

Mr. Michael Forde

Green Lane Dental Surgery

Inspection Report

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Overall summary

We carried out this announced inspection on 7 August 2018 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 not 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

Green Lane Dental Surgery is in Liverpool and provides NHS and private treatment to adults and children.

The approach to the practice is served by three large stone steps, with level access beyond this point for people who use wheelchairs and those with pushchairs. Car parking spaces are available immediately in front of the practice and in front of the community pharmacy next door to the practice.

Summary of findings

The dental team includes one dentist, three dental nurses, one of whom is the practice manager, and two part time dental hygienists. The practice has two treatment rooms. An implantologist visits the practice to provide care and treatment as required.

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

On the day of inspection, we collected 33 CQC comment cards filled in by patients and spoke with one other patient.

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

The practice is open on Tuesday, Wednesday and Thursday from 8.45 am to 5.30pm; Monday from 8.45am to 7pm, and Friday from 8.45am to 2.00pm. The practice closes for lunch Monday to Thursday from 1pm to 2pm.

Our key findings were:

- The practice appeared clean and well maintained. We found some areas of the practice required more focussed cleaning.
- The practice staff had infection control procedures in place; we noted that not all staff had received up to date infection control training; staff did not have protocols to follow in the management of dental unit water lines.
- Staff knew how to deal with emergencies. Medicines and life-saving equipment were available. On inspection we found the medical oxygen cylinder to be out of date for pressure testing and that it was below the size recommended by the Resuscitation Council UK.
- The practice had some systems in place to help them manage risk; several of these had not been regularly reviewed for example, in relation to fire risks, personal evacuation plans and in respect of Legionella control.
- The practice staff could describe safeguarding processes and staff knew their responsibilities for safeguarding adults and children.

- The practice had staff recruitment procedures in place but copies of documents to support this were not in place for all staff. There was no overarching system in place to ensure checks were carried out on the indemnity cover of all clinical staff.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect.
- The practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- The practice had leadership and direction from the dentist.
- 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 in place but this required improvement.

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 is not meeting are at the end of this report.

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

- Review the practice's protocols for completion of dental care records taking into account the guidance provided by the Faculty of General Dental Practice.
- Review the content of meeting agendas to establish core subjects for discussion each month, for example significant events, staff training requirements and to share essential safety and clinical updates.
- Prioritise computerisation of the practice, to facilitate improved governance processes and management of documents.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services safe?

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

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns. Training in several areas required review, including fire training, to ensure all staff received regular updates.

Staff were qualified for their roles; recruitment procedures were in place but documentary evidence of all the required checks was not available.

Premises and equipment appeared clean and properly maintained. When we made checks on some parts of the practice, we saw they were dusty and more attention was required in the cleaning of other areas. When we reviewed procedures in the decontamination room, we found the practice did not adhere to all national guidance for cleaning, sterilising and storing dental instruments. There was no protocol in place for dental nurses to follow in the management of dental unit water lines.

Standards of cleaning in the dental surgeries could be improved.

Risk assessments in respect of fire and Legionella required review.

Checks on the electrical safety of the building had not been conducted; gas safety checks carried out were in line with those required in a domestic property, as opposed to a commercial property.

The practice had suitable arrangements for dealing with medical and other emergencies. These should be reviewed to ensure that emergency medicines, including medical oxygen, are held in the quantities recommended by the Resuscitation Council UK. Staff were not confident in the use of the automated external defibrillator held by the practice.

Requirements notice



Are services effective?

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 wonderful, excellent and outstanding. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records. Records we reviewed showed that each consultation was recorded. Patients did not have documented care and treatment plans within their records.

No action



Summary of findings

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. Systems to help them monitor this could be improved.

Are services caring?

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

We received feedback about the practice from 33 people. Patients were positive about all aspects of the service the practice provided. They told us staff were caring, understanding and helpful. One comment card gave feedback saying that access to urgent care was very good, but that follow-up waiting times could be lengthy.

Patients said that they were given several treatment options, costs associated with these and the advantages and any disadvantages of each treatment option. All patients commented that the dentist listened to them. Patients commented that the dentist and all staff made them feel at ease, especially when they were anxious about visiting the dentist.

