Burnawn House Dental Practice

Burnawn House Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 16 March 2020 under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a Care Quality Commission (CQC) inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

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

Burnawn House Dental Surgery is in Raunds, a small market town in rural Northamptonshire. It provides mostly NHS dental care and treatment for adults and children.

There is one step access to the practice with use of a portable ramp for people who use wheelchairs and those with pushchairs.

Summary of findings

Free car parking spaces are available in a public car park and on the street within a close distance of the practice.

The dental team includes two dentists, one dental nurse and one receptionist. The practice also uses locum/ agency dentists and dental nurses when required.

The principal dentist has responsibility for practice management. The practice has two treatment rooms, both on ground floor level.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection, we collected 17 CQC comment cards filled in by patients.

During the inspection we spoke with two dentists, the dental nurse, and the receptionist. We looked at practice policies and procedures, patient feedback and other records about how the service is managed.

The practice is open: Monday to Friday from 9am to 5.30pm. It closes during lunchtimes between 12.30pm to 2pm.

Our key findings were:

- We found that most areas of the practice were visibly clean, although we found some areas that had been missed when cleaning of the general areas of the premises took place.
- The provider had infection control procedures which mostly reflected published guidance. We noted that tiled flooring in one of the treatment rooms was not adhering to best practice.
- Staff knew how to deal with emergencies. Not all appropriate medicines and life-saving equipment were available however and we found some that had expired.
- Systems to manage risks to patients and staff were not all working effectively.
- The provider did not have suitable safeguarding processes and therefore, staff were not sufficiently aware of their responsibilities for safeguarding vulnerable adults and children.
- The provider had staff recruitment procedures, although a policy was not held. Only one staff member had been appointed since the current provider had taken ownership. Checks were completed except for references. Agency staff had checks in place.
- We saw evidence to support that clinical staff provided patients' care and treatment in line with current guidelines. We also noted exceptions where guidance was not followed. One of the clinicians did not use dental dam (for root canal treatment) and they did not ensure that alternate measures used to protect the airway were recorded in written patient records.
- Staff provided preventive care and supported patients to ensure better oral health.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system took account of patients' needs.
- The provider asked staff and patients for feedback about the services they provided.
- The provider had not received any formal complaints.
- The provider did not demonstrate effective leadership or a culture of continuous improvement.
- The provider demonstrated they were taking some responsive actions after the day of our visit and told us they would continue to address these.

We identified regulations the provider was not complying with. They must:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider was not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Take action to ensure dentists are aware of the guidelines issued by the British Endodontic Society for the use of rubber dam for root canal treatment.

Summary of findings

- Improve the practice's recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Improve the practice's waste handling protocols to ensure waste is segregated and disposed of in compliance with the relevant regulations, and taking into account the guidance issued in the Health Technical Memorandum 07-01.
- Take action to ensure that clinicians take into account the guidance provided by the Faculty of General Dental Practice when completing dental care records.
- Implement audits for prescribing of antibiotic medicines taking into account the guidance provided by the Faculty of General Dental Practice.
- Take action to ensure the service takes into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

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?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**Requirements notice** ✖

Are services safe?

Our findings

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). We will be following up on our concerns to ensure they have been put right by the provider.

The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low.

Safety systems and processes, including staff recruitment, equipment and premises and radiography (X-rays)

Staff did not have all systems in place to keep patients safe.

Not all staff knew their responsibilities regarding the safety of children, young people and adults who were vulnerable due to their circumstances. Whilst we were shown a policy document dated October 2018, it was not clear that it had been reviewed on an annual basis. The document did not include contact details for external agencies for reporting concerns, this information was not found elsewhere. The policy did not refer to whom the nominated lead was in the practice for safeguarding. Staff were not clear who the lead was; we were told different names by them.

The principal dentist had completed training in safeguarding within the previous three years; certificates did not show the level of training completed by them. We saw certificates that showed the dental nurse and associate dentist had completed training, this was dated over three years ago. Guidance recommends that clinical staff complete safeguarding training within every three years and to an appropriate level. The receptionist told us they had completed this training in a former role but not since they had started working for the practice in 2018.

