MLL Portchester Limited

Castle Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 January 2017 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
Castle Dental Practice is a dental practice providing NHS and private treatment for both adults and children. The practice is based in a converted office based in Portchester, a town close to Portsmouth, in south Hampshire.

The practice has three dental treatment rooms all of which are based on the ground floor and a separate decontamination area used for cleaning, sterilising and packing dental instruments. The practice is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs two dentists, one hygienist and three dental nurses who also cover reception.

The practice's opening hours are between 8.30am and 7pm on Monday and Tuesday, 8.30am and 5pm on Wednesday and 8.30am and 12.30pm on Thursday and Friday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by the principal dentist and an out-of-hours service, via 111.

Summary of findings

Dr Martin Law, the principal dentist, is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

We obtained the views of nine patients on the day of our inspection.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Clinical leadership was provided by the principal dentist.
- Appropriate emergency medicines and life-saving equipment were available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was maintained.
- Infection control procedures generally followed published guidance.
- The practice had processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- Dentists provided routine dental care in accordance with current professional guidelines.
- The practice carried out intravenous sedation for a small number of patients each year. We found shortfalls in the clinical governance systems that underpinned the provision of conscious sedation.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- The practice had some clinical governance and risk management structures in place, but we found several shortfalls in systems and processes.
- Areas where we found that required improvements were the governance systems underpinning the health and safety systems including fire, infection control, practice records, conscious sedation, safer sharps usage, medicines management and clinical audit.
- Information from 50 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Ensure the training, learning and development needs of staff members are collated and reviewed at appropriate intervals.
- Ensure risk assessments in key areas such as infection prevention and control, recapping needles following administration of local anaesthetic and sedation are carried out.
- Ensure written policies and procedures are reviewed regularly and updated to reflect changes in legislation and guidelines.
- Ensure there is a robust system to record, respond and learn from significant events and accidents.
- Ensure that the governance arrangements for sedation take into account the guidance set out in the Department of Health document, conscious sedation in the provision of dental care 2003.
- Ensure staff assisting in conscious sedation have the appropriate training and skills to carry out the role.
- Ensure medicines dispensing follow the secondary dispensing guidelines of the British Pharmacological Society.

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

- Review the practice's infection control procedures and protocols taking into account The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance. Specifically, the review the use of residual protein testing for the ultrasonic cleaning bath.
- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

Summary of findings

- Review the monitoring frequency of the emergency oxygen and automated external defibrillator so that they are reviewed at least weekly rather than on the existing monthly arrangements.
- Review the safety arrangements of the window blinds in the practice, this could include either ensuring the pull cords are made secure or carrying out a suitable risk assessment in relation to the pull cords.
- Consider the provision of an external name plate providing details of the dentists working at the practice including their General Dental Council (GDC) registration number in accordance with GDC guidance March 2012.
- Review the contents of the practice website, practice leaflet and NHS Choices to bring information up to date.
- Review the storage arrangements of the emergency medicines and lifesaving equipment so that they are stored in one central location in the practice.
- Review the security of the decontamination room which contained prescription only medicines to prevent unauthorised access by the public.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as Public Health England (PHE).

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 some arrangements in place for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We noted that improvements were required to the systems and processes underpinning health and safety systems including fire safety, conscious sedation and medicines management. We found that the equipment used in the dental practice was maintained in accordance with manufacturer's instructions.

There were systems in place for identifying, investigating and learning from patient safety incidents although systems required improving.

Staff were aware of their responsibilities regarding safeguarding children and vulnerable adults and had received safeguarding training but five of the six staff had not been trained to the recommended level.

Are services effective?

No action

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

The dental care provided for routine care was evidence based and focussed on the needs of the patients. The practice used current national professional guidance to guide their practice.

The practice carried out intravenous sedation for a small number of patients each year. We found shortfalls in the clinical governance systems that underpinned the provision of conscious sedation.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. Staff generally received professional training and development appropriate to their roles and learning needs although there were gaps in training in some areas.

Are services caring?

No action

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

We obtained the views of 50 patients before our visit and nine patients on the day of our visit. These provided a positive view of the service the practice provided.

Patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Summary of findings

Are services responsive to people's needs?

No action

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

The service was aware of the needs of the local population and took these into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

The practice had three ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

Requirements notice 

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

Leadership was provided by the principal dentist. Staff had an open approach to their work and shared a commitment to continually improving the service they provided.

Staff told us that they felt well supported and could raise any concerns with the principal dentist. All the staff we met said that they were happy in their work and the practice was a good place to work.