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 our inspection we did note that throughout the day, the door to a dental hygienist's treatment room was open whilst treating patients. To increase privacy, this door should be closed.

No action



Are services responsive to people's needs?

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 three large stone steps leading to the front door; a call bell was available for people to ring if they required assistance with the steps. Access to the practice beyond this point was suitable for wheelchair users, those with other mobility aids and for prams and pushchairs. Patients with specific needs were known to the dentist and staff at the practice, and arrangements to assist these patients were in place.

The practice had access to telephone interpreter services, although this service had never been requested. There was also a hearing loop facility for patients with reduced hearing.

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

No action



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).

The practice had arrangements to ensure the smooth running of the service, and business continuity arrangements in place for when the service may be disrupted due to weather, power failure or other unforeseen events. Systems for the practice team to discuss the quality and safety of the care and treatment provided could be improved.

There was a defined management structure and staff felt supported and appreciated.

The practice team kept patient dental care records which were, clearly written and stored securely. These could be improved by producing formal dental care plans for patients.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. When we reviewed systems in place to support this, we saw that some of these were not effective. This included areas of governance and audit, and oversight and scrutiny checks, monitoring of staff training, staff access to alerts and updates, and the holding of regular, structured communication meetings.

Requirements notice

Are services safe?

Our findings

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

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

The practice had systems designed to keep patients safe. Some of these required review.

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, but this was out of date for several staff members. When we looked at staff training records, we noted that safeguarding training that had been delivered did not include topics such as modern slavery and how to spot signs of this, or of female genital mutilation (FGM). Staff knew about the more recognisable signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

There was a system to highlight vulnerable patients on records for example, 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. All patient records were paper based, so sharing this information across the practice was by direct communication between colleagues. This did not take place in formal practice meetings so it was unclear how all staff would be included on any update on, for example, a child's changing safeguarding status.

The practice also had a system to identify adults that were in other vulnerable situations for example, those with learning difficulties supported by carers.

The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination. When we reviewed the whistleblowing policy, we found that this required review, to include the correct contacts, including the National Freedom to Speak Up Guardian.

The dentist used a latex free dam in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where this was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was suitably documented in the dental care record and a risk assessment completed.

The practice had a business continuity plan describing how the practice would deal with events that could disrupt the normal running of the practice. When we spoke with the practice manager, we established that the only appointment booking system was through a large appointment book held on reception. There was no system in place to copy the dentist and hygienist appointments for each day, should the appointment book be lost, damaged or unavailable due to unforeseen circumstances.

The practice had a staff recruitment policy in place. When we made some checks on recruitment records, we saw that the procedures were not always followed, and all checks required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, were not recorded and documents to support these checks were not in place. For example, for all staff, there was no evidence of identity checks, proof of address checks or references. For the two dental hygienists, there was no evidence held of their levels of indemnity cover. We were sent evidence of this following the inspection.

We noted that clinical staff were qualified and registered with the General Dental Council (GDC) and had practice nurses had professional indemnity cover afforded by the policy of the dentist. We were not shown any evidence of checks on the indemnity of the two dental hygienists working at the practice. The provider was able to provide this in the weeks following inspection.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. When reviewing records, we saw the practice gas safety checks had been conducted to the standard for domestic premises, rather than a business premises. This was addressed at the inspection and a gas engineer was booked to visit the premises within seven days of our inspection. The practice had not had an electrical safety check of the premises carried out. This was

Are services safe?

addressed at the inspection, with an electrical inspector booked to visit the practice on 1 September 2018 for a full electrical installation check, and for 10 September 2018 to conduct portable appliance testing.

When we reviewed the fire risk assessment, we saw that this had been carried out in 2013 and had not been updated or reviewed since then. This had not taken account of the residential accommodation above the practice or its occupants, for whom the practice front corridor and front door was their means of escape. Records showed that emergency lighting was not present at the practice. There were smoke detectors in the practice but no fire alarm. Consideration had not been given as to whether residents in the accommodation above the practice would hear smoke alarms in the practice, in the absence of a fire alarm. There were large amounts of stored paper records at the practice in the basement area, which had not been considered in the risk assessment.

Firefighting equipment was regularly tested and available in various, accessible locations in the premises.

