

Avtar Pardesi Ltd

Cambridge Street Dental Practice

Inspection Report

28 Cambridge Street
St Neots
Cambridgeshire
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Tel:01480 475438
Website: N/A

Date of inspection visit: 28 November 2016
Date of publication: 10/02/2017

Ratings

Overall rating for this service	No action	✓
Are services safe?	No action	✓
Are services effective?	No action	✓
Are services caring?	No action	✓
Are services responsive?	No action	✓
Are services well-led?	Requirements notice	✗

Overall summary

We carried out an announced comprehensive inspection on 28 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

Summary of findings

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

Cambridge Street Dental Practice provides NHS dentistry to patients of all ages. A dental hygiene therapist is also available to patients who pay privately for this service. The practice is situated close to the town centre and public parking is nearby. The practice has three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments. The building is at ground floor level and it has steps at the front door. A portable ramp is available for patients who require this.

The practice opens from 8.30am to 5.30pm Monday to Friday and closes for lunch between 1 and 2pm. The practice has two dentists, a dental hygiene therapist, two dental nurses and a receptionist.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We received feedback from 20 patients who used the service either in person or through the CQC comments cards that had been completed during the two weeks leading up to the inspection visit. Patients provided a positive view of the service the practice provided. All of the patients told us that the quality of care was very good, staff were welcoming and provided them with sufficient information about their dental care and treatment.

Our key findings were:

- Patients told us they were able to get an appointment when they needed one and the staff treated them with respect.

- Information from completed CQC comments cards gave us a positive picture of a friendly, caring and professional service.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained. However the practice did not complete regular checks of the emergency equipment.
- Dentists provided dental care in accordance with current guidelines from the Faculty for General Dental Practice guidelines and the National Institute for Care Excellence (NICE)
- A number of safety procedures were in place although these were not always followed to ensure that quality and safety was improved.
- The governance arrangements required improvement to assist with the safe running of the practice. This was because some systems to assess, monitor and improve the quality of the service were not in place or were not working effectively.

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

- Ensure the practice's recruitment process is in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure there are systems and processes in place to assess monitor and improve the quality and safety of the service provided by:
 - Ensuring regular monitoring of the work environment in relation to infection control in the treatment and decontamination rooms and ensuring that appropriate cleaning of these areas is completed.
 - Ensuring there is an effective process in place for checking the emergency medical equipment and the fridge temperature used to store emergency medicines.
 - Implementing a system to communicate quality issues to promote learning and improvement within the staff team.
- Ensure there are systems and processes in place to identify, assess and manage risks in relation to the following:

Summary of findings

- Systems for recording, investigating and reviewing accidents, incidents or significant events and for sharing safety alerts
- Monitoring the training, learning and development needs of staff members at appropriate intervals including induction and annual appraisal
- Systems to track the use of prescriptions.
- An effective process to assess, monitor and mitigate health and safety risks including sharps handling procedures in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

You can see full details of the regulations not being met at the end of this report.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review staff awareness of Gillick competency and the requirements of the Mental Capacity Act (MCA) 2005 to provide assurance that all staff are aware of their responsibilities.
- Review the availability of an interpreter service for patients who do not speak English as their first language and a hearing induction loop system.
- Review the information about the complaints process to ensure it is accessible to patients.

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?

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

A process was in place to report, investigate and manage accidents although this was not followed consistently. Staff were unsure how to identify significant events or incidents and were not familiar with the policy that was in place. The provider received safety alerts including medicines alerts although there was no process in place to share these with staff. The procedure for managing sharps injuries was unclear and the practice did not have a designated first aider. General risk assessments were not effective. Environmental cleaning and the storage of clinical waste had not been regularly checked to ensure that national guidelines were being met and that safety was prioritised.

There were clear guidelines in place for reporting safeguarding concerns and staff had received relevant training. A recruitment procedure was available but there were no records to demonstrate that it had been followed.

Emergency medicines and equipment were available although items were not regularly checked to ensure they were ready for use. Prescription pads were stored securely but there was no system in place to track and account for their use. There was a clear process for decontaminating dental instruments although the decontamination room was cluttered and untidy. Some treatment rooms were also cluttered, had no clear zoning and the storage of some items of equipment required a review.

Equipment was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely. X-rays equipment was well maintained and record keeping in relation to X-rays was clearly documented.

