Queen Street Surgery Limited

12 Queen Street

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 July 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice is located within a renovated property in Colchester Town and offers NHS primary care dentistry and private dental treatments to adult patients and children.

The practice is open and offers appointments for NHS patients between 9am and 4pm on Mondays to Fridays. Patients who pay privately for dental care and treatments can access appointments between 9am and 6pm Monday to Friday and between 8am and 6pm on alternate Saturdays. The practice is closed between 1pm and 2pm for lunch each day.

The dental practice is managed by two dentist partners. The practice employs one associate dentist, three dental nurses, one hygienist who works on Tuesdays and Thursdays, and one receptionist.

At the time of our inspection there was no registered manager. 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. Health and social care providers who are not registered as individuals are required to have a registered manager.

The practice has three treatment rooms, a waiting room and a reception area. Decontamination takes place in a

Summary of findings

dedicated decontamination room (Decontamination is the process by which dirty and contaminated instruments are bought from the treatment room, washed, inspected, sterilised and sealed in pouches ready for use again).

We left comment cards at the practice for the two weeks preceding the inspection. 13 people provided feedback about the service in this way. All of the comments spoke highly of the dental care and treatment that they received and the professional attitude, kindness and understanding of the dentists and dental nurses.

Our key findings were:

- The practice had systems in place for investigating and learning from safety incidents or accidents. Some staff were unaware of their responsibilities to report incidents.
- The practice was visibly clean and clutter free. However Infection control practices were not audited to test their effectiveness.
- There were a number of systems in place to help keep people safe, including safeguarding vulnerable children and adults. The practice had a health and safety policy in place and risks to the health and safety of staff and patients had been assessed.
- The procedures in place to ensure that conscious sedation techniques were carried out safely were not in line with current guidelines.
- Medicines and equipment for use in the event of a medical emergency were not in line with current guidelines.
- Some staff did not have updated training in respect of their roles and responsibilities within the practice.
- Patients reported that they were treated with respect and that staff were polite and helpful.
- Patients were involved in making decisions about their care and treatments.
- The practice provided a flexible appointments system and could normally arrange a routine appointment within a few days or emergency appointments mostly on the same day.
- There were limited governance arrangements in place for the smooth running of the service.
- Patient's views were sought however these were not routinely used to make improvements to the service where these were identified.

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

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. This includes implementing and maintaining effective systems for investigating and learning from complaints, accidents and other incidents, reviewing and monitoring infection control practices, auditing infection control practices and X-rays in line with current guidance, monitoring staff training and development.

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

- Review staff records so that they include details of training and appraisal.
- Review the arrangements for advising patients about the practice complaints procedures and how they can make complaints.
- Review the availability of an interpreter service for patients who do not speak English as their first language.
- Submit an application to CQC for a relevant person to be registered as the manager for the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had systems and processes in place to provide safe care and treatment and to assess and minimise risks. The practice had procedures in place to safeguard children and vulnerable adults. However some staff did not have updated training. All staff who we spoke with were aware of their roles and responsibilities to keep people safe and to report concerns,

The practice offered treatments carried out under conscious sedation. The practice did not follow the revised national guidelines in relation to this and dental nurses who assisted in these procedures had not been appropriately trained.

The practice was visibly clean however infection control procedures were not audited to test their effectiveness. The cleaning and decontamination of dental instruments was carried out in line with current guidelines.

Equipment within the practice was regularly checked, serviced and maintained according to the manufacturer's instructions.

The practice had a range of equipment and medicines for use in medical emergencies. However these were not in line with national guidance. We were told that staff had undertaken appropriate training. However there were no records maintained to demonstrate. Staff we spoke with able to demonstrate that they understood how to use medicines and equipment in the event of a medical emergency.

New staff were appropriately recruited In line with the practice recruitment procedures.

Are services effective?

No action

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

Consultations were carried out in line with good practice guidance from the National Institute for Health and Care Excellence (NICE). On joining the practice, patients underwent an assessment of their oral health and were asked to provide a medical history. This information was regularly reviewed and used to plan patient care and treatment. Patients were recalled after an agreed interval for an oral health review, during which their medical histories and examinations were updated and any changes in risk factors recorded.

