IDH Limited

Kingswood Dental Centre

Inspection Report

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Date of inspection visit: 18 January 2016
Date of publication: 20/06/2016

Overall summary

We carried out an announced comprehensive inspection on 18 January 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 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 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

Kingswood Dental Centre is situated at one end of the main street in the Kingswood area of Bristol. It has five surgeries a waiting area and reception area. It provides general dentistry, including endodontics and restorative services, to NHS patients, but will also treat private patients. The split is approximately 80% NHS and 20% private treatments There is a car park at the rear of the practice with a provision for 'Disabled Parking'. Wheelchair access to the practice is via the rear entrance to the building and there is a disabled toilet facility.

The practice has five full time dentists and two part time dentists one of whom only worked on Saturday mornings. Supporting the dentists are six qualified dental nurses and a trainee dental nurse; a practice manager and three part time receptionists. The practice also has a dental hygienist two days a week who offers private only treatments.

There is no registered manager at the practice. 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.

Summary of findings

The practice is open Monday to Wednesday from 7.30am - 7.30pm Thursday from 8.30am - 7.00pm Friday 9.00am - 5.00pm and Saturday from 9.00am - 1.00pm. The practice is closed Saturday afternoons and all day Sunday.

The practice had not received any CQC comment cards for patients to complete, prior to our visit, about the services provided. However we looked at the 17 practice feedback forms for the month of November and saw positive comments about the practice and practitioners. In addition we spoke with nine patients on the day of our inspection. Feedback from patients was positive about the care they received from the practice. They commented staff put them at ease, listened to their concerns and they had confidence in the dental services provided. We saw the practice had received eight complaints in the last 12 months which related to poor care and treatment; long waiting times; lack of appointments and unhelpful staff.

Our key findings were:

- The practice mostly carried out oral health assessments and planned treatment in line with current best practice guidance, for example from the Faculty of General Dental Practice (FGDP). Patient dental care records were detailed and showed on-going monitoring of patients oral health for some but not all dentists.
- Dental care records did not always have an up to date medical history recorded and there was limited evidence of preventive practice to maintain and improve patients' oral health.
- There were systems in place to help ensure the safety of staff and patients with regard to safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. However there were ineffective systems to manage the safety of staff and patients in the premises and from equipment used.
- The practice was seen to be clean and tidy; and appeared well organised with instruments correctly stored. There were systems and procedures in place for infection prevention and control. Decontamination procedures in place met the essential requirements as required by legislation.
- Staff were supported to maintain their continuing professional development and had undertaken training appropriate to their roles. However they did not feel well supported in their work.
- Patients commented they felt involved in their treatment and that it was fully explained to them. We reviewed 17 practice feedback cards completed by patients. Common themes were patients felt they received very good care in a clean environment from a helpful practice team.
- The practice had an efficient appointment system in place to respond to patient's needs. Patients were mostly able to make routine and emergency appointments when needed although some feedback seen reported long waiting times and lack of appointments. There were clear instructions for patients regarding out of hours care.
- The dental practice did not have effective clinical governance and risk management processes in place for health and safety management and monitoring the safety and quality of service provision.
- The practice did not have a comprehensive system to monitor and continually improve the quality of the service through a detailed programme of clinical and non-clinical audits.
- The practice did not have an accessible and visible leadership team with clear means of sharing information with staff.

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

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking the regulated activities in a timely way. This to include learning from accidents and incidents and how they are shared with practice staff to mitigate risks and improve safety and quality of service.
- Ensure the training, learning and development needs of staff members are reviewed at appropriate intervals and an effective process is established for the on-going assessment and supervision of all staff employed.

Summary of findings

- Ensure all dental care records are maintained appropriately, including patients medical history, giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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

- Review the practice arrangements for further assessment and referral where high scores for gum disease are found.
- Review the systems and procedures and implement a system to check all staff have completed mandatory training and appropriate continuing professional development.
- Review 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'

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).

There were systems in place to help ensure the safety of staff and patients in relation to safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control and responding to medical emergencies. However no action had been taken to mitigate the risks identified in the practice risk assessments of the health and safety and environmental risks to patients and staff.

There were no clear procedures regarding the maintenance of equipment in order to deliver care safely. In the event of an incident or accident occurring the practice had limited systems for documenting it and no process for investigating, learning from it and sharing it with practice staff.