No action 

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. However protocols for the use of rubber dam for root canal treatment required a review. We saw good examples of personalised care and evidence of good communication with other dental professionals. However we found that some staff did not have sufficient knowledge of the Mental Capacity Act 2005 and were not familiar with Gillick principles. The staff received professional training and development but had not received a performance appraisal. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

No action 

Summary of findings

Are services caring?

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

We collected 18 completed Care Quality Commission patient comment cards and obtained the views of a further two patients on the day of our visit. These provided a positive view of the service the practice provided. All of the patients told us that the quality of care was very good, staff were welcoming and provided them with sufficient information about their dental care and treatment.

No action



Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Patients could access treatment and urgent and emergency care when required. The practice made reasonable adjustments to the service to ensure it was accessible and responsive to patients who may have a disability or specific need. Some information was available to patients although there was no general practice information leaflet and no accessible information on how to raise a concern or complaint. There was no arrangement in place to access an interpreter service if this was required.

The entrance to the practice had step access although a portable ramp was available to improve access for patients with restricted mobility meaning that the service was then on one level. A complaints process was in place although none had been received and patients did not have easy access to information explaining how to raise any concerns or complaints.

No action



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).

Although there were some systems in place to monitor the overall quality of the service, others were not effective or had not been established. For example, there was no system to share safety alerts, and there was no appraisal process used for staff. Systems to check and monitor emergency equipment and environmental cleaning were not effective. Recruitment records and records of staff meetings were not available. Practice policies were available although some required a review so that they were clear to staff. This included for example the sharps injury policy and the policy for significant events

There were designated lead roles within the practice although these were not always fulfilled to best effect. There was a small team of staff and the principal dentist had overall responsibility for both clinical and managerial issues. Staff told

Requirements notice



Summary of findings

us the team worked well together and were supportive of one another but there was no formal system to communicate quality issues. The practice participated in the NHS friends and family test but there was no other formal system for seeking patient feedback.

Cambridge Street Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

This inspection took place on 28 November 2016 and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information for review which included a summary of complaints received and general practice information.

During the inspection we spoke with one dentist, a dental nurse and a receptionist. We reviewed policies, procedures

and other documents. We also obtained the views of two patients on the day of the inspection and received 18 comment cards that we had provided for patients to complete during the two weeks leading up to the inspection.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had an accident book in place and we saw this had been used on three occasions during 2016 and once in 2012. Records of the accident did not provide sufficient detail of the action taken or the learning identified. We tracked two of the accidents and saw that a record of the incident and actions taken had been made in the patient's dental record. A special note had been made on one patient's records to raise awareness of the incident in the future but it was not noted for the other patient. A third accident recorded several weeks ago had not been reported to the principal dentist for further action. We were told that staff meetings took place to discuss accidents or incidents although these were not always recorded.

There was an incident policy and process in place which included reference to the duty of candour. We found that staff did not fully understand the definition of a significant event or incident so that a complete investigation and learning could be shared.

The principal dentist described the process used for reporting of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations). A clear process was in place to report such incidents if they occurred.

The principal dentist received patient safety alerts although there was no process in place for sharing any relevant alerts with the relevant staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for safeguarding vulnerable adults and children which linked to the local guidelines. The principal dentist was the designated lead for safeguarding concerns and escalated these to the local safeguarding team appropriately. Information on the reporting process was visible and accessible to staff who had received relevant training and were able to describe an example of a concern they had identified and escalated for further investigation.

We spoke with dentist and dental nurse to ask about the use of rubber dam for root canal treatments and found this was in routine use. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or

small instruments used during root canal work. Staff were able to describe their assessment of the risk and the importance of documenting this in the patient's dental care record.

Medical emergencies

Staff had access to an automated external defibrillator (AED) in line with current guidance. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. We found this was not being checked each day to ensure it was ready for use in an emergency situation. We checked emergency equipment and found that airways used for patients who were not conscious and some syringes were out of date. Replacement items were available in another location but had not been stored with the emergency pack. The principal dentist took immediate action to remove the items and replace them.

Staff we spoke with described the emergency procedures and told us they had received basic life support training. Records supported this.

The practice had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. We checked the emergency medicines and saw that they were all in date. The dental nurse was responsible for checking emergency medicines. We saw records to show that the drugs were checked monthly.