The practice generally had some clinical governance and risk management structures in place. We found some areas where improvements must be made.

The governance systems underpinning health and safety systems including fire safety, infection control, practice records, conscious sedation, safer sharps usage, medicines management and the systems for reviewing practice policies required improvement.

Castle Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 17 January 2017. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of five members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of nine patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The principal dentist explained their system operated under RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). They explained that they would use the on-line reporting system which operates through the Health and Safety Executive website.

The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. We noted that the accident reporting book retained copies of previous accidents which should have been archived to protect the confidentiality of patients and staff when subsequent accidents are written up in the accident book.

The practice reported that a power cut had occurred previously that resulted in suspension of services for a period of time. We found that the practice had kept no records of the incident including the effects on the delivery of patient care or any measures taken to mitigate the effects of such an incident should this type of event occur in the future.

The principal dentist explained that they received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). We noted that there were no records showing recent relevant alerts that affected primary dental care, or how these alerts were shared with members of staff.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentists used the 'scoop' method when recapping a used needle following the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles.

Although a sharps policy was in place the policy did not contain a written protocol and accompanying risk assessment for the recapping of used needles in line with the safe sharp guidelines.

We asked the staff how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. 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 and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

The practice had systems in place should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. This policy was written in 2011 with a review date of 2017.

We noted that training records showed that clinical staff had not received appropriate safeguarding training for both vulnerable adults and children in accordance with current guidelines. Current guidelines indicate that dental nurses should receive training to level two. We found that the dental nurses had only received training to level one.

The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

Are services safe?

Although we found that the emergency medicines and oxygen were all in date, the systems used for checking should be reviewed. We saw records that showed that the medical oxygen and AED were checked monthly.

We noted that the storage of the emergency medical equipment was not in one central location. We found that the emergency medicines were stored in one room and the oxygen and AED in another.

Guidelines recommend that emergency medicines and equipment is stored in one central local to aid an efficient response to a medical emergency and is checked at least weekly.

The practice held training sessions each year for the whole team so they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

All but one member of staff had evidence available to confirm basic life support training had been carried out within the last 12 months.

Staff recruitment

All of the dentists, dental hygienist and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.

The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to 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.

All the staff employed had been in post for a number of years prior to registration of the practice with Care Quality Commission. Staff recruitment records were stored securely to protect the confidentiality of staff member's personal information.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. We noted shortfalls with respect to managing fire safety risks and the systems within the building. These included; lack of regular testing of fire alarms and emergency lighting and fire safety training. We have since been provided evidence to confirm the provider and a practice nurse have booked a place on a fire safety training course at a local fire station on 16 March 2017.

The practice did not have in place a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place a Control of Substances Hazardous to Health (COSHH) file.

Window blinds in the practice with hanging pull cords were insecure and available to unauthorised people.

The practice did not have a current electrical safety certificate available for inspection. We have since been provided evidence which confirmed a safety test was carried out two days following our inspection. The results of this identified a number of areas which required attention. We were told by the principal dentist these were being addressed.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice, however there were shortfalls with some elements of the governance underpinning the infection control systems and processes. The practice had in place an infection control policy which was written in 2011 with a review date of 2017. We noted that the policy needed to be reviewed to reflect any changes during the intervening period. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention and control in dental practices) Essential Quality Requirements for infection control was being met. Although the practice told us they carried out auditing of their infection control processes records were unavailable to confirm audit had been carried out.

We saw that the three dental treatment rooms, waiting area, reception and staff toilet were visibly clean and tidy. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities

were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of one treatment rooms were inspected and these appeared clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in March 2014. The recommended procedures contained in the report were carried out and logged appropriately.

The practice had a separate decontamination room used for instrument cleaning, sterilisation and the packaging of processed instruments. This room also housed emergency equipment and medicines.

The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system from dirty through to clean.

The practice used an ultra-sonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched or stored without being pouched until required in the clinical treatment room. All pouches were dated with an expiry date in accordance with current guidelines. We were told any instruments stored un-pouched were reprocessed at the end of the clinical session if they were not used during that session in accordance with current guidelines.

We were shown the systems in place to ensure that the autoclaves used in the decontamination process worked effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. The recommended tests for validation of the ultra-sonic cleaning bath were carried out and recorded appropriately. This included the recommended foil test however the recommended residual protein test was not being used.

The segregation and storage of clinical waste followed current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by a waste contractor. Waste consignment notices were available for inspection.

General environmental cleaning was carried out by an external cleaning company according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

We found the practice did not produce an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in November 2011 and other equipment used in the decontamination processes had been serviced in May 2016.