Are services effective?

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

Most of the dentists kept detailed electronic and paper records of the care given to patients including comprehensive information about patient's oral health assessments, treatment and advice given. There was limited monitoring for changes in patient's oral health. Referrals to specialist services for further investigations or treatment, if required, were slow.

The practice was not always proactive in providing patients with advice about preventative care and supporting patients to ensure better oral health. Patients spoken with and comments received via the practice comment cards reflected most patients were satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced.

Staff we spoke with told us they had accessed training in the last 12 months to maintain their continuing professional development. However they did not have personal development plans which identified specific training to assist them in developing their knowledge and skills.

Are services caring?

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

We reviewed 17 completed practice comment cards and spoke with nine patients on the day of the inspection. Comments were positive about how they were treated by staff at the practice. Patients commented they felt involved in their treatment and that it was fully explained to them by caring and competent staff.

The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

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

Summary of findings

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed. The practice supported patients to attend their forthcoming appointment by having a reminder system in place. Patients who commented on this service reported it was helpful.

The practice audited the suitability of the premises for patients with mobility difficulties and ensured they were able to accommodate them. There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients.

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).

The practice carried out some audits as part of a system of continuous improvement and learning however the results were not acted upon to improve service provision. There were clearly defined leadership roles within the practice. The practice did not always assess risks to patients and staff and the practice manager had not taken action to mitigate identified risks.

The practice had limited leadership and they were not always accessible or responsive. There were no structured arrangements for sharing information across the team, however regular meetings had been held and limited notes taken until November 2015.

The practice had systems in place to seek and act upon feedback from patients using the service.

Kingswood Dental Centre

Detailed findings

Background to this inspection

This inspection took place on 18 January 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector, a second inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We informed NHS England area team we were inspecting the practice; however we did not receive any information of concern from them.

We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

During the inspection we toured the premises and spoke with practice staff including, the dentists, dental nurses and receptionists. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice did not have systems in place to learn from and make improvements following any accidents or incidents. Staff told us accidents or incidents were verbally reported to the practice manager. We were told of a recent sharps injury and saw the accident form which was in the individuals recruitment file. We saw there was no system for logging accidents, incidents or injuries. The form was accessed because one member of staff suggested that the accident form might be filed in the staff recruitment file. The accident form contained the minimum of details and had no information about how the injury happened; how it was handled and if it had been reported to the company according to policy guidance.

The practice did not have an understanding of the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR), however company guidance and policy information was available in the practice. There were no procedures in place for reporting adverse drug reactions and medicines related adverse events and errors. The practice did not maintain a significant event log and some, but not all, events once recorded were sent to the provider's head office for monitoring.

The dentists spoken with told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a reoccurrence. However there were no systems to support this. Staff reported there was a good rapport between most staff at the practice.

The practice demonstrated little response to national patient safety and medicines alerts that affected the dental profession. There was no lead dentist and no evidence the practice manager had reviewed alerts or spoken with staff to ensure they were acted upon.

Reliable safety systems and processes (including safeguarding)

The practice had up to date child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to a flow chart of how to raise concerns and contact details for both child protection and adult safeguarding teams in the local area.

The practice manager was the safeguarding lead professional in the practice and all staff had undertaken safeguarding training in the last 12 months. Staff we spoke with told us they were confident about raising any concerns.

The practice had some safety systems in place to help ensure the safety of staff and patients. The practice used dental safety syringes which had a needle guard in place to support staff use and to dispose of needles safely in accordance with the European Union Directive; Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. However these systems were not always used appropriately as one member of staff had recently received a sharps injury.

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 not feel able to raise concerns with the current manager. They did not know they could contact the Care Quality Commission (CQC) if any concerns remained unaddressed.

We asked to see the practice risk assessments. We were shown the Fire risk assessment that had been completed by the provider's designated person in 2013. This showed all appropriate actions had been taken to mitigate risks. However when we reviewed the Fire Safety folder we saw that at the maintenance check on 15 January 2016 only 99% of fire alarms were working and six of the emergency lights in the building had failed when tested. There were no records to demonstrate if these shortfalls had been reported appropriately and when any action would be taken for the safety and wellbeing of patients and staff.