The practice's systems were not adequate to identify any children with concerns or vulnerable adults.

Following our visit, the principal dentist sent us a copy of their updated level two training certificate they had completed after the inspection along with the updated dental nurse's level two certificate. They also sent a copy of their reviewed safeguarding policy which contained external contact information.

The provider had an infection prevention and control policy and procedures. The policy was not bespoke to the practice, for example, it referred to four treatment rooms when there were only two. The practice mostly followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices, (HTM 01-05), published by the Department of Health and Social Care, although we noted exceptions. Clinical staff completed infection prevention and control training and received updates as required.

The provider had arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM 01-05. The records showed equipment used by staff for cleaning and sterilising instruments was validated, maintained and used in line with the manufacturers' guidance. The provider had suitable numbers of dental instruments available for the clinical staff and measures were in place to ensure they were decontaminated and sterilised appropriately. We did note that some dental instruments (forceps) in the surgery displayed signs of wear and rust.

The staff had systems in place to ensure that patient-specific dental appliances were disinfected prior to being sent to a dental laboratory and before treatment was completed.

We saw staff had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. The risk assessment had been undertaken by an external contractor in 2011 and had been reviewed by the practice since.

Records of water testing and dental unit water line management were maintained.

The practice did not have cleaning schedules to ensure the practice was kept clean. We saw that the two cleaning mops used were stored in the patient toilet facility. Staff did not follow the National Colour Coding Scheme; they told us the two colours identified their use in clinical and non-clinical areas.

When we inspected, we saw that most areas of the practice were visibly clean; we also noted some exceptions. In one of the surgeries, the windowsill had some dead insects and we noted dust in areas that were more difficult to reach in the patient toilet facility. The floor in one of the surgeries was tiled with grouting in between, this meant it was not impervious or easy to clean. Not all flooring in this surgery

Are services safe?

was coved to the wall which would prevent the accumulation of dirt where the floor meets the wall. The provider informed us that the surgery would be improved as part of their future ongoing plans.

The provider had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We noted that the dates on sharps bins showed they had been held in excess of three months; guidance advises the disposal of these after this time.

The provider had carried out an infection prevention and control audit, although we were not assured these were undertaken twice a year as recommended. The latest audit in March 2020 showed the practice was meeting the required standards. It had not identified the issues that we found with the flooring in one of the surgeries.

The provider had a whistleblowing policy. This did not include contact information for whom could be approached for whistleblowing concerns. The dental nurse was not aware there was a policy and another staff member thought it was the dental nurse who was the lead in this area.

One of the dentists told us they did not use dental dam as directed in guidance from the British Endodontic Society when providing root canal treatment. Suitable airway protection for the patient was therefore not in place. We did not see that the use or non-use of rubber dam was recorded in a sample of patients' records for other dentists.

The provider could not locate a recruitment policy. We looked at one staff recruitment file for a non-clinical team member as they were the only one who had been recruited since the current provider had taken ownership of the practice. References or evidence of satisfactory conduct in previous employment were not held on the file. The practice utilised agency/locum staff; we were provided with evidence to show that the employing agency undertook the required legislative checks.

We observed that clinical staff were qualified and registered with the General Dental Council and had professional indemnity cover.

Staff ensured equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. We noted facilities management required improvement as five-year fixed wiring testing was overdue for completion. This was due in 2018.

A fire risk assessment had not been carried out in line with the legal requirements. The provider told us the issues would be resolved as soon as they were able to address them following the COVID-19 outbreak.

We saw there were fire extinguishers and smoke alarms in the building and the fire exit was kept clear. Fire drills had not been undertaken by staff, but they told us how they would exit the building in the event of an emergency.

The practice had arrangements to ensure the safety of the X-ray equipment and we saw the required radiation protection information was available. Evidence of three yearly testing for one of the X-ray units couldn't be located on the day but was forwarded to us afterwards.

We saw evidence the dentists justified, graded and reported on the radiographs they took.

There was evidence that the provider carried out some radiography audit. We saw records dated January to March 2020.