X-ray sets were serviced on an annual basis with records showing that this was carried out in June 2016. With respect to the recommended calibration tests, we found records that showed one set had been calibrated and tested in April 2016 and due again in 2019. The other was not due a test as this was installed in January 2016.

Are services safe?

Portable appliance testing (PAT) had been carried out in January 2017.

The practice also dispensed medicines as part of a patient's dental treatment. These medicines were a range of antibiotics and analgesics. We noted that not all of the medicines dispensed were in accordance with current secondary dispensing guidelines. The specific medicines were amoxicillin and ibuprofen. We brought this to the attention of the principal dentist who assured us that this would be addressed as soon as practically possible.

The practice carried out intravenous conscious sedation. We found there were some shortfalls in the governance arrangements with respect to medicines management for the medicines used for this treatment. For example, there was not an effective written system of stock control in place and the storage for the medicines used in intravenous sedation. The practice stored these medicines as well as other medicines in a cupboard in the decontamination room. Although the cupboard had a detachable lock this was not in place during our visit.

The decontamination room was not secure to prevent unauthorised access to these medicines by members of the public during the day.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a radiation protection file that was generally in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). We found that some records for one X-ray set maintenance were missing. Otherwise the file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, HSE notification and documentation pertaining to the maintenance of the X-ray equipment. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

The practice used a daily recording sheet to capture the justification of X-rays, comments about the findings on the X-rays and a quality score for each X-ray.

We saw training records in relation to update training in radiography but these were not always retained within the radiation file which made monitoring staff training needs in this area less efficient.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists described to us how they carried out consultations, assessments and treatment in line with recognised general professional guidelines. One dentist we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

The dental care records we saw were not always as detailed as they could be. We referred each dentist to the new Faculty of General Dental Practice guidelines in relation to record keeping and that these guidelines and others were available free of charge through the Faculty's open standards initiative.

The practice carried out intra-venous conscious sedation for patients who were very nervous of dental treatment. The number of treatments involving sedation was very small, at the most one or two per month. Although some of the essential features of governance underpinning conscious sedation were in place such as having in place the correct monitoring equipment, consent form and recording sheets showing some of the details of the sedation procedure, there were several shortfalls identified. The dentist carrying out conscious sedation confirmed they had not undergone any update training in the last five years and the nurse supporting them had received no initial formal training in conscious sedation.

There were also shortfalls in record keeping in relation to the patient assessment and during and after the sedation procedure. It is good practice to maintain a sedation file which details the governance arrangements underpinning the patient journey through a course of sedation treatment. No such file was in place.

We referred the principal dentist and the associate dentist to the guidance set out in the Department of Health document, conscious sedation in the provision of dental care 2003. Following our discussions with the provider and the associate dentist told us they would not provide any further treatment involving sedation until they could achieve the standards as set out in the Faculty guidelines.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim, the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care.

The dentists provided preventative interventions such as prescribing high concentrated fluoride tooth paste or the application of fluoride varnish applications for those patients who were at an increased risk of suffering from dental decay. This was in line with the Department of Health's Delivering Better Oral Health Toolkit, an evidenced based set of advice for securing and maintaining oral health.

The practice also sold a range of dental hygiene products to help maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

We noted that the external name plate which detailed names of the dentists working at the practice did not

Are services effective?

(for example, treatment is effective)

include their General Dental Council (GDC) registration number in accordance with GDC guidance from March 2012. This was the same for the practice website, NHS Choices and the practice leaflet.

All but one of the patients we asked told us they felt there was enough staff working at the practice. Staff told us there were enough staff. Staff we spoke with told us they felt supported by the principal dentist.

The practice employed two dentists, one hygienist and three dental nurses who also covered reception duties.

Training records examined showed that one member of staff had allowed their mandatory training to lapse. For example, fire safety, infection control, safeguarding children and vulnerable adults and basic life support.

One of the six staff members had evidence to confirm the required level of safeguarding children and vulnerable adults had been carried out and one of the six staff had evidence to confirm fire safety training had been undertaken.

The dental hygienist worked without chairside support. We pointed this out to the practice manager and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team', specifically standard 6.2.2 working with other members of the dental team.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

A dentist we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

A dentist went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005.

Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors of one treatment room was not always closed when patients were with the dentist. This could compromise the dignity and confidentiality of the patient. We pointed this out to the dentist concerned.

Patients' clinical records were stored manually, with paper records stored in an area of the practice not accessible to unauthorised members of the general public.

