Mr. Conor Farrell

# Pomfret & Farrell Dental

## Inspection Report

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## Overall summary

We carried out this announced inspection on 29 January 2019 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 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 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

Pomfret & Farrell Dental is in Chelmsford, Essex and provides NHS and private treatment to adults and children.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces are available in the practice car park behind the practice. Short and long stay car parks are available near the practice.

The dental team includes four dentists, eight dental nurses, two dental hygienists, five receptionists and the practice manager. The practice has five treatment rooms.

# Summary of findings

The practice is owned by a partnership and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run. The registered manager at Pomfret & Farrell Dental was one of the partners.

On the day of inspection, we collected 39 CQC comment cards filled in by patients and spoke with two other patients.

During the inspection we spoke with three dentists, three dental nurses, one dental hygienist, one receptionist and the practice manager. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open: Monday to Friday from 9am to 5.30pm.

### Our key findings were:

- We received positive comments from patients about the dental care they received and the staff who delivered it.
- The practice appeared clean and well maintained.
- The practice staff had infection control procedures which reflected published guidance. We found the practice did not have records of six monthly infection control audits however.
- Staff knew how to deal with emergencies. Appropriate medicines and some life-saving equipment were available. The practice was missing some essential medical emergency equipment such as some clear face masks. Other items were stored loose in a dusty state in an open plastic bag.
- Risk assessments to identify potential hazards were limited.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- Audits to assess the quality of service were limited.
- There was no system to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect. We found that not all dental care records were stored securely.
- The practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice staff dealt with complaints positively and efficiently.
- The practice staff had some information governance arrangements.

### We identified regulations the provider was not meeting. They must:

- Ensure care and treatment is provided in a safe way to patients.
- 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/is not meeting are at the end of this report.

- Review the practice's protocols for domiciliary visits taking into account the 2009 guidelines published by British Society for Disability and Oral Health in the document "Guidelines for the Delivery of a Domiciliary Oral Healthcare Service".
- Review the practice's protocols for patient assessments and ensure they are in compliance with current legislation and take into account relevant nationally recognised evidence-based guidance.
- Review the practice's storage of dental care records to ensure they are stored securely.

# 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 to provide safe care and treatment.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Not all the dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

We noted from dental care records that some dentists had worked without chairside support on occasion. There was no risk assessment in place for dentists generally working without chairside support or for when dentists attended patients in their own home or in residential homes.

Staff were qualified for their roles. We found that the practice did not always follow their recruitment procedure. We noted that references for two new members of staff recruited in 2018 had not been obtained. There were no risk assessments in place to assess the potential risks of no recent DBS checks being undertaken.

Premises and equipment were clean. Not all equipment had been serviced in line with manufacturers guidance. The practice followed national guidance for cleaning, sterilising and storing dental instruments. Not all dental care records were stored securely.

Appropriate life-saving equipment were not all available. We noted the practice was missing some essential medical emergency equipment such as some clear face masks. Other items were stored loose in a dusty state in an open plastic bag.

### Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patients described the treatment they received as excellent, attentive and outstanding. The dentists discussed treatment with patients so they could give informed consent. We noted these discussions were not always detailed in dental care records. Improvements were needed to ensure that patient dental care records, where applicable, had suitable documentation of details of basic periodontal examination (BPE) - a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. The practice confirmed that following the inspection they had reviewed their process for the recording of BPEs to ensure these were easily identified in patient dental records.

# Summary of findings

Not all dentists were aware of the prevention of wrong site extraction in Dentistry or were aware of the Delivering Better Oral Health toolkit.

Not all staff were aware of the need to consider Gillick competence, by which a child under the age of 16 years of age can consent for themselves, when treating young people under 16 years of age. Staff were not fully aware of the need to establish and confirm parental responsibility when seeking consent for children and young people.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

**Are services caring?**

**No action** 

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

We received feedback about the practice from 41 people. Patients were positive about all aspects of the service the practice provided. They told us staff were courteous, professional and kind.

They said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

Not all staff were aware of how to access interpretation services which were available for patients who did not speak or understand English. We were informed that patients could invite family relations to attend to assist. This may present a risk of miscommunications /misunderstandings between staff and patients.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect. During the inspection we saw examples of a caring and a respectful attitude shown towards patients from staff.