Staff recruitment

All of the employed dental professionals had current registration with the General Dental Council, the dental professionals' regulatory body. We asked to review evidence of the recruitment process and found that personnel files were not used and records were therefore incomplete. We spoke with a dental nurse who had been employed four years ago who confirmed that an interview had taken place. A locum dentist had been employed in recent months for a short term period. However, there was no record of employment checks held for this member of staff. A recruitment policy dated May 2016 gave appropriate guidance although there was no reference to the completion of criminal records checks with the Disclosure and Barring Service (DBS). The principal dentist informed

Are services safe?

us he had recently obtained CQC guidance on DBS checks and planned to develop a policy to address this. We found records that some staff had DBS checks completed but there were no records held for three clinical staff.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The principal dentist had overall responsibility for health and safety issues and delegated some responsibilities to other staff. We reviewed the general risk assessment dated August 2016 and found this had not been completed accurately and most of the control measures had not been recorded. Assessment information for the Control of Substances Hazardous to Health (COSHH) was in place and was regularly reviewed. Safety kits were available in the practice for cleaning and disposing of spillages of mercury or body fluids in a safe way. A first aid kit was also available although there was no a designated member of staff to act as a first aider.

The practice had procedures in place to reduce the risk of injuries through the use of sharp instruments and had recently introduced a safe sharps system. We found there were two versions of the sharps management procedure in the practice, one more detailed than the other. A sharps risk assessment had been completed in 2015 and was overdue a review. Staff knew how to take appropriate and immediate action if an injury occurred. However, we saw that a recent injury had not been reported to the principal dentist to ensure appropriate follow up actions were taken. All relevant staff had received immunisation for Hepatitis B.

A fire risk assessment had been completed in June 2016 and we saw this was completed annually. Firefighting and detection equipment had been serviced and fire drills were in place. Staff had completed fire safety training in August 2016.

The practice had a business continuity plan in place to deal with any emergencies that could disrupt the safe and smooth running of the service.

Infection control

The practice had a detailed infection control policy in place that was regularly reviewed. The dental nurse was responsible for the decontamination of used dental instruments although the principal dentist had lead responsibility for infection control overall. We spoke with

the dental nurse and observed the procedures and practice that was being followed. We found that overall the practice was meeting HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control although some improvements were needed to identify clean and dirty zones and the storage of some specific dental instruments.

An infection control audit had been completed in October 2016. This resulted in actions to improve compliance with HTM 01 05 guidelines.

We saw that the waiting area, reception and toilet were clean and tidy. Two out of three treatment rooms were cluttered and untidy which meant it was difficult to maintain hygienic cleaning. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

The dental items were all stored within drawers of the treatment rooms. We found that the treatment rooms had no defined clean and dirty zones. Burrs were stored without covers and local anaesthetic was not stored in blister packs. The cover of one dental chair was damaged and required repairing to enable hygienic cleaning.

The practice had a separate decontamination room for instrument processing. There were plans to refurbish this room in the future. We found it was cluttered, and untidy. We observed that an oil can was rusty and a container next to the sink looked unclean. The threshold at the entrance to the decontamination room had black tape holding down cables which made it difficult to ensure hygienic cleaning.

We observed the decontamination process from taking the dirty instruments through the cleaning process to ensure they were fit for use again. The process included manual cleaning before being cleaned in an ultrasonic washer and visual inspection with a magnifier before being sterilised in an autoclave. Cleaned instruments were dried, pouched and date stamped in accordance with HTM 0105 guidelines. Used dental instruments were transported to the decontamination room in a large unlabelled plastic box and once cleaned were returned to the treatment rooms in their pouches.

Records demonstrated that systems were in place to ensure that the decontamination equipment was working effectively. Dental water lines were maintained to prevent

Are services safe?

the growth and spread of Legionella bacteria (legionella is a term for a particular bacteria which can contaminate water systems in buildings). A legionella risk assessment had been completed by an external advisor in July 2016. Identified actions had been completed.

The segregation and storage of clinical waste required a review to be in line with current guidelines laid down by the Department of Health. Arrangements were in place to ensure that an approved contractor removed clinical waste from the premises on a weekly basis. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. However the external clinical waste store was not secure as it was not locked to a wall. Action was taken by the principal dentist to request an urgent replacement. Cleaning equipment for the premises followed the current NHS guidelines for safe management. The general and clinical cleaning of the premises was completed by the dental nurses who followed a cleaning schedule although no records were made to demonstrate completion.