There was no evidence a Health and Safety risk assessment which related to the premises and equipment had been completed. In discussion with the recently appointed Regulatory Manager we were told there was an imminent date for the stair flooring to be repaired, however other risks would be addressed during the refurbishment planned for June 2016.

Are services safe?

We saw a number of policy documents which reflected current activity in the practice and the most recent guidance from the provider.

Staff recruitment files contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment such as face visors, gloves and aprons to ensure the safety of patients and staff.

Rubber dams were used in root canal treatment in line with guidance from the British Endodontic Society. 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 and fit for use. 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 emergency medicines were within their expiry date. Staff had attended their annual training in emergency resuscitation and basic life support as a team within the last 12 months and told us they felt confident they could use the equipment effectively.

One member of staff was trained in first aid and a first aid box was available in the practice.

Staff recruitment

The provider had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the provider's policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Records confirmed most of these checks were in place but we were not shown evidence that photographic identification had been obtained.

Not all the staff recruitment files and information were all available in the practice. However we looked at the recruitment files in the practice and found all but one file contained appropriate recruitment documentation. The file for the most recently recruited clinical member of staff did not contain a DBS check or risk assessment or their immunisation status for hepatitis B.

Newly employed staff had an induction period to familiarise themselves with the way the practice ran before being allowed to work unsupervised.

The provider had a system in place for monitoring staff had up to date medical indemnity insurance and professional registration 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 United Kingdom. Records we looked at confirmed these were up to date.

Monitoring health & safety and responding to risks

The provider had systems to monitor health and safety however these had not been implemented in the practice. The systems to monitor and deal with foreseeable emergencies had been implemented. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. We were shown records to demonstrate fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly tested. Staff told us fire drills had not taken place.

The provider had a risk management process for the practice manager to implement, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, we saw a fire risk assessment had been completed although appropriate actions had not been taken. This process was not always followed as we saw and were told the fan in the decontamination room was not working and it had been reported to the practice manager some time ago. There was a 'to do' book in which we saw this had been reported but no action had been taken to mend it and staff had not been advised of a date.

Are services safe?

However we did see a log in the decontamination room which had recorded when the washer disinfector had broken down and the date it had been repaired. There was no central log in the practice.

The practice manager from another practice who was helping with the inspection told us the risk assessments would be reviewed annually; however there was no evidence available to demonstrate this had been the case. The practice had a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations; however it was not comprehensive and did not provide information for many of the products used in the practice.

The practice did not have a business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The supplementary practice manager pulled from the company system a record of two episodes in November 2015 when significant events had happened and interrupted the service. There were no records in the practice to demonstrate how these had been managed for the safety and well-being of patients. They had not been reported as required to CQC.

Infection control

The senior dental nurse was the infection control lead professional and they ensured there was a comprehensive infection control policy and set of procedures to help keep patients safe. These included hand hygiene, use of the washer disinfector, ultrasonic bath and where necessary manual cleaning, managing waste products and decontamination guidance. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 -Decontamination in primary care dental practices (HTM 01-05)' and the 'Code of Practice about the prevention and control of infections and related guidance'. These documents and the practice policy and procedures relating to infection prevention and control were accessible to staff. Posters about good hand hygiene, safe handling of sharps and the decontamination procedures were clearly displayed to support staff in following practice procedures.

We looked around the premises during the inspection and found the treatment rooms and the decontamination room appeared clean and hygienic. They were free from clutter and had sealed floors and work surfaces that could be cleaned with ease to promote good standards of infection control. The practice had cleaning schedules and infection control daily checks for each treatment room which had been completed daily. Staff cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards.

There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment for the protection of patients and staff members. Patients we spoke with were positive about the cleanliness of the practice.

The senior dental nurse showed us the procedures involved in rinsing dirty instruments; and in inspecting, cleaning, sterilising, packaging and storing clean instruments. The practice routinely used either a washer disinfector or an ultrasonic washer to clean the used instruments, and then examined them visually with an illuminated magnifying glass to check for any debris or damage before sterilising them in the autoclave (sterilising machine). Staff wore eye protection, an apron and heavy duty gloves throughout the cleaning stages. Sterilised instruments were then placed in sealed pouches with an expiry date.