**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 practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had arrangements to help patients with sight or hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

# Summary of findings

**Are services well-led?**

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

We identified a number of shortfalls in the practice's governance arrangements including the analysis of untoward events, recruitment processes, the management of known risks, systems to ensure dental practitioners were up to date with current evidence-based practice, and the availability of emergency medical equipment. Not all the staff understood what constituted a significant or untoward event. We found where incidents had occurred there was no learning processes in place or systems to manage different types of incidents.

We were told that circumstances over the previous two years had impacted greatly on the effective management of the practice. The dentists and the practice manager were aware of the shortfalls in the practice's governance procedures and it was clear they were working hard to try to improve the service.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff. The staff enjoyed their work and felt supported by the principal dentists and practice manager.

**Requirements notice** 

# Are services safe?

## Our findings

### Safety systems and processes (including staff recruitment, Equipment & premises and Radiography (X-rays)

The practice had clear systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff received safeguarding training. All staff including the safeguarding lead were trained to Level 2. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns.

There was a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

Not all the dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, other methods were not always used to protect the airway. This was not documented in the dental care record, and no risk assessment had been completed to mitigate any risk.

We did not see the practice business continuity plan. There was a business continuity policy, which outlined how the practice plan would deal with events that could disrupt the normal running of the practice.

The practice had a staff recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at five staff recruitment records. We found that the practice did not always follow their recruitment procedure. We noted that references for two new members of staff recruited in 2018 had not been obtained. One of these members of staff had a DBS check in place, however this had been completed in 2014 by a previous employer. There was no risk assessment in place to assess the potential risks of the time difference since the previous DBS had been undertaken.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

The practice ensured that facilities were safe including electrical and gas appliances. We found that not all equipment was maintained according to manufacturer's instructions. There were two washer disinfectors in the decontamination room. These had not been serviced, we were told they were no longer used, the practice manager confirmed these would be removed from the practice soon. We did not see any servicing documentation for the two ultra-sonic baths and there was no evidence of quarterly efficiency testing.

Records showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested and firefighting equipment, such as fire extinguishers, were regularly serviced. A fire risk assessment had been completed by an external organisation on 24 January 2019 with an outcome of a low risk. We noted a fire drill had been undertaken the day before the inspection on 28 January 2019.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. We were told the practice carried out radiography audits every year following current guidance and legislation, however we only saw the most recent audit undertaken 29 October 2018. We noted that not all clinicians were using rectangular collimation. This is a metallic barrier with an aperture in the middle used to reduce the size and shape of the X-ray beam, thereby reducing the dose to the patient.

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

### Risks to patients

There were some systems to assess, monitor and manage risks to patient safety.

# Are services safe?

The practice had recently signed up to an information governance system to support the governance of the practice and help manage potential risk. The practice's health and safety policies, procedures and risk assessments were up to date and had been recently reviewed.

The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken as part of the health and safety audit, we were told this would be updated annually.

The provider had some system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, there was scope to ensure the effectiveness of the vaccination had been checked for all staff. We found for one member of staff there was no record of immunity in their records. The practice had not undertaken a risk assessment to mitigate any potential risks.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. We saw that staff had training scheduled for March 2019.

Emergency equipment and medicines were mostly available. We found that some items were missing including some clear face masks. Other items were stored loose in a dusty state and in an open plastic bag.

A dental nurse mostly worked with the dentists when they treated patients in line with GDC Standards for the Dental Team. We noted from patients' dental care records that some dental treatments had been completed without chairside support. We noted a risk assessment was in place for when the dental hygienist worked without chairside support and when the dentists worked without chairside support for treatment out of hours. However, there was no risk assessment in place for dentists generally working without chairside support or for when dentists attended patients in their own home or in residential homes.

The hygienist would usually request nurse support for charting and decontamination.

The provider had some risk assessments to minimise the risk that can be caused from substances that are hazardous to health. We noted these were lacking detail and risk assessment for all substances held at the practice.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required. There was no named lead for infection control as this duty was shared by the dental nurses.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. Records we saw did not evidence that all equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. We found there was no evidence of servicing or records of decommissioning for the two washer disinfectors in the decontamination room. Or servicing documentation or quarterly efficiency testing for the two ultra-sonic baths.