Equipment and medicines

There were systems in place to check that the equipment had been serviced regularly and in accordance with the manufacturer's instructions. This included the items used for decontamination of the dental equipment, the dental chairs, electrical items and firefighting equipment.

A refrigerator was used to store some dental materials and glucagon, a medicine for treating diabetic patients in an emergency situation. Temperature checks of the refrigerator were not completed to ensure that medicine was stored at a constant and safe temperature.

We found that the practice stored prescription pads securely but they did not have a clear tracking system to monitor prescriptions that were issued. Records of prescriptions issued to patients were recorded in dental records.

Radiography (X-rays)

We reviewed the radiation protection file and found this was in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation in relation to the maintenance of the X-ray equipment. This included the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. We found that training records showed all staff where appropriate, had received training for core radiological knowledge under IRMER 2000.

We saw that radiographic audits were completed regularly for each dentist. Dental care records included information when X-rays had been taken, the rationale and the findings. This showed the practice was acting in accordance with national radiological guidelines to protect both patients and staff from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described how they carried out their assessment of patients for routine care which began with the patient completing a medical history questionnaire. The medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. The dentists took time to explain and discuss any dental issues with patients including the condition of their oral health, any changes since their last appointment and any relevant treatment options.

We were shown examples of dental care records that contained details of the proposed treatment and treatment options that were discussed with the patient. A treatment plan was then given to each patient and this included details of the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental records included detailed oral health assessments and included the condition of the patient's gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed in relation to a patient's gums. These were carried out where appropriate during a dental health assessment and appropriate referrals were made to the dental hygienist.

Health promotion & prevention

Preventative dental information was given to adults and children in order to improve their health outcomes. This included dietary smoking and alcohol advice where appropriate in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients.

The waiting room and reception area contained leaflets that explained the services offered at the practice as well as information on dental hygiene such as sensitive teeth and avoiding plaque. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate.

Patients could be referred to the hygienist who was employed at the practice one day each week.

Staffing

The practice was led by a principal dentist who employed an associate dentist two days each week and a dental hygienist one day a week. In addition, a temporary associate was working at the practice for one day a week. They were supported by two dental nurses and a receptionist. The principal dentist took responsibility for the management of the service. Staff told us they had sufficient numbers of staff to meet patient's needs.

Patients we spoke with on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards and the compliment cards that were displayed in the practice. We observed a friendly atmosphere at the practice.

There was no system to monitor staff training although there was good evidence to demonstrate that staff could access, and were supported to attend training. Training certificates demonstrated that staff had received core training such as safeguarding adults and children and responding to medical emergencies.

There was no formal induction process in place and staff had not received an annual appraisal. The practice aimed to have a formal meeting every two or three months but these were not routinely recorded. It was a small practice team and staff told us that most communication occurred as part of daily activity.

Working with other services

The dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time. The practice kept a log of the referrals made so that patients could be followed up in a timely manner.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The practice sought valid consent from patients for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and an estimate of costs. Staff described the importance of ensuring that patients were given time to consider and make informed decisions about their treatment options which were then recorded in their dental records. There were very few patients with limited English language skills registered at the practice. Some dental staff spoke alternative languages however; in the event that staff was unable to communicate information to patient relatives of the patient assisted with this. There was no arrangement in place for accessing an interpreting service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for them. The dentist was able to demonstrate their understanding of the MCA and how this applied to patients and their capacity to consent to dental treatment. They were able to provide us with an example when this required consideration in relation to treating a patient in their best interests. They were also familiar with the Gillick principles to help them judge when children and young people were able to make their own decisions about their treatment. However not all of the staff we spoke with had an understanding of these principles.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas. We saw that doors were closed when patients were with dentists so that conversations could not be overheard and patient's privacy was protected. Records were stored electronically and computers were password protected. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed by others. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to share their experience of the practice. We collected 18 completed CQC patient comment cards and obtained the views of two patients on the day of our visit. We found that patients had

a positive view of the service the practice provided. They told us that staff were welcoming, friendly and treated them with care and respect. During the inspection our observations and discussion with staff supported this view.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area. The dentist told us that explanations about care and treatment options were always provided to enable patients to feel involved in decisions. This included when making a decision to refer a patient to another service for specialist advice. Dental records were maintained to reflect this. Patient feedback confirmed that they received clear information about their treatment and assessment and the dentists listened to their views.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

In reception information about opening hours, treatment costs for NHS services, the complaint process and the code of practice for the service was displayed. The practice information leaflet was not readily available for patient reference. Health information was available in the waiting room.