Summary of findings

Patients were offered options of treatments available and were advised of the associated risks and intended benefits. Consent to care and treatment was sought in line with current relevant guidelines. Patients were provided with detailed information and a written treatment plan which described the treatments considered and agreed together and the costs involved.

Patients were referred to other specialist services where appropriate and in a timely manner.

The principal dentists and dental nurses were registered with the General Dental Council (GDC) and maintained their registration by completing the required number of hours of continuing professional development activities. However some staff records did not include details of the training that they had recently undertaken or an appraisal of their performance from which personal development needs were identified.

Are services caring?

No action 

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

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. A private room was available should patients wish to speak confidentiality with the dentist or reception staff. Staff had access to policies around respecting and promoting equality and diversity.

Both patients we spoke with said that they were treated with respect and kindness by staff. They said that reception staff were friendly and welcoming and that the dentists were caring and understanding. Comments on the 13 completed CQC comment cards we received also reflected that patients were satisfied with how they were treated by staff. Patients indicated that staff were helpful and treated them with kindness. They said that staff were understanding and sensitive particularly when patients were experiencing pain or anxiety.

Patients said that they were able to be involved in making decisions about their dental care and treatment. They said that they were allocated enough time and that treatments were explained in a way that they could understand, which assisted them in making informed decisions.

Comments on the 13 completed CQC comment cards we received included statements by patients saying they were happy with the care that they received and how they staff treated them.

Are services responsive to people's needs?

No action 

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

Patients could access routine treatment and urgent care when required. Appointments could be booked in person or by telephone. The practice operated

Summary of findings

a triage system to help identify and prioritise urgent same day access for patients experiencing dental pain which enabled them to receive treatment quickly. Patients we spoke with told us that the dentist offered a flexible service including lunchtime appointments.

The practice was open and offered appointments for NHS patients between 9am and 4pm on Mondays to Fridays. Patients who pay privately for dental care and treatments could access appointments between 9 am and 6 pm Monday to Friday and between 8am and 6pm on alternate Saturdays. The practice closed between 1pm and 2pm for lunch each day.

The practice premises were accessible. Staff told us that they were unaware of language translation services available or how to access these.

The practice had a complaints process which was available to support any patients who wished to make a complaint. The process described the timescales involved for responding to a complaint and who was responsible in the practice for managing them. Information about how to raise complaints was displayed within the waiting area, but not available within the patient leaflet or on the practice website. However complaints were not reviewed or used to make improvements where needed.

Are services well-led?

Requirements notice ✖

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

There were some systems for keeping up to date with reviews and changes to current guidance. However these were not always followed. For example the principal dentist was unaware of the updated guidance in relation to treating patients using conscious sedation techniques.

There were limited governance arrangements within the practice to ensure that appropriate systems were in place to monitor and improve the quality and safety of services. However some of these systems and processes were not followed routinely. For example X-ray audits were not carried out as a means to monitor and improve dental care and treatment.

The systems in place for monitoring the quality and safety of practices were not sufficiently robust. For example there was no oversight or measures in place for ensuring that audits and checks such as infection control audits were carried out in accordance with current guidance. There were limited systems in place for investigating and learning from when things went wrong such as complaints, accidents and other incidents

There were no systems in place to ensure that staff undertook relevant training according to their roles and responsibilities within the practice.

Summary of findings

The practice manager had recently left the practice and the principal dentist told us that they were covering lead areas such as infection control and complaints until such time as a new practice manager was appointed. The principal dentist assured us that these audits would be introduced and carried out periodically to identify any areas for improvements.

The practice sought feedback from patients and this was used to improve the quality of the service provided.

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Detailed findings

Background to this inspection

The inspection was carried out on 22 July 2016 and was led by a CQC inspector. The inspection team also included a dental specialist advisor.

The methods that were used to collect information at the inspection included interviewing patients and staff, observations and reviewing documents.

During the inspection we spoke with one of dentist partners, one associate dentist, two dental nurses and three patients. We reviewed policies, procedures and other records relating to the management of the service. We reviewed 13 completed Care Quality Commission comment cards.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures in place to investigate, respond to and learn from significant events and complaints. However some staff who we spoke with were unaware of the practice reporting procedures including their responsibilities under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) or reporting significant events.