The practice had systems in place to ensure that any work was disinfected prior to being sent to a dental laboratory and before treatment was completed.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment which had been undertaken on 20 January 2019. We noted there was a low risk with no recommendations; records of water testing and dental unit water line management were in place.

The practice was clean when we inspected and patients confirmed that this was usual. We did not see any cleaning schedules for the premises. The practice manager told us an external cleaning company had been attending the practice when it was closed.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

The practice policy stated the practice carried out infection prevention and control audits twice a year. The practice

# Are services safe?

manager had until recently only been undertaken every two years. The latest audit undertaken January 2019 showed the practice was meeting the required standards. We did not see any previous infection control audits.

We noted the three exterior clinical waste bins were locked but had not been secured.

### 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 a sample of dental care records to confirm our findings and noted that in some dental care records recorded information detailing discussions between the dentist and patient regarding diagnosis, treatment options available, any associated risks and consent before the treatment commenced was not always recorded. Conversations were not always clearly detailed in patients' dental records.

We noted that the practice had undertaken a recent audit of patients' dental care records in January 2019 for all clinicians. This had identified actions, discussions of the outcome from this audit had been undertaken.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

### Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

Storage and records of NHS prescriptions were not secure and did not reflect current guidance.

We found that there was potential for over supplying medicines to patients because the practice dispensed full boxes of antibiotics to patients irrespective of the clinical situation. In addition, we found medicine labels did not contain the name and address of the practice and the dentists did not routinely audit their antibiotic prescribing as recommended.

### Track record on safety

There were some risk assessments in relation to safety issues. We noted a general health and safety risk assessment had been undertaken on 22 January 2019.

We were told in the previous 12 months there had been no safety incidents. However, we noted four incidents recorded in the practice accident book, two involving patients' trips and falls and one sharps injury that had not been investigated, documented and discussed with the rest of the dental practice team to prevent such occurrences happening again in the future.

### Lessons learned and improvements

Staff were generally not aware of the Serious Incident Framework or the need to record, respond to and discuss all incidents to reduce risk and support future learning in line with the framework.

There were some systems for reviewing and investigating when things went wrong. However, we were told these were not always documented in staff meeting minutes to ensure they had learned and shared lessons.

The practice team confirmed they were no longer receiving safety alerts. We discussed this with the dentists and practice manager and during the inspection. The practice confirmed they had signed up to receive patient and medicine safety alerts and would be implementing a system for receiving, sharing with the team and acting on safety alerts.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment, care and treatment

The practice had some systems to keep dental practitioners up to date with current evidence-based practice. We saw that the dentist assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. There was no protocol was in place to prevent wrong site surgery. We found the dentists were not aware of guidance for wrong site extraction in Dentistry.

Our discussion with the dentists and review of dental care records demonstrated that improvement was needed in the recording in patients' dental records. Not all the dental care records we looked at showed proposed treatment options had been discussed. We discussed this with the principal dentists who confirmed this had been identified and discussed following a recent records audit.

The principal dentist undertook some dental care in domiciliary settings such as care homes of people's residence. The dentist described how they ensured someone would be with the patient to act as chaperone, the dentist only performed examinations of denture fittings and did not undertake invasive procedures. However, they did not undertake risk assessment prior to the visit to mitigate any risk as set out in guidelines by the British Society for Disability and Oral Health when providing dental care in domiciliary settings.

### Helping patients to live healthier lives

The practice was providing preventive care and supporting patients to ensure better oral health. The dentists were following aspects of the Delivering Better Oral Health toolkit. However not all dentists we spoke with were fully of aware of it.

The dentists told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children and adults based on an assessment of the risk of tooth decay.

The dentists where applicable discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns and local schemes available in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentists and dental hygienist described to us the procedures they used to improve the outcome of periodontal treatment. This involved preventative advice, taking plaque and gum bleeding scores and detailed charts of the patient's gum condition. We noted this was not always recorded in patient's records.

Patients with more severe gum disease were recalled at more frequent intervals to review their compliance and to reinforce home care preventative advice.

### Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. These discussions were not always notated in the clinical record.

The dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves. The staff were not aware of the need to consider this when treating young people under 16 years of age. Staff were not fully aware of the need to establish and confirm parental responsibility when seeking consent for children and young people.

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

Our discussion and review of dental care records demonstrated that improvement was needed in the continuity of recording in some patients' dental records. Improvements were needed to ensure that patient dental care records, where applicable, had suitable documentation of details of BPEs. The practice confirmed that following the inspection they had reviewed their

# Are services effective?

## (for example, treatment is effective)

process for the recording of BPEs to ensure these were easily identified in patient dental records. The practice undertook an audit of dental care records which confirmed these were in place.

We found that in some dental care records recorded information detailing discussions between the dentist and patient regarding diagnosis, treatment options available, any associated risks and consent before the treatment commenced was not always recorded.

### Effective staffing

We saw that staff had undergone training and had the skills, knowledge and experience to carry out their roles.

Staff new to the practice had a period of induction based on a structured induction programme.

We saw that staff had not had appraisals since 2016. We discussed this with the practice manager who confirmed that these had been delayed. We noted that all staff had recently completed a pre-appraisal assessment for a scheduled appraisal in early 2019.

### Co-ordinating care and treatment

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

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

The practice had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems and processes for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

# Are services caring?

## Our findings

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patients commented positively that staff were courteous and professional. We saw that staff treated patients respectfully and kindly and were supportive and friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding and they told us they could choose whether they saw a male or female dentist.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

### Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

The layout of reception and waiting areas provided some privacy when reception staff were dealing with patients. Staff told us that if a patient asked for more privacy they would take them into another room. We noted that computer screens on the reception desk were not visible to patients in the waiting room. Staff did not leave patients' personal information where other patients might see it.

We found patients paper dental records were stored on open shelves in treatment rooms. The practice cleaning company had access to the practice when it was closed. The practice manager could not confirm if confidentiality agreements had been signed by all those that attended the practice.

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

### Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and told us they were aware of

requirements under the Equality Act.

- Not all staff were aware of how to access interpretation services which were available for patients who did not speak or understand English. We were informed that patients could invite family relations to attend to assist. This may present a risk of miscommunications/ misunderstandings between staff and patients.
- Staff communicated with patients in a way that they could understand and communication aids and easy read materials were available. For example, staff described how they supported patients with reduced vision and hearing, supporting patients who lip-read by speaking clearly or writing things down when needed and directing patients to chairs or supporting them with paperwork.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Patients confirmed that the practice gave them clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush 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. We noted these conversations were not always clearly detailed in patients' dental records.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included photographs and X-ray images. There was scope to extend the range of methods and health leaflets available to patients to help them better understand the diagnosis and treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### 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 were clear on the importance of emotional support needed by patients when delivering care.

We saw examples of how the practice team supported vulnerable members of society such as patients with dental phobia, vulnerable groups in care homes, adults and children with a learning difficulty, and those living with dementia, and other long-term conditions. Staff described how they supported patients to complete or understand paperwork if they were unable to see or read it.

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

The practice had made reasonable adjustments for patients with disabilities. These included step free access and accessible toilet with hand rails and a call bell. However, we found the call bell had been secured high up above a picture out of reach of a patient in distress, we were told this was to prevent it being pulled in error.

Staff told us that they sent patients emails to confirm their appointment and to remind them the day before, they also telephoned some patients on the morning of their appointment to make sure they could get to the practice.

### 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 practice information leaflet and on their website.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day.

Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

They took part in an emergency on-call arrangement with the NHS/111 out of hour's service.

The practice website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

### Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The practice manager and registered manager was responsible for dealing with these. Staff would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The practice aimed to settle complaints in-house and patients were invited to speak with the practice manager or partners in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received in the previous 12 months.

These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service.

# Are services well-led?

## Our findings

### Leadership capacity and capability

The principal dentists had overall responsibility for the management and clinical leadership of the practice. Staff told us both the principal dentists and practice manager were approachable and listened to them.

### Vision and strategy

There was a clear vision and set of values. The practice had a realistic strategy and had recently introduced supporting business plans to achieve priorities.

The practice aimed to provide dental care and treatment of consistently good quality for all patients. Its objectives included to deliver a service of high standard in line with professional standards.