Clinical staff completed continuing professional development in respect of dental radiography.

Risks to patients

The provider had not implemented all the required systems to assess, monitor and manage risks to patient safety.

Not all practice specific risk assessments or policies were held. It was not evident that those that were held were adequate or subject to regular review.

We looked at the practice's arrangements for safe dental care and treatment. The practice had not implemented a safer sharps system as described in EU directive. The dentists used traditional needles. We were informed that dentists dismantled used needles. Needle guards were not used by them when doing so. One of the dentists told us they used a one-handed technique. Whilst we were shown a brief and general risk assessment, this was not specific to the practice. For example, it did not refer to the process that the dentists were following.

Are services safe?

There was a sharps injury poster on the wall in the decontamination room and in the treatment rooms, which included contact details if staff had an injury.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked.

All but one member of the team had completed sepsis awareness training. The receptionist had not received this training. We did not see that sepsis prompts for staff or patient information posters were displayed throughout the practice.

A coordinated team approach to the risk presented by sepsis would ensure that staff could make triage appointments effectively to manage patients who present with dental infection and where necessary refer patients for specialist care.

Staff knew how to respond to a medical emergency and had completed training in emergency resuscitation and basic life support every year.

Emergency equipment and medicines were not all available as described in recognised guidance. We found that midazolam had expired in August 2017, glucagon was held outside of refrigeration and the expiry date had not been shortened to reflect this. The child oxygen face mask and separate tubing expired in January 2020. The practice did not have scissors or a razor in their kit or a spacer device for inhaled bronchodilators. On the day of our visit, we were not shown the portable suction; the provider sent us a photograph of this after the day and assured us it was held on the premises. We were informed that an order had been placed for the midazolam, masks and tubing after the day.

Staff undertook monthly checks on the kit held, and not weekly as recommended. The logs did not include that the AED was subject to checks. The provider assured us that it was checked periodically by staff.

The checks were not working effectively, as they did not identify the issues that we had found on the inspection date.

The dental nurse worked with the dentists when they treated patients in line with General Dental Council Standards for the Dental Team.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice occasionally used locum or agency staff. We did not view documented records to show these staff received an induction to ensure they were familiar with the practice's procedures.

The provider had current employer's liability insurance.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at dental care records with clinicians to confirm our findings and observed that those individual records which were typed were managed in a way that kept patients safe. One of the dentists used a paper-based record system and we found that not all information about patients' needs was included, as recommended in national guidance.

The principal dentist told us that action had been ongoing to encourage the associate dentist to move to the electronic based patient record system.

Electronic dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements. Paper based records were not all complete but were kept securely.

The provider had systems for referring patients with suspected oral cancer under the national two-week wait arrangements. These arrangements were initiated by National Institute for Health and Care Excellence to help make sure patients were seen quickly by a specialist.

Safe and appropriate use of medicines

We found that some of the provider's systems for appropriate and safe handling of medicines required review.

We were not assured that staff stored and kept records of NHS prescriptions as described in current guidance. Prescription pads were not locked away when they were not in use and there was no monitoring of the individual prescription pad numbers which would identify if one was taken inappropriately. The provider assured us after the day that the pads had now been secured.

Are services safe?

The dentists were aware of current guidance with regards to prescribing medicines. There was no log maintained for general, antibiotic and prophylaxis prescribing in line with national guidance.

There was a poster displayed in the waiting area to inform patients about antibiotics.

Antimicrobial prescribing audits had not been undertaken.

Track record on safety, and lessons learned and improvements

The provider did not demonstrate that they had all comprehensive risk assessments in relation to safety issues, for example an effective sharps risk assessment.

There was an accident book held. Whilst this had some pages removed, staff told us they did not think there had been any recent accidents.

There was a significant event policy, although this was not specific to the practice. For example, it referred to a practice manager and the provider did not employ one at this location. We were told there had been no incidents identified or reported, and this was supported in some practice meeting minutes that we reviewed.

The lack of reporting of any incidents, particularly those less serious or untoward events presented a risk that they were not being correctly identified or managed. It was therefore not evident that any learning was shared amongst the team when things went wrong.