We reviewed accident records and found that these were not completed fully and did not for example include details of what actions were taken in the event of needle stick injuries. The principal dentist told us that any safety incidents arising were discussed at the practice meetings, however minutes from these meetings did not include details of accidents or incidents, or any learning arising from complaints or when things went wrong.

The principal dentist was aware of their responsibilities under the duty of candour and there was a policy in place in relation to this. This described if there was an incident or accident that affected a patient they would be contacted and offered an apology and an explanation of what actions had been taken to address the issues.

The principal dentist told us that they received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness. There were systems in place for reviewing, sharing and acting on relevant alerts.

Reliable safety systems and processes (including safeguarding)

The practice had child and adult safeguarding policies and procedures in place. These included the contact details for the local authority's safeguarding team, social services and other relevant agencies. The principal dentist told us that all staff had undertaken safeguarding training; however they could not provide evidence of this for some staff. Staff we spoke with were aware of whom to report concerns to outside of the practice.

The dentists told us they routinely used a rubber dam when providing root canal treatment to patients in accordance with the guidance issued by the British Endodontic Society. A rubber dam is a small square sheet of latex (or other similar material if a patient is latex sensitive) used to isolate the tooth operating field to increase the efficacy of the treatment and protect the patient.

The principal dentist confirmed that the practice did not carry out patient dental care record audits in accordance with the Faculty of General Dental Practice (FGDP) guidance – part of the Royal College of Surgeons that aims to promote excellent standards in primary dental care.

The practice had a whistleblowing policy which the staff were aware of. They told us they felt confident and supported to raise concerns without fear of recriminations.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency. The principal dentist told us that all staff had undertaken training in basic life support and staff who we spoke with confirmed this. There were no certificates available to support. However staff were aware of their roles and responsibilities in relation to this.

The practice had a range of medicines and equipment for use in a medical emergency including the use of an Automated External Defibrillator (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). Some of the emergency medicines were not in line with the 'Resuscitation Council UK' and British National Formulary guidelines. For example the emergency medicines included intravenous Midazolam rather than the buccal format which is recommended for treating epileptic seizures. Other medicines were also for intravenous use such as glucose and not suitable for managing medical emergencies within a dental practice setting. There was no aspirin or glucagon available. The practice had one oxygen cylinder which was also used for carrying out treatments using conscious sedation techniques. There were no measures in place for monitoring its use to ensure that there would be sufficient oxygen available should this be required.

Regular checks were carried out to ensure that emergency equipment was working properly and in date. However we found that paediatric pads were out of date.

Are services safe?

Following our inspection we were provided with documentary evidence that the recommended emergency medicines, paediatric AED pads and additional oxygen for medical emergency use had been purchased and that refresher staff training was arranged for all staff.

Staff recruitment

The practice had a recruitment policy, which included the process to be followed when employing new staff. This included obtaining proof of their identity, checking their skills and qualifications, registration with relevant professional bodies, taking up references and conducting interviews. We reviewed the personnel files for eight members of staff, which confirmed that the processes had been followed. Employment references had been sought, interviews had been conducted and documentary proof of identity obtained in line with the practice recruitment procedure.

We saw that staff had been checked by the Disclosure and Barring Service (DBS). The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We saw that all relevant members of staff had personal insurance or indemnity cover in place. These policies help ensure that patients could claim any compensation to which they may be entitled should the circumstances arise. In addition, there was employer's liability insurance which covered employees working at the practice

Monitoring health & safety and responding to risks

The practice had policies and procedures and risk assessments to cover the health and safety concerns that might arise in providing dental services generally and those that were particular to the practice. There was a Health and Safety policy and risks associated with the practice premises and equipment had been assessed. There was a detailed fire risk assessment and this was reviewed regularly. There were procedures for dealing with fire including safe evacuation from the premises. Fire safety equipment was regularly checked and fire safety procedures were discussed at practice meetings.