We obtained the views of 50 patients prior to the day of our visit and nine patients on the day of our visit. These provided a completely positive view of the service the practice provided. Patients commented that the dentists were good at treating them with care and concern. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS and private fees was displayed in the waiting area and private treatment fees was listed on the practice website.

A dentist told us they paid attention to patient involvement when drawing up individual treatment plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable and estimates and treatment plans for private patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information which included; opening hours, emergency 'out of hours' contact details and arrangements about how to make a complaint. The practice website also contained useful information to patients such as how to provide feedback to the practice, details of out of hour's arrangements and the costs of treatment under NHS and private care. We noted that not all of the information was up to date in each of these formats which could lead to confusion for patients.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist.

The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services.

The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

To improve access for patients who found steps a barrier, the practice installed block paving and new low-threshold door in the building and all treatment rooms were on the ground floor.

Due to the size of the practice a toilet was unavailable. The practice provided a hearing loop for patients who used hearing aid.

Access to the service

The practice's opening hours were between 8.30am and 7pm on Monday and Tuesday, 8.30am and 5pm on Wednesday and 8.30am and 12.30pm on Thursday and Friday.

We asked nine patients if they were satisfied with the hours the surgery was open; all but one patient said yes. This patient said they did not have an opinion.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed and the principal dentist gave out an emergency telephone number. This information was publicised in the practice leaflet and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room and the practice leaflet. These included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. We asked nine patients if they knew how to make a complaint if they had an issue and seven said yes and two patients were not sure.

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

For example, a complaint would be acknowledged within three working days and a full response would be given in 10 days. We were told the practice had not received any complaints in the previous 12 months.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of the principal dentist who was responsible for the day to day running of the practice.

The practice had some clinical governance and risk management structures in place however we found areas where improvements were required. For example, the governance systems underpinning health and safety systems including fire, infection control, record keeping, conscious sedation, safer sharps usage, medicines management and the systems for reviewing practice policies and clinical audit.

Improvements were also required to the Systems used to mitigate the risk of fire within the building and there was a lack of regular testing of fire alarms and emergency lighting and fire training.

We noted that practices policies were written in 2011 with review dates of 2017. This long review period meant that policies may not reflect any changes to legislation and recommended guidelines during the intervening period. For example, sharps and conscious sedation.

We found that the governance arrangements for sedation did not reflect the governance arrangements set out in the Department of Health document, conscious sedation in the provision of dental care 2003.

There were weak governance arrangements for the management of medicines including storage arrangements and records management for practice held prescription only medicines.

There were issues relating to general record keeping standards of the practice. Dental care records did not contain the level of detail set out in current guidance. Infection control audits, maintenance certificates for items of equipment and the training records of staff were not available on request.

Leadership, openness and transparency

The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. All of the comment cards we saw reflected this approach.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal dentist. There was a no blame culture within the practice. They felt they were listened to and responded to when they raised a concern. We found staff to be hard working, caring and committed to the work they did.

Staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence that staff received an annual appraisal.

With respect to clinical audit, we saw results of an audit of the quality of X-rays which demonstrated that good standards were being maintained.

We noted there was not an established system in place for collating the records of completed training and development needs of staff members.

Although some audit was being carried out by the practice systems required improvement. The principal dentist told us they undertook an audit of infection control procedures on an annual basis. Current guidelines state that audit should be carried out twice yearly. The owner was unable to demonstrate when the last audit took place.

Our findings demonstrated that an audit of record keeping standards would be beneficial.

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

The practice was listed on NHS Choices website. Information was not completely up to date. This included out of date information about building accessibility.

As a result of patient feedback the practice changed the physical access for disabled patients and people with reduced mobility.

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff told us that they had frequent meetings and described the meetings as good with the opportunity to discuss successes, changes and improvements. For example, changes included the introduction of latex free gloves.

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 **The registered person did not have effective systems in place to ensure that the regulated activities at the Castle Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** How the regulation was not being met: • Risk assessments in key areas such as infection prevention and control, recapping needles following administration of local anaesthetic and sedation had not been carried out. • Written policies and procedures were not reviewed regularly and updated to reflect changes in legislation and guidelines. • The practice did not have a robust system to record, respond and learn from significant events and accidents. Staff did not know what constituted a significant event and did not manage the accident book effectively. • Training records of staff members were not maintained to demonstrate relevant training had been undertaken by all relevant staff. • Protocols in place for conscious sedation did not take into account guidance for sedation set out in the Department of Health document, conscious sedation in the provision of dental care 2003. • Staff assisting in conscious sedation did not have the appropriate training and skills to carry out the role. • Medicines dispensing did not follow the secondary dispensing guidelines of the British Pharmacological Society.