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. The practice carried out radiography audits every year following current guidance and legislation.

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

Risks to patients

There were systems to assess, monitor and manage risks to patient safety. Some of these required updating; others required action to address recommendations made, which would further reduce risks.

The practice had health and safety policies, procedures and some risk assessments. The Legionella risk assessment required review and updating, and for any action points identified to be addressed, such as identified dead legs on the water system being removed.

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 and was reviewed recently.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. Paper records held by the practice supported this was carried out.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS).

Emergency equipment and medicines were available, but not all items held met recognised guidance. For example, the medical oxygen cylinder at the practice was smaller than the recommended 460 litre cylinder, referred to in Resuscitation Council UK guidance. This cylinder was also overdue for the recommended pressure testing to check its efficacy. We noted that there were no signs on the surgery doors or at the entrance to the building to indicate that medical oxygen was held on the premises.

Staff kept records of checks made to make sure these medicines were available, within their expiry date, and in working order.

We asked a staff member who carried out checks on the emergency equipment, to show us the practice automated external defibrillator and how this worked. This staff member was not confident in how they would use this piece of equipment. They told us they had never been given the opportunity to practice or learn with this piece of equipment. This confirmed that refresher training on emergencies and basic life support was required for some staff.

A dental nurse worked with the dentists and the dental hygienists when they treated patients in line with GDC Standards for the Dental Team. The principal dentist and all staff confirmed that there was never any lone working at the practice.

The provider had risk assessments to minimise the risk that can be caused from substances that are hazardous to health. Staff who were responsible for cleaning the

Are services safe?

surgeries and dental equipment in the decontamination room, could identify what products used were for and any precautions to be taken, for example, in the use of substances by staff who may be pregnant.

The practice had an infection prevention and control policy and procedures. They followed much of 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. From conversations with staff on the day of our inspection, we found that further training and understanding was required in this area.

Staff had completed infection prevention and control training but required updates in several areas. For example, to increase their understanding in relation to the management of dental water lines, on the materials and detergents suitable for use in the manual cleaning of dental instruments, on the temperature for water used in manual cleaning of instruments, and on general cleaning of dental surgeries and the decontamination room itself. We found staff were using domestic washing up liquid to clean dental instruments and there was no thermometer available to staff to measure the temperature of the water used to clean instruments. When we asked staff, they told us dental water lines were being flushed at the beginning and end of the day, but not at the start of afternoon surgery and between patients. Some staff were not aware how long the lines should be flushed for.

The practice had suitable arrangements for transporting, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. We noted that there were some items that were being cleaned and re-used, which were designed for single use only. When we checked the stock of dental instruments and materials in the surgeries, we found some items, such as tooth coloured filling materials, that had exceeded the expiry dates.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a dental laboratory and before the dental laboratory work was fitted in a patient's mouth.

Dental nurses were responsible for cleaning the surgeries each day, with a domestic cleaner visiting the practice one

day each week. Some areas of the practice were not consistently cleaned. For example, in one surgery we could see evidence of a spillage which had seeped onto an equipment tray, which had not been cleaned; this had been in this condition for some time. Some of the surfaces within the practice in both the clinical rooms and the decontamination room were dusty. There were no protocols detailing how often the practice would be deep cleaned, or evidence that this was carried out on a regular basis.

Feedback from patients was that the practice appeared clean.

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

The practice carried out infection prevention and control audits twice a year. The latest audit had failed to identify any of the concerns or areas requiring improvement, highlighted by our inspection.

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 individual records were written and managed in a way that kept patients safe. Dental care records we saw were accurate and legible and were kept securely and complied with the General Data Protection Regulations (previously referred to as the Data Protection Act). We discussed with the principal dentist the current format of dental records and prompts used when making notes during consultations. At present, records are stamped at the time of the consultation, and the stamp has prompt fields. Currently, treatment plans are discussed verbally with patients but not formally recorded. We discussed the need to have formal patient records that can be reviewed by external bodies, should this be required.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance. Evidence on the day showed there was no system in place to track any referrals, so these could be followed up, should this be required.

Are services safe?

Safe and appropriate use of medicines

Overall, the practice had reliable systems for appropriate and safe handling of medicines. We noted that there were no signs displayed in appropriate places in the practice, to warn that medical oxygen was held on the premises.