The practice had maintained a Control of Substances Hazardous to Health (COSHH) folder. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. We saw the practice had a system in place to regularly update their records which included receiving COSHH updates and changes to health and safety regulations and guidance.

Infection control

The previous practice manager who had recently left the practice had been the infection control lead and the principal dentist told us that they would adopt this role until such time that a new practice manger was employed. There was an infection control policy which was reviewed regularly. The majority of staff had undertaken recent infection control training including decontamination of dental instruments and hand hygiene and training for all staff was scheduled for September 2016. We saw that the practice had not carried an infection control audit within the previous 12 months to test the effectiveness of the infection prevention and control procedures. All staff had access to and used appropriate protective equipment including disposable gloves and protective eyewear.

All areas of the practice were visibly clean and uncluttered. There were systems in place for cleaning in the dental surgery, reception and waiting areas. Cleaning schedules were used and these were maintained and reviewed regularly.

The decontamination of dental instruments was carried out in a dedicated decontamination room. The practice procedures for cleaning and sterilising dental instruments was carried out in accordance with the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01- 05), decontamination in primary care dental practices. We found that instruments were being cleaned and sterilised in line with published guidance (HTM01-05). One dental nurse demonstrated that they followed the correct procedures. The designated 'clean and 'dirty' areas within the decontamination areas were clearly identified and staff followed the work flow from 'dirty' to 'clean' when carrying out decontamination procedures.

Sterilised instruments were correctly packaged, sealed, stored and dated with an expiry date.

We saw records which showed that the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. Appropriate

records were kept of the decontamination cycles of the autoclaves to ensure they were functioning properly. Records in respect of the checks that should be carried out the start and end of each day were also maintained.

There were adequate supplies of liquid soap and paper hand towels in the surgery, and a poster describing proper hand washing techniques was displayed above the hand washing sink. Paper hand towels and liquid soap was also available in the toilet. Gel hand sanitisers were available in the patient waiting area.

The practice had procedures in place for handling sharps including needles and dental instruments, and dealing with needle stick and other sharps related injuries. These procedures were displayed in the dental surgery. However these systems were not robust and some members' staff who we spoke with could not demonstrate that they followed these procedures. For example we reviewed the accident records, which included needle stick injuries were incomplete. Details of actions which should be undertaken were not recorded within the accident record or patients notes, where this was relevant. Records showed that all relevant staff had received inoculations against Hepatitis B. It is recommended that people who are likely to come into contract with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections.

We saw that the sharps bins were being used correctly and located appropriately in the surgery. Clinical waste was stored securely for collection. The registered provider had a contract with an authorised contractor for the collection and safe disposal of clinical waste.

There were effective procedures in place for assessing and managing risks of legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A legionella risk assessment had been carried out at the practice in 2015 and this identified no areas for concern. We found that appropriate measures were in place including hot and cold water temperature monitoring and monthly tests of waterlines to help detect the likelihood of any contamination.

Equipment and medicines

The practice carried out some dental treatments under conscious sedation. (Conscious sedation are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

The practice was meeting some of the standards set out in the guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry, Department of Health 2003. There were procedures in place around areas such as patient information, clinical environment, sedation techniques, peri-operative care and managing complications and recovery. However dental nurses who assisted in conscious sedation techniques had not undertaken relevant training and there were no systems in place to audit these procedures. The principal dentist was not aware of the updated guidance issued in 2015 and, did not have a plan in place to achieve the standard outlined in the 2015 guidance.

The principal dentist told us that these procedures were carried out very infrequently and patient appointments records we were shown confirmed this. The principal dentist confirmed that they would cease treatments under conscious sedation until such time as dental nurses had undertaken the appropriate training and their procedures were reviewed to take into account the updated guidance. Following the inspection the principal dentist informed us that the dental nurses had commenced training.

Portable Appliance Testing (PAT) was undertaken annually for all electrical equipment. (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.) We saw that the last PAT test had taken place in May 2016. The practice displayed fire exit signage and had appropriate firefighting equipment in place, which was regularly checked and serviced.

Records were kept in respect of checks and maintenance carried out for equipment such as the X-ray equipment and autoclaves which showed that they were serviced in accordance with the manufacturers' guidance. The regular maintenance ensured that the equipment remained fit for purpose.