The practice had systems in place for daily quality testing of the decontamination equipment. We saw, and they told us, they were able to validate the equipment to ensure it was working effectively to clean and sterilise instruments.

Records showed risk assessment for Legionella had been carried out by an external company. (Legionella is a bacteria found in the environment which can contaminate water systems in buildings). This ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise the risk to patients and staff of developing Legionnaires' disease. These included running the water lines in the treatment rooms at the beginning of each session and between patients, water testing weekly and monitoring cold and hot water temperatures each month. Records seen corroborated these actions were being completed.

Are services safe?

The senior dental nurse helped to ensure staff had the right knowledge and skills to maintain hygiene standards. Records showed they carried out staff observations for example regarding hand washing and the correct disposal of clinical waste. They provided staff with on going training to ensure best practice standards were maintained.

The practice carried out some audits to ensure standards were being maintained and to identify areas for further improvement. For example, the self-assessment audit relating to the Department of Health's guidance about decontamination in dental services (HTM01-05) had been completed. This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment.

Records showed a decontamination audit was carried out in October 2015. We were told the audit results indicated the practice was meeting the required standards and had improved from the audit in May 2015 however documentary evidence of this audit was not available. During the inspection we observed the practice was meeting the essential and some best practice standards as required by HTM01-05.

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; however the practice was unable to demonstrate the washer disinfectors had bene appropriately maintained. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out in 2015 by an appropriately qualified person to ensure the equipment was safe to use.

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)

The practice's radiation protection file was maintained in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IR(ME)R). It was detailed and up to date with an inventory of all X-ray equipment and maintenance records**.** X-rays were digital and images were stored within the patient's dental care record. We found there were suitable arrangements in place to ensure the safety of the equipment. For example, local rules relating to each X-ray machine were maintained; a radiation risk assessment was in place.

X-rays were taken in accordance with the Faculty of General Dental Practice (FGDP) good practice guidelines. The justification for taking X-rays was recorded in dental care records to evidence the potential benefit and/or risks of the exposure had been considered and x rays taken had been reported upon. Staff authorised to carry out X-ray procedures were clearly named in all documentation and records showed they had attended training. An X ray audit had been completed in 2015 but there was no evidence to demonstrate results were shared and any learning discussed. There was no planned date for re-audit.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed paper and electronic records of the care given to patients. The supplementary practice manager told us they were slowly moving to all electronic records. We reviewed the information recorded in nine patient dental care records and found they provided comprehensive information about patient's oral health assessments, treatment and advice given. They included details about the condition of the teeth, soft tissues lining the mouth and gums and an extra oral assessment.

For example we saw details of the condition of patients gums were recorded using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were reviewed at each examination in order to monitor any changes in the patient's oral health. However we identified this was not the case for one of the dentists and the provider told us they were working with the dentist to address the issues.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to wisdom teeth removal and in deciding when to recall patients for examination and review. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure every NHS patient gets fair access to quality treatment.

Medical history checks were mostly updated at every visit and patient dental care records we looked at confirmed this. However for two dentists we saw these were never recorded and asked the provider to take action to address these concerns. The other dentists' records included an update about patient's health conditions, current medicines being taken and whether they had any allergies. Patients spoken with and comments received via practice feedback cards reflected patients were satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

Health promotion & prevention

The practice had a focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health toolkit' (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). For example, fluoride applications for children, high concentrated fluoride toothpaste and oral health advice were provided.

The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

The practice provided health promotion information to support patients in looking after their general health using leaflets, posters, and a patient information file and via their noticeboard situated in the waiting room. This included making patients aware of the early detection of oral cancer. Patients we spoke with told us they found the noticeboard and patient information leaflet informative.

Staffing

The practice team consisted of five full time dentists and two part time dentists one of whom only worked on Saturday mornings. Supporting the dentists were six qualified dental nurses and a trainee dental nurse; a practice manager (who was not available on the day of inspection) and three part time receptionists. The practice also has a dental hygienist two days a week who offered private only treatments.

The staff we spoke with told us staffing arrangements were reactive to need and not planned for ahead of time for example when it was known the practice would be busy as in school holidays. The senior dental nurse told us there was an extra dental nurse for several of the pratices in the area and they could call in their services when needed as long as another practice was not already using them. If this were the case they would seek to employ an agency nurse. They were therefore unable to always ensure there were sufficient staff to run the service safely and meet patient needs.