There was a stock control system for medicines which were held on site. This was in place to ensure that medicines did not pass their expiry date and enough medicines were available if required. This was not completely effective, as it had not identified that the medical oxygen was beyond its pressure testing date.

The practice stored NHS prescriptions as described in current guidance. The dentist was the only prescriber at the practice. There was no log in place to record batch numbers of prescriptions used, should there ever be a requirement to check on the issue of a prescription.

The dentists were aware of current guidance with regards to prescribing medicines.

Antimicrobial prescribing audits were carried out annually. The most recent audit demonstrated the dentist was following current guidelines.

Track record on safety

The practice had a good safety record.

There were risk assessments in place in relation to safety issues, but some of these required review. The practice monitored and reviewed incidents, for example, by recording them in an accident book, which helped it to understand how risks had developed and presented in the work environment. The principal dentist confirmed that any incidents were discussed but these were not recorded as significant events, and learning from these was not routinely shared with all staff at practice meetings.

Lessons learned and improvements

Some staff were aware of the Serious Incident Framework; some of the dental nurses could not describe this.

The principal dentist had a system for receiving and acting on safety alerts. We found that these were not routinely shared with all staff in the practice. There was no evidence that these were discussed at practice meetings, where staff would have the opportunity to ask any questions to increase understanding.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The principal dentist had systems to keep them up to date with current evidence-based practice. This was managed by individuals to meet their own needs, rather than the needs of all practice staff. For example, the dentist was signed up to receive alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), but there was no evidence that these alerts were shared and discussed with staff. The same was true for updates from the National Institute of Health and Care Excellence (NICE). The dental hygienists at the practice were both self-employed and worked one day each week. There was no evidence to show that the principal dentist had systems in place to ensure that these staff had sight of these updates. When staff were asked about alerts and updates, they were not aware of alerts from the MHRA or any other updates. As an example, staff were not aware that guidance from the Resuscitation Council UK, had recommended an increase in the size of medical oxygen cylinder required in dental practice, to ensure that sufficient oxygen is available to treat patients, when required.

From discussion with the principal dentist on the day, we saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

The practice offered referral onwards to dentists who could offer dental implants. These were placed by the visiting dentist who had undergone appropriate post-graduate training in this area. The provision of dental implants was in accordance with national guidance.

Helping patients to live healthier lives

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

The dentist 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 based on an assessment of the risk of tooth decay.

The dentist told us that where applicable they 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 dentist 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. 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 obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist told us they 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 aware of the need to consider this when treating young people under 16 years of age.

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

Monitoring care and treatment

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

Are services effective?

(for example, treatment is effective)

We saw that the practice audited patients' dental care records to check that the dentist recorded the necessary information. We noted that there were no detailed patient treatment or care plans within the dental records.

Effective staffing

Staff had the skills and experience to carry out their roles. Some staff required refresher training for example, fire training, basic life support and emergency procedures, updated infection prevention and control and safeguarding training. When we made checks, we found one staff member had not received fire training since 2013. One staff member said they had training in basic life support and emergency procedures, but when questioned, could not demonstrate how to use a defibrillator or how to check it was ready for use. Although refresher training may have been delivered through the medium of a practice meeting, this did not support staff to confidently manage and use emergency equipment. Another member of staff had not received an update on safeguarding training since 2012. The dentist who was the safeguarding lead had been trained to L2 in SG of children and adults, but this was due for renewal in January 2018. One of the hygienists had last done safeguarding training in May 2014; for two of the nurses, there was no record of when safeguarding training was last undertaken.

Staff new to the practice had a period of induction based on a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at annual appraisals. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff. As the practice did not monitor staff training it was difficult to maintain oversight of when staff required any training updates.

Co-ordinating care and treatment

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

The dentist 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 good communication between all staff in relation to patient referrals. When we made checks, there were no formal systems and processes in place to manage and follow up referrals of patients for specialist care.

The practice 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 these 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 kind, supportive, considerate and thoughtful. We saw that staff treated all patients respectfully, appropriately and with consideration and were friendly towards patients at the reception desk and over the telephone.

Patients said staff were compassionate and understanding and kind and helpful when they were in pain, distress or discomfort.