The provider had a system for receiving and acting on safety alerts, and these were shared with staff if relevant.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We received positive feedback from 17 patients in CQC comment cards. They described treatment received as gentle, professional and very good.

Dental professionals kept up to date with current evidence-based practice. We saw clinicians assessed patients' needs and generally delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. We noted exceptions in relation to dental dam use and aspects of record keeping by one of the dentists; this did not follow national guidance.

Helping patients to live healthier lives

We saw some information displayed in the waiting room to help inform patients about their oral health. For example, this included information about the effects of acidic drinks.

The practice provided preventive care and supported patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists prescribed high concentration fluoride products if a patient's risk of tooth decay indicated this would help them.

The dentists where applicable, discussed smoking, alcohol consumption and diet with patients during appointments.

Staff were aware of national oral health campaigns which supported patients to live healthier lives, for example, smoking cessation. They directed patients to support services when appropriate.

The dentist described to us the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition.

Records showed patients with severe gum disease were recalled at more frequent intervals for review and to reinforce home care preventative advice.

Consent to care and treatment

Staff obtained consent to care and treatment in line with legislation and guidance.

The practice team told us they understood the importance of obtaining patients' consent to treatment and provided patients with the information necessary so they could make informed decisions.

We found inconsistencies between the dentists in the recording of aspects of consent. This was in relation to treatment options, risks and benefits discussed with the patient. One of the dentists (and locums) used an electronic based record system which included further detail and one dentist had used a paper-based system.

Not all the staff were aware of the need to obtain proof of legal guardianship for children who are looked after.

Patients confirmed their dentist listened to them and gave them clear information about their treatment.

We were provided with two policies about the Mental Capacity Act 2005. One was dated in June 2019 and the other was not dated.

The dentists understood their responsibilities under the Act when treating adults who might not be able to make informed decisions.

Staff were aware of Gillick competence, by which a child under the age of 16 years of age may give consent for themselves in certain circumstances.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept detailed computerised dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentists assessed patients' treatment needs in line with recognised guidance.

The provider's quality assurance processes to encourage learning and continuous improvement required review. For example, record keeping audits had been undertaken inconsistently. We were provided with audits dated February to March 2020 and March 2017.The latest audit had not identified any areas for improvement or a resultant action plan.

Effective staffing

Are services effective?

(for example, treatment is effective)

Staff had the clinical skills, knowledge and experience to carry out their roles. We noted areas where greater improvement in skills and knowledge were required by staff such as the undertaking of practice management duties and tasks.

There had only been one new member of staff; they had received a structured induction. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Co-ordinating care and treatment

Staff told us they worked together and with other health and social care professionals to deliver effective care and treatment.

The dentists confirmed they referred patients to a range of specialists in primary and secondary care for treatment the practice did not provide.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness and respect.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were polite, considerate and helpful.

We saw staff treated patients respectfully and appropriately and were friendly towards patients at the reception desk.

Patients said staff were compassionate and understanding. Comments from patients included that nothing was too much trouble and that staff were accommodating of nervous patients' needs. Another patient said they had travelled a long way to attend the practice by choice and others had been receiving treatment there for many years.

There was a children's toy box and magazines available in the waiting room to occupy patients until they were seen.

Privacy and dignity

Staff respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and the separate waiting area provided privacy when reception staff were dealing with patients. If a patient asked for more privacy, the practice would respond appropriately. The reception computer screen was not visible to patients and staff did not leave patients' personal information where other patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Involving people in decisions about care and treatment

We looked at how staff helped patients to be involved in decisions about their care and their awareness of the Accessible Information Standard and requirements under the Equality Act.

The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given. We noted:

- Reception staff were aware of a service provided for those who may require British Sign language interpretation. However, they were not specifically aware of interpreter services for patients who did not speak or understand English. We were informed that there was not a demand for this service based on the geographical location of the practice. We were told that patients could bring a family member to assist if needed. This may present a risk of mis-communications. There were multi-lingual staff who may be able to assist some patients, if this was required.
- Staff were not aware of how they could obtain information in other formats such as easy read or larger font.

