and control and fire safety.** 12 (1) (2) (a), (b), (h)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems and processes in place to assess, monitor and improve the quality and safety of services provided.** **The provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others.** **The provider did not have effective systems in place to seek and act on feedback from patients and staff** 17 (1) (2) (a), (b), (e), (f)