Information folders, patient survey results and thank you cards were available for patients to read.

Privacy and dignity

The practice staff told us they respected and promoted patients' privacy and dignity. We did notice that throughout our inspection day, the door of one of the surgeries was left open whilst treatment was being performed. We could not overhear any conversation between the clinician and patient.

Staff told us they were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided 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. Documents in relation to patients on the reception desk were not visible to patients and staff did not leave patients' personal information where other patients might see it.

All patient records were stored securely.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the

Accessible Information Standards and the requirements under the Equality Act.

The Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpreter services were available for patients who did not have English as a first language. Staff communicated with patients in a way that they could understand, for example, communication aids for example a hearing loop and easy read materials were available if required.
- 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.

The practice gave patients 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. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

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

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, photographs, models and X-ray images.

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.

Feedback from patients described how children in short term foster care were accommodated at the practice, so that their dental health could be maintained.

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

Staff told us that they had patients for whom they needed to make adjustments to enable them to receive treatment. For example, staff assisted those with reduced mobility on arrival at the practice, by helping them up the stairs to the front door.

The practice had made reasonable adjustments for patients with disabilities. This included step free access inside the practice, a hearing loop, a magnifying glass and accessible toilet with hand rails and a call bell.

A disability access audit had been completed which showed that the installation of a ramp at the front of the practice was not achievable due to the limited space at the front of the practice.

Staff told us that they telephoned some older patients on the morning of their appointment to make sure they could get to the practice.

Timely access to services

Patients were able to 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.

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.

The practice information leaflet 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 dentist was responsible for dealing with these. Staff told us they would first tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

The dentist told us they aimed to settle complaints in-house and invited patients to speak with them 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 within the past 12 months. These showed the practice responded to concerns appropriately and discussed outcomes with staff to share any learning and improve the service.

Are services well-led?

Our findings

Leadership capacity and capability

The dentist had the capacity and skills to deliver high-quality, sustainable care. We found they were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges they faced and were addressing them. For example, the dentist told us they had reviewed available computer systems suitable for dental practices, and had plans in place to computerise the practice.

The dentist and the practice manager were visible and approachable. They worked closely with all staff to make sure they practised inclusive leadership. Throughout the day, we saw areas of work within the practice, that were not supported by protocols and procedures to follow. As a result, the practice did not have effective processes in place in several areas, including the development of leadership capacity and skills.

Vision and strategy

The dentist told us of their vision for the practice and about the values they embraced. The practice had some supporting business plans to achieve priorities. The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture of quality sustainable care which was patient focussed.

Staff stated they felt respected, supported and valued. They were proud to work in the practice.

The practice focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Paperwork to record this was often incomplete or absent. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff told us they could raise concerns and were encouraged to do so. They had confidence that any concern would be addressed.

Governance and management

There was a lack of clear responsibilities attached to staff roles and systems of accountability to support good governance and management within the practice.

The dentist 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 said they knew the management arrangements and their roles and responsibilities. Throughout our inspection day, we saw that there were some systems for clinical governance in place which included policies, that were accessible to all members of staff. When we looked at specific areas, we could see that job roles and descriptions were insufficiently detailed to ensure each staff member knew what they should be doing to fully complete a task. As an example, the dental nurses were responsible for cleaning the surgeries at the practice. Systems in place to check that cleaning was carried out to the required standard, were ineffective. There was a lead nurse for decontamination processes. When we reviewed systems in the decontamination room, we saw that there was no cleaning schedule in place for the cleaning of this room at the end of each day. A domestic cleaner visited the practice once a week to clean all non-clinical areas. There was no cleaning schedule for the cleaner to follow, and no indication that anybody would check all areas had been effectively cleaned.

With regard to other areas of governance, this required improvement. We found:

- There was no process in place to ensure all the required checks on staff for the recruitment process, had been carried out. The practice manager was unaware of all documents that are required to be held following recruitment.
- There was no system in place to trigger checks on each staff members professional registration, or on the indemnity of the two self-employed dental hygienists and the visiting implantologist.
- There was no monitoring system for staff training, to show when this was due for each staff member. As a result, some staff refresher training had not been delivered.

Are services well-led?