Staff told us they gave patients information to help them make informed choices about their treatment. Patients confirmed that staff listened to them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information leaflet provided patients with some information about treatments available at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff understood the importance of emotional support needed by patients when delivering care. There were vulnerable patients who received care and treatment at the practice. For example, those with autism and local care home residents with learning difficulties and other disabilities. The practice information leaflet stated that anxious patients' needs were understood and extended opening times could be undertaken by special arrangement.

Patients described their levels of satisfaction with the responsive service provided by the practice.

Two weeks before our inspection, CQC sent the practice 50 feedback comment cards, along with posters for the practice to display, encouraging patients to share their views of the service.

17 cards were completed, giving a patient response rate of 34%.

100% of views expressed by patients were positive.

Common themes within the positive feedback were the friendliness and helpfulness of staff, the treatment received, and that patients' needs were met.

The practice currently had some patients for whom they needed to make adjustments to enable them to receive treatment.

The practice had made some, but not all reasonable adjustments for patients with disabilities. This included a portable ramp to enable ease of access into the premises. The practice did not have a hearing loop, magnifying glass or reading glasses at the reception desk. Whilst the toilet was accessible for those who used wheelchairs, it was not fitted with a handrail or call bell.

Staff contacted patients in advance of their appointment to remind them to attend. This was based on patient preference of communication.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises and included it in their information leaflet.

The practice had an appointment system to respond to patients' needs. Patients who requested an urgent appointment were offered an appointment the same day. Time was allocated in the dentists' diaries for any emergency appointments. On the day of our inspection, we noted that two patients had utilised these.

Patients had enough time during their appointment. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Patients who had dental emergencies outside of usual working hours were directed to the appropriate out of hours service. A Bupa dental practice based in Wellingborough opened from 8am to 8pm every day. Patients were also directed to NHS 111.

The practice's information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was closed. Patients confirmed they could make routine and emergency appointments easily.

Listening and learning from concerns and complaints

Staff told us the provider would take complaints and concerns seriously and would respond to them appropriately to improve the quality of care, if any were to be received.

The practice information leaflet explained how to make a complaint. There was also information at the reception desk that advised patients about this. The information at the desk stated that the associate dentist was the lead for complaints whereas the practice leaflet informed patients to contact the principal dentist.

The principal dentist was responsible for dealing with complaints. Staff told us they would tell them about any formal or informal comments or concerns straight away to enable patients to receive a quick response.

The principal dentist aimed to settle complaints in-house and said they would invite patients to speak with them in

Are services responsive to people's needs?

(for example, to feedback?)

person to discuss these, if any were to be received. Information was available about organisations patients could contact if not satisfied with the way the practice had dealt with their concerns.

We were told that the practice had not received any formal or written complaints since the current provider had taken ownership of the practice.

Are services well-led?

Our findings

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). We will be following up on our concerns to ensure they have been put right by the provider.

Leadership capacity and capability

The principal dentist supported by the team had capacity and skills to deliver clinical care for patients; we found a significant number of improvements could be made to improve the service and ensure that all risks were identified and suitably managed.

Following our visit, we noted that the provider was responsive in seeking to improve their existing arrangements; they were making efforts to rectify some of the shortfalls we identified. This included review of their safeguarding responsibilities.

Leaders were approachable by staff.

Staff planned the services to meet the needs of the practice population; they were predominantly providing NHS care and treatment.

The provider had taken ownership of the practice within the previous 12 months. The principal dentist had been undertaking some practice renovations, these included relocation of the reception area. There were ongoing plans which included the construction of an office. Other implementations had included the move for all clinicians to use an electronic based patient record system.

Culture

A culture of high-quality sustainable care was yet to become embedded within the practice operation.

We were not shown evidence to show that directly employed staff had received an appraisal. The most recently employed staff member had been recruited in 2018; they had not yet received a formal review. Records held for the dental nurse indicated they were significantly overdue an appraisal by the point of when the new provider had taken over the practice. The provider told us they had plans in place to undertake the appraisals.