Local anaesthetics, intravenous anaesthetics, antibiotics and emergency medicines were stored appropriately and accessible as needed. There were procedures in place for checking medicines to ensure that they were within their

expiry dates. However there were no systems in place for monitoring prescription pads to minimise the risk of misuse. We found that pre-stamped prescriptions were kept in the dental surgeries and there were no systems for logging their use.

Radiography (X-rays)

The practice had a radiation safety policy in place. There was a radiation protection advisor and supervisor identified to oversee the radiation procedures within the practice. There was a radiation protection file available with information for relevant staff to access and refer to as needed. We were told that the X-ray equipment had been tested and there was documentary evidence to support this.

There were local rules available and displayed in all areas where X-rays were carried out. Local rules state how the X-ray machine in the surgery needs to be operated safely. The dentists and other relevant staff were up to date with their continuing professional development training in respect of dental radiography.

The patient records we reviewed showed that X-rays were justified and graded. However the practice did not carry out audits of their X-rays in accordance with the National Radiological Protection Board (NRPB) guidelines to help ensure that X-rays are appropriately justified and correctly graded to an acceptable standard. We were provided with a log of X-rays which were carried out. These had all been reported as grade 1 (Grade 1 X-ray images are described as excellent with no errors of exposure, positioning or process). There were no reports of grade 2 X-ray images, which are considered diagnostically acceptable, with some errors of exposure, positioning or process but which do not detract from diagnostic utility of the image. We discussed these findings with the principal dentist who agreed that it was very unlikely that these were being reported on and recorded accurately. They told us that they would review the procedures for grading and monitoring the quality of X-ray images.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

New patients to the practice were asked to complete a medical history form which included their health conditions, current medication and allergies prior to their consultation and examination of their oral health with the dentist. The practice recorded the medical history information in the patient's electronic dental care records for future reference. In addition, the dentists told us they discussed patients' life styles and behaviours such as smoking and alcohol consumption and where appropriate offered them health promotion advice. This was recorded in the patient's dental care records. We saw from the dental care records we looked at all subsequent appointments patients were always asked to review their medical history form. This ensured the dentists were aware of the patients' present medical condition before offering or undertaking any treatment. The records showed routine dental examinations including checks for gum disease and malignancies had taken place.

The dentists told us they always discussed the diagnosis with their patients and, where appropriate, offered them any options available for treatment and explained the costs. We saw from the dental care records these discussions took place and the options chosen and fees were also recorded. Patients' oral health was monitored through follow-up appointments and these were scheduled in line with the National Institute for Health and Care Excellence (NICE) recommendations.

Patients requiring specialist treatments that were not available at the practice were referred to other dental specialists. Their oral health was then monitored at the practice after the patient had been referred back to the practice. This helped ensure patients had the necessary post-procedure care and satisfactory outcomes.

Health promotion & prevention

The patient reception and waiting area contained a range of information that explained the services offered at the practice including information on diet, alcohol and tobacco consumption and maintaining good oral hygiene. This information was also available on the practice website. Staff told us that they offered patients information about effective dental hygiene and oral care in the surgery.

The dentists advised us they provided advice in accordance with the Department of Health's guidance 'The Delivering Better Oral Health' toolkit. Treatments included applying fluoride varnish to the teeth of patients who had a higher risk of dental decay. Fluoride treatments are a recognised form of preventative measures to help protect patients' teeth from decay. The dental care records we reviewed confirmed this.

Staffing

The dentists and dental nurses working at the practice were currently registered with their professional body. Staff training records contained documents which showed that they were maintaining their continuing professional development (CPD) to maintain update and enhance their skill levels. Completing a prescribed number of hours of CPD training is a compulsory requirement of registration for a general dental professional.

The principal dentist told us that staff had undertaken an appraisal of their performance with the previous practice manager. However there were no records available to support this and some members of staff who we spoke with could not tell us when they had last had an appraisal. The practice had arrangements in place to provide staff training in areas including safeguarding children and adults, basic life support and infection control. However some staff had not undertaken recent training updates. The principal dentist told us that they were reviewing the practice training arrangements and that they were organising dates for all outstanding refresher training. We were shown a list of training dates for staff in areas including basic life support and safeguarding.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient and in line with NICE guidelines where appropriate. For example, referrals were made to hospitals and specialist dental services for further investigations.