### Culture

The practice was small and friendly, something which patients particularly appreciated. Staff enjoyed their job and felt supported, respected and valued in their work. Staff reported they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

The practice had a Duty of Candour policy in place, although staff were not aware of their responsibilities under it, and there was no evidence to show the policy had been shared with them.

### Governance and management

We identified a number of shortfalls in the practice's governance arrangements including:

- recruitment processes,
- the management of known risks,
- systems to ensure dental practitioners were up to date with current evidence-based practice,
- availability of emergency medical equipment.
- Not all the staff understood what constituted, or the analysis of significant or untoward events.
- We found where incidents had occurred there was no learning processes in place or systems to manage different types of incidents.
- We saw one infection control audit undertaken in January 2019, staff could not confirm when or how often these were undertaken before this.
- We were told previous records had not been retained. Recruitment process were not in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- There was no system in place to ensure staff received regular appraisal of their performance.
- Systems to ensure detailed dental record keeping were not robust.
- Team meetings were not held regularly and not always documented.

The principal dentists had overall responsibility for the management and clinical leadership of the practice. The practice manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

The provider had recently introduced a software system of clinical governance which included policies, protocols and procedures. Not all the processes undertaken at the practice reflected the new protocols and policies. For example, the infection control protocol stated audits were undertaken six monthly but the practice staff told us these were undertaken every two years. The dentist and practice manager confirmed that a lot of governance work had been undertaken in the two weeks prior to the inspection and that much of this had yet to be embedded across the practice and practice team.

The dentists and the practice manager were aware of the shortfalls in the practice's governance procedures and it was clear they were working hard to try to improve the service.

### Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

The practice used patient surveys, social media pages and verbal comments to obtain patients' views about the service.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. Results from the most recent patient survey had been collected but not audited yet into a report. Survey comments we reviewed were wholly positive.

# Are services well-led?

The practice gathered feedback from staff through meetings and informal discussions. We were told regular six weekly team meetings were held. However, from minutes we looked at, we noted the last staff meeting was recorded in September 2018. Previous meetings were held in July 2018, February 2018 and January 2018. We discussed this with the practice manager who told us they had scheduled regular six weekly meetings throughout 2019 for all staff.

Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

### Continuous improvement and innovation

The practice had some quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. There was only one recent infection control audit available to review during our inspection.

There was no system in place to ensure staff received regular appraisal of their performance. We found appraisals had not been undertaken for all staff annually.

The dentists valued the contributions made to the team by individual members of staff.

Staff completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. The provider supported and encouraged staff to complete CPD.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Regulation 12- Safe Care and Treatment.<br>Care and treatment must be provided in a safe way for service users.<br>The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:<br>How the regulation was not being met.<br>· The registered person failed to ensure consistent use of rubber dams or other methods used to protect patients' airways.<br>· The registered person failed to ensure a protocol was in place to prevent wrong site surgery.<br>· The registered person had not signed up to receive national patient safety and medicines alerts.<br>· Appropriate life-saving equipment was not all available. We noted the practice was missing some essential medical emergency equipment such as clear face masks. Other items appeared dated and were stored loose in a dusty state in an open plastic bag.<br>· The dentist did not follow national guidance in relation to chair side support.<br>· The registered person failed to ensure there was a system in place to ensure the security of NHS prescription pads in the practice.<br>Regulation 12 (1) |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 Good governanceSystems 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.

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

· The registered person failed to ensure a system was in place to ensure that untoward events were analysed and used as a tool to prevent their reoccurrence.

· The registered person failed to have systems in place to ensure clinicians were up to date with current evidence-based practice.

· The registered provider had failed understand their responsibilities in relation to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Gaining references and DBS checks.

· Audits for infection control were not undertaken in line with national guidance. No action plans and learning outcomes were in place.

· Staff did not receive regular appraisal of their performance.

· Staff did not have a clear understanding of Gillick competence and how this might impact on treatment decisions or the need for the practice to establish parental responsibility when seeking consent for children and young people.

· Medicine prescribing protocols were not in line with national guidance.

· Protocols for the completion of dental care records were not in line with the guidance provided by the Faculty of General Dental Practice.

Regulation 17 (1)