During the inspection we were unable to access the records of all training carried out by staff which was held electronically by the provider's head office, to ensure they had the right skills to carry out their work. Staff told us and we saw some evidence of staff training in the practice

Are services effective?

(for example, treatment is effective)

which demonstrated mandatory training undertaken included basic life support and infection prevention and control. New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The newest member of staff told us this had been very helpful and informative. Dental nurses told us they received day to day support and supervision from the dentists but there was no formal system for this.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an ongoing programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was no appraisal system in place to identify training and development needs. All members of staff spoken with told us they had not received an appraisal. There was no evidence of recent appraisal or personal development plans for members of staff.

Working with other services

The practice worked with other professionals where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. The practice completed a detailed proforma and referral letter to ensure the specialist service had all the relevant information required. Three of the dentists told us they had good access to urgent dental care services and could make telephone contact initially with the specialist service to ensure patients were seen quickly.

Dental care records contained details of the referrals made and the outcome of the specialist advice. However there was no system for tracking referrals to support them to complete referrals in a timely manner and to check the progress of urgent referrals.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded. Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and their responsibilities to ensure patients had enough information and the capacity to consent to dental treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met. Staff had received specific MCA training and had a good working knowledge of its application in practice.

All of the dentists we spoke with were also aware of and understood the use of the Gillick competency test in relation to young persons (under the age of 16 years). The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We reviewed a random sample of nine dental care records. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Consent to treatment was recorded. Feedback in practice comment forms and from patients we spoke with confirmed they were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed 17 completed practice feedback forms and spoke with nine patients on the day of the inspection. Comments from patients were positive about how they were treated by staff at the practice. However three patients had reported poor treatment, delayed referrals and long waits for appointments.

Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients arriving for their appointment and how staff were helpful and discreet to patients on the telephone.

The supplementary practice manager and senior dental nurse told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

The waiting area was adjacent to the reception; however staff were aware of the importance of providing patients with privacy and told us there was a room available if patients wished to discuss something with them away from the reception area. All treatment room doors remained closed during consultations.

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 provided patients with information about the services they offered in the practice leaflet and via the website. The services provided include preventative advice and treatment and routine and restorative dental care**.**

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

The practice is in an ethnically diverse area of Bristol, where a variety of languages other than English are spoken. Non-English speaking patients were mostly accompanied by interpreters but if there was a pre-booked appointment, then a telephone interpreter could be booked. However there were no signs around the surgery in different languages.

The practice had an equality and diversity policy in place and provided training to support staff in understanding and meeting the needs of patients.

The practice had easy access into the building and we saw one of the treatment rooms was on the ground floor which was accessible for patients with reduced mobility. The practice had a disabled patient toilet and a car park to the rear of the building. The surgery had a hearing loop system and a sign-language interpreter was available for a pre-booked appointment. If a patient was anxious about their upcoming treatment, the staff offered a chaperone service, where one staff member would accompany the patient and sit with them during treatment.

Dental care records included alerts about the type of assistance patients required.

Access to the service

The practice is open Monday to Wednesday from 7.30am - 7.30pm Thursday from 8.30am - 7.00pm Friday 9.00am - 5.00pm and Saturday from 9.00am - 1.00pm. The practice is closed Saturday afternoons and all day Sunday.

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. Patient feedback forms reflected patients felt they had good access to routine and urgent dental care. There were clear instructions in the practice and via the practice answer machine for patients requiring urgent dental care when the practice was closed. The out of hour's number was also clearly displayed on the practice door.

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

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. Staff told us they had been able to raise formal and informal comments or concerns with the practice manager but they had not always been acted upon. They did not feel there was anyone else in the company with whom they could speak. Staff told us despite several requests materials and equipment were not easily accessible and they did not feel their requests were responded to appropriately and in a timely manner.

The practice had received eight complaints in the last 12 months. They related to poor care and treatment; patients left in pain; poor organisation of appointments with long waiting times and rude and unhelpful staff. During the inspection we observed and corroborated delayed appointments and one dentist whose records suggested not all care and treatment was completed in accordance with the Faculty of General Dental Practitioners. However we did not observed or corroborate the complaint relating to rude and unhelpful staff as all staff observed were polite and helpful to patients.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was a system in place which ensured a timely

Are services responsive to people's needs?