The dentist explained that they would refer patients to other dental specialists for minor oral surgery and orthodontic treatment when required. The referrals were based on the patient's clinical need. In addition, the practice followed the two week referral process to refer patients for suspected oral cancer.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The practice had policies and procedures in place for obtaining patients consent to their dental care and treatment. These procedures included reference current legislation and guidance including the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for acting and making decisions on behalf of adults who may lack the capacity to make particular decisions. Both dentists described how they would obtain consent from patients who they thought would experience difficulty in understanding their treatment and / or consenting to this. The process described was consistent with the provisions of the MCA.

Both dentists demonstrated that they were aware of the need to determine parental responsibilities when obtaining consent in relation to the treatment of children. Regular audits were carried out to ensure that patient consent was obtained and recorded appropriately.

Patients and staff told us that the benefits, complications and risks of the treatment options and the appropriate fees were discussed before treatment commenced. Patient records which we viewed showed that treatment options, intended benefits and potential risks had been discussed with the patients and that consent had been obtained before their treatment commenced. Patients said that they were given time to consider and make informed decisions about which option they preferred. Staff were aware that consent could be removed at any time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The practice had procedures in place for respecting patients' privacy, dignity and providing compassionate care and treatment. If a patient needed to speak to confidentially they would speak to them in a private room or spare surgery.

Staff understood the need to maintain patients' confidentiality. One of the dentist partners was the lead for information governance with the responsibility to ensure patient confidentiality was maintained and patient information was stored securely.

Comments made by patients we spoke with on the day and on the 13 completed CQC comment cards were complimentary about the service received. People told us that the dentists, nurses and receptionists kind and helpful. Some patients said that the dentists were caring and understanding when treating patients who were experiencing anxiety or dental pain.

Involvement in decisions about care and treatment

Both patients we spoke with said that the dentists involved them in making decisions about their dental care and treatment. Patients told us that the dentists explained their treatments in a way that they could understand. They said that the intended benefits, risks and potential complications were explained so that patients could make informed decisions about their dental care and treatment. Comments made by 13 patients who completed the CQC comment cards also confirmed that patients were involved in their care and treatment.

The dentists demonstrated that they understood the principles of the Gillick competency test and applied it. The 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 about their care and treatment. They also understood their roles and responsibilities to determine parental responsibilities when treating children. Staff told us that patients with disabilities or in need of extra support were given as much time as was needed to explain and provide the treatment required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Information displayed in the waiting area described the range of services available, the practice opening times and how to access emergency treatment when the practice was closed. Information was also available explaining the practice's complaints procedure. A range of information leaflets on oral care and treatments were available in the practice and information was also available on the practice website.

The practice was open and offered appointments for NHS patients between 9 am and 4 pm on Mondays to Fridays. Patients who pay privately for dental care and treatments could access appointments between 9 am and 6 pm Monday to Friday and between 8 am and 6 pm on alternate Saturdays. The practice was closed between 1 pm and 2 pm for lunch each day.

The practice had equality and diversity and disability policies to support staff in understanding and meeting the needs of patients. The dental practice was located on the first floor of a purpose adapted building. The premises had disabled access toilet facilities and sufficient space to accommodate patients who used wheelchairs. There was step free access from street level into the surgery via a passenger lift.

We saw that the practice had equality and diversity policy and staff demonstrated that they understood this and adhered to this. Staff told us that patients were offered treatment on the basis of clinical need and they did not discriminate when offering their services.

The principal dentist told us that they did not have access to a translation service for patients whose first language was not English. They said that they had not required this service and that patients who did not speak English were accompanied by a family member when they attended the practice.

Access to the service

Patients who we spoke with told us that they could usually get an appointment that was convenient to them. They said that they had been able to access an appointment on the same day if they needed urgent treatment. Patients who completed CQC comment cards also said that could access the service in a timely way. The dentists told us that priority would be given to patients who required urgent dental treatment.