We noted some examples which supported where staff focused on the needs of patients. This included dental emergencies where patients were allocated a same day appointment to enable their urgent needs to be addressed.

We did not view evidence to show how the provider applied the requirements of the duty of candour. The practice had not recorded any significant or untoward incidents, and we were informed that they had not received any formal complaints. A lack of documentation meant it was difficult to assess how the practice learnt when things went wrong.

Staff could raise issues or concerns. We saw some documented records of staff meetings held.

Governance and management

The principal dentist had overall responsibility for the management and clinical leadership of the practice. They were also responsible for the day to day running of the service, although they were not present in the premises on a daily basis.

Staff were not clear on who held some of the designated roles and responsibilities. For example, safeguarding and whistleblowing.

The provider's system of clinical governance which should include policies, protocols and procedures required immediate review as some were not in place or were not sufficiently supporting the operation of the service. We noted that not all appropriate risk assessments had been completed, for example, fire and a specific sharps assessment. The practice did not have access to all emergency equipment that may be required. Some medicines and equipment had expired and checks made by staff had not identified the issues that we found on the day.

We found there was scope to improve governance arrangements, for example, the provider having enough oversight of staff training completion and ensuring that policies were relevant and specific to the practice.

There were not clear and effective processes for managing risks, issues and performance.

Appropriate and accurate information

Are services well-led?

Systems required oversight. The practice did not readily hold all appropriate information needed. For example, three yearly testing for one of the X-ray units couldn't be located on the day but was found and forwarded to us afterwards. Five-year fixed wiring testing was overdue.

Staff were aware of the importance of protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The provider used patient surveys, including the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used. They also encouraged verbal comments to obtain patients' views about the service.

The provider told us that the reception desk had been moved as a result of feedback received.

The provider gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service. We were told that new uniforms, some equipment and instruments had been purchased and staff had received an increase to their pay.

Continuous improvement and innovation

There were insufficient systems and processes for learning and continuous improvement.

The provider had some limited quality assurance processes to encourage learning and continuous improvement. These included radiography and record keeping audits. We were not assured these were undertaken on a regular or consistent basis however. They did not contain robust action plans as a result. Whilst we were provided with one infection and prevention control audit, this was ineffective as it had not identified the issues that we did in one of the dental surgery rooms.

Audit was not used as a tool to drive improvement in the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. **How the regulation was not being met** The registered person had not done all that was reasonably practicable to mitigate the risks to the health and safety of service users receiving care and treatment. In particular: • Not all equipment that may be required in an emergency was held, for example, some medicines and equipment had expired, glucagon was held outside of refrigeration and the expiry date had not been shortened. The practice did not have scissors or a razor in their kit or a spacer device for inhaled bronchodilators. Logs maintained by staff did not show that the AED was subject to checks to ensure it was working properly. • The provider had not identified that electrical fixed wiring testing was overdue for completion. • Risk assessments had not been implemented effectively in relation to safety issues including the use of sharps and fire. **Regulation 12 (1) (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

The registered person had failed to establish systems to prevent abuse. In particular:

- Safeguarding training had not been completed within a reasonable time threshold by some members of the team at the point of inspection. Staff were not aware of the correct contact details for reporting concerns. The practice's systems were not adequate to identify and follow up any children with concerns or vulnerable adults.

Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • Policy was not specific to the practice or some policy had not been implemented. For example, infection and prevention control policy, significant event policy, recruitment policy. • Effective procedures were not in place for significant event and untoward incident reporting. • There was lack of oversight in relation to cleaning schedules that had not been implemented to help ensure staff maintained all areas of the premises effectively. • There was ineffective monitoring for staff training requirements. For example, safeguarding training, sepsis training.

This section is primarily information for the provider

Requirement notices

- A systematic comprehensive approach had not been implemented for staff appraisals.
- There were limited systems for monitoring and improving quality. For example, radiography audit and infection prevention and control.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- Prescription pads were not held securely with adequate systems in place to monitor their use.

There were no systems or processes that enabled the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- Written patients' dental assessments did not include all information regarding the consent process.

Regulation 17 (1) (2)