- There was no overarching tool to assist in the scheduling of essential checks on the premises and its fittings, fixtures and equipment. For example, the medical oxygen cylinder was past its date for being pressure checked or renewed.
- There was no electrical safety check in place for the building; gas checks had been conducted to a domestic standard, rather than a business standard.
- Legionella risk assessment recommendations had not been met, and fire risks had not been addressed.
- There was no clearly defined system in place to facilitate the receipt, dissemination and discussion of safety alerts, clinical guidance updates and local health care bulletins.
- There was a lack of a consistent meeting agenda, to support regular practice meetings, where key topics could be discussed and any learning shared.
- There was a lack of awareness amongst staff of the need to record, investigate and document findings and learning points accurately in relation to any significant events that occurred within the practice.

Overall, there was a lack of effective processes for managing known risks within the practice and for identifying emerging risks.

Appropriate and accurate information

The practice told us they acted on appropriate and accurate information but there was a lack of documented evidence to fully support this. Operational information was used to ensure and improve performance, for example in relation to treatment targets in line with NHS contracts. Performance information was combined with the views of patients.

Engagement with patients, the public, staff and external partners

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

The practice sought patient feedback and staff feedback to obtain their views about the service. We saw examples of suggestions the practice had acted on, for example, by having a doorbell outside the practice for use by any patients who needed assistance when negotiating the steps outside the building.

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 for the practice were high with patients saying they were either likely or highly likely to recommend the service to a friend or family member.

The practice gathered feedback from staff through meetings and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were some systems and processes for learning, continuous improvement and innovation.

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, radiographs and infection prevention and control. They had clear records of the results of these audits. Where any improvements were required in relation to radiography, the dentist, who was the only person conducting radiographs, managed the improvements necessary. In the case of infection control audit, this required some improvement in the understanding of the standards required throughout the practice. Audits completed in the last six months had not identified any of the concerns raised by our inspection.

The dentist showed a commitment to learning and improvement in the practice and valued the contributions made to the team by individual members of staff.

The dental nurses had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually. Review of records held showed that some staff had not received basic life support training on an annual basis. We also noted that staff could not access on-line learning facilities during working hours as the practice was not computerised. This presented challenges in managing the learning of staff at the practice.

Are services well-led?

The General Dental Council also requires clinical staff to complete continuing professional development. Staff told us the practice provided support and encouragement for them to do so.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment How the regulation was not being met The registered person was not carrying out assessments of the risks to the health and safety of service users of receiving care or treatment, nor doing all that was reasonably practicable to mitigate these risks. In particular: 1. Not all the recommended medical emergency and life support equipment was available at the practice, namely, medical oxygen in the quantity recommended and in a tank that had been pressure tested for its efficacy. 2. Staff training required updating, for example, fire training, basic life support and emergency procedures, updated infection prevention and control and safeguarding training. 3. The cleaning of clinical rooms required review to ensure this met guidance set out in Health Technical Memorandum 01-05. 4. Decontamination processes require review to ensure that staff understand this fully and have the materials and understanding to complete these duties. 5. Maintaining oversight and scrutiny of the processing of instruments in the decontamination room, to assure that staff recognise those items designed for single use only. 6. The fire risk assessment for the building required renewing to cover the whole building, taking account of accommodation above the dental practice. 7. The Legionella risk assessment required action to ensure all recommendations were addressed. Regulation 12(1)

Requirement notices

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17 Safe care and treatment

How the regulation was not being met

There were insufficient systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

1. Records to demonstrate that all required staff recruitment checks had been conducted, were not in place. Full job descriptions for all staff, covering the extent of their duties and responsibilities were not available to staff.
2. Records to demonstrate that all staff had received appropriate training and that this had been refreshed in accordance with guidance, were not in place.
3. There were no records in place to demonstrate that cleaning was monitored. There were areas of the practice and clinical rooms that required greater attention in cleaning. This had not been picked up by any visual checks or by infection control audits.
4. There was no protocol in place for staff to follow in the flushing of dental water lines and in the daily management of these.
5. Records were not in place to demonstrate that alerts and updates, for example, from the MHRA, NICE and CAS were disseminated, shared and discussed with staff.

Regulation 17(1)