Staff and patients told us that appointments usually ran to time and that they did not have to wait too long to be seen. The receptionist told us that they advised patients if the dentists were running behind time.

For NHS patients in need of urgent care out of the practice's normal working hours they were directed by answerphone message to the NHS 111 service. Callers would then be directed to the relevant out of hour's dental service for treatment. Patients who paid for their dental treatment privately were provided with a telephone number to access out of hour's emergency treatment, which was provided by the practice 'on-call' service for advice and / or emergency treatment as required.

Concerns & complaints

The practice had a complaints policy and procedures. This was in line with its obligations to investigate and respond to complaints and concerns.

Information which described how patients could raise complaints was displayed in the waiting. There was no information about the complaints process either in the practice patient leaflet or on the practice website.

Records we viewed showed that complaints were processed in accordance with its complaints policy. We saw that an acknowledgement letter and a copy of the practice complaints code were sent to patients within three days of receipt of complaints. A full response and an apology was sent once the complaint had been investigated. Patients were made aware of their rights to escalate their complaint should they remain dissatisfied with the outcome or the way in which their complaint was handled. However complaints were not reviewed or used to make improvements where needed.

Are services well-led?

Our findings

Governance arrangements

The principal dentist told us that the practice manager had recently left the practice and that they were taking over lead roles and monitoring systems until such time as a new practice manager was employed.

The practice had limited governance arrangements in place for monitoring and improving the services provided for patients. For example, there were policies and procedures in relation to recruitment, health and safety and infection prevention and control. These policies and procedures were practice specific, however many procedures were not followed consistently by some staff and there were limited systems in place for monitoring this. Staff were not following policies in relation to reporting and dealing with accidents and incidents and learning from complaints was not shared, reviewed or used to make improvements where these were identified.

There were limited systems in place for monitoring areas such as staff training and development. There were insufficient systems in place for monitoring infection control procedures.

We found the practice did not carry out audits of various aspects of the service such as dental record audits or X-ray audits in accordance with current guidelines.

There were some systems and processes in place to assess monitor and mitigate the risks relating to the health, safety and welfare of patients and staff. Risks associated with the premises, X-ray equipment and legionella were regularly assessed.

Leadership, openness and transparency

The practice manager had recently left the practice and the principal dentist was covering lead roles such as infection control. Staff who we spoke with told us that they felt supported. The principal dentist told us that they were finding managing some aspects leadership and oversight at the practice difficult in the absence of a practice manager.

The dentists who we spoke with could demonstrate that they understood and discharged their responsibilities to comply with the duty of candour and they told us if there was an incident or accident that affected a patient the practice would act appropriately and offer an apology and an explanation. Some improvements were needed in how learning from incidents and complaints was shared and used to secure improvements.

Learning and improvement

The principal dentist told us that there was a culture of learning and improvement within the practice. They told us that learning and areas for improvement was shared with staff through practice meetings and daily communications. However minutes from practice meetings, which we were shown did not include records such as learning from complaints, accidents or incidents.

The practice had a system for annual staff training, development and appraisal. However some staff records which we were shown did not include appraisal records or training certificates. Staff told us that they were supported and that they had access to training and development.

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

The practice had systems in place for obtaining the views of patients and staff. The practice participated in the NHS Friends and Family and the results from this were submitted to NHS England on a monthly basis. The results from the most recent submission showed that 100% of patients who responded were either extremely likely or likely to recommend the dental practice to friends and family. The practice conducted patient satisfaction surveys for patients who paid privately for their treatments. The results from these also showed that patients were very satisfied with dental treatments that they received and how they were cared for by staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HCSA 2008 Regulations 2014 Good governance** How the regulation was not being met: There were insufficient systems in place for monitoring the quality and safety of services provided. • There were no systems in place for auditing infection control procedure and X-rays in line with current guidance to make improvements where needed provider did not always ensure all staff members received appropriate support, training and supervision necessary for them to carry out their duties. • There were insufficient systems in place to ensure that learning from where things went wrong including complaints, accidents and incidents was shared with staff to make improvements where these were identified. • There were insufficient systems in place for monitoring staff training and development needs. **17(1)**