(for example, to feedback?)

response and sought to address the concerns and effect a satisfactory outcome for the patient. Information for patients about how to raise a concern or offer suggestions was available in the reception area and practice information leaflet.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements in place to ensure risks were identified however they were not managed appropriately. We saw some risk assessments but no control measures had been put in place to manage those risks, for example fire and health and safety. Staff we spoke with were aware of their roles and responsibilities within the practice but did not feel they had access to the necessary systems and documents to wholly fulfil their duties.

Health and safety and risk management policies were in place however the staff were unable to implement actions and processes to ensure the safety of patients and staff members. Staff told us the provider had said these identified risks would be dealt with when the practice was refurbished. However no specified date when this would take place was available.

We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw there were few risk assessments and limited control measures had been put in place where risk assessment had been undertaken. There were limited systems for reporting risks and no management mechanism for ensuring these were followed up and acted upon for the safety and well-being of patients. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members. However not all team members attended team meetings and there was no mechanism for ensuring the information was shared across the practice team.

There we no systems in place to record and learn from incidents and accidents.

There were relevant policies and procedures in place to govern activity. There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them in as far as possible but were not always supported by the practice manager. These included guidance about infection control, confidentiality, record keeping, managing violence and aggression, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service.

There had been monthly practice meetings until November 2015 but no evidence of any since that date. In the minutes of practice meetings seen there was no record to demonstrate practice issues and incidents were discussed or learning identified and disseminated to all staff.

Leadership, openness and transparency

The practice had a statement of purpose that described their vision, values and objectives. Staff told us there was a culture of undue pressure which impacted negatively on staff within the practice and did not encourage candour and honesty. The limited management of the practice impacted negatively on staff, and within their defined roles, as they told us they were not able or fully supported to fulfil them and ensure quality dental care. The supplementary practice manager and dentists told us patients were informed when they were affected by something which went wrong, given an apology and told about any actions taken as a result however the lack of incident reporting processes did not support this .

The reception staff expressed some satisfaction with career development opportunities provided by the surgery. We were told enhanced skills courses included a range of on-line and in-house options were available. For example, the head receptionist attended two reception-focused courses over a three-year period; and another receptionist completed an online course in their role as the surgery's fire marshal.

Although all reception staff claimed they felt supported and well-managed by their immediate line managers. A number of staff expressed their unhappiness with the management of the practice who they experienced as distant and with whom they found it difficult to communicate. Staff also told us they felt additional pressure from senior managers which impacted negatively on their performance and care of patients.

Learning and improvement

The provider had a clear understanding of the need to ensure staff had access to learning and improvement opportunities however staff told us they were not always supported in the practice to access these. Staff working at

Are services well-led?

the practice maintained their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

We saw there was a limited system to monitor and continually improve the quality of the service as few audits had been completed, shared with practice staff and followed up to address issues found. There was no clear programme of clinical and non-clinical audits. However the lead nurse showed us audits of record keeping which had identified issues of concern and required action. They had not been supported by the practice manager to take action to address these concerns for the safety and well-being of patients.

We were shown audits relating to radiographs and the cleanliness of the environment had been completed. Where areas for improvement had been identified in the clinical audits there was no evidence the results of these audits had been shared with practice staff or any learning noted and action taken to implement charge for the protection of patients. There was no evidence repeat audits were planned to monitor improvements had been maintained.

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

The practice had systems in place to seek and act upon feedback from patients using the service which fed into the provider's system of continuous feedback and monthly analysis. We saw the results for this practice which showed approximately 80% of patients were satisfied with the service they received. The practice had a compliments book in the waiting area which had four positive comments recorded for the last year.

Patients were encouraged to complete the NHS Friends and Family Test but no data was available. This is a national programme to allow patients to provide feedback about the services provided.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1)(2)(a)(b) How the regulation was not being met: **Regulation 17** - Good Governance • The provider had not taken action to mitigate fire and health and safety risks identified for the safety of patients and staff. • The provider did not have effective governance, systems in place which assessed, monitored and drove improvement in the quality and safety of services provided.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) How the regulation was not being met: • Staff did not receive regular appraisal of their performance in their role from an appropriately skilled and experienced person.