Staff reported (and we saw from the appointment records) that the practice had a system in place to schedule enough time to assess and undertake patients' care and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Emergency appointment slots for the dentists were held each day so that patients requiring urgent assessment could be accommodated quickly. Patients who were experiencing pain were always prioritised. If the patient was able to wait, they were placed onto a short notice cancellation list. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment. On the day of the inspection, a patient who required treatment was provided with an appointment in three days' time and routine appointments were available with both dentists within two weeks.

Tackling inequity and promoting equality

Staff told us they treated everybody equally and welcomed patients from different backgrounds and cultures or with a disability. There was no level access at the entrance to the practice although a ramp was available for positioning in

readiness for patients who required it if this information was already known. The practice made a note on patient's dental records to indicate whether a patient had particular needs, for example access issues, a disability or the patients preferred dentists. A comprehensive equality, diversity and human rights policy was in place to reflect the Equality Act (2010). However, the practice did not have a portable hearing induction loop available. The Equality Act requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

Access to the service

The practice opened weekdays from 8.30 am until 5.30 pm and closed for lunch 1-2pm. The service did not open at weekends and a recorded message on the practices ansaphone advised patients to call the NHS 111 service for advice on their urgent dental needs. The practice treated NHS patients only and paid privately for treatment received from the dental hygienist. Patients told us they were satisfied with access to routine and emergency appointments.

Concerns & complaints

The principal dentist was the complaints lead although the practice had not received any complaints since they were registered with the Care Quality Commission. A complaints flow chart and policy was in place and information about complaints management was displayed behind the reception desk. However, information leaflets explaining how to raise a concern or complaint and how this would be managed by the practice were not readily available.

Staff told us they responded to any patient concerns at the time they were raised to resolve the issue as soon as practically possible. Patients would receive an immediate apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

The systems and processes for monitoring and maintaining the quality of the service were not fully effective. The principal dentist had overall responsibility for governance and quality monitoring issues. Some areas had been delegated to the dental nurses such as health and safety and the infection control audit.

A number of policies and procedures were in place to guide practice. However, some key policies were missing or unclear (recruitment, induction and the safe management of sharp injuries) and staff did not always understand or follow them (incident/accident and significant events).

We saw that some quality monitoring checks worked well and were effective, for example the servicing of key equipment and the management of radiography. However, some infection control issues had not been identified for action, there was no evidence to demonstrate that a safe recruitment process was followed and the health and safety risk assessment was inadequate.

We found that some staff meetings had taken place although a regular pattern for these had not been established and any records of discussion and agreed actions were not always made. Staff told us that issues were often discussed informally during their working day.

Leadership, openness and transparency

There was a leadership structure in place and staff understood their roles and responsibilities within the practice. Some staff had worked at the practice for a number of years and the small size of the team helped them to communicate change or improvements very easily on an informal basis. Formal meetings had taken place from time to time but were not well established. Records of these meetings were very limited.

It was apparent through our discussions with the dentists and staff that the patient was at the heart of the practice and they were committed to providing patients with a personal service that met their expectations and delivered a positive care and treatment experience.

Staff told us the principal dentist was approachable, listened to them and valued their contribution to the service. Staff felt confident to raise any concerns with the team or the principal dentist and told us they felt supported in the roles.

Learning and improvement

Staff had access to, and were supported to receive core training such as safeguarding, infection control and medical emergencies. However, there was no system in place to monitor training that was due or had been completed. We saw evidence that registered dental professionals maintained their professional development, as required through the General Dental Council (GDC) and had a valid GDC registration. However the practice did not use an appraisal system and the principal dentist told us they intended to reinstate this as staff had not received an appraisal for a few years.

Although the process for reporting incidents, accidents and significant events required strengthening we saw examples where action and learning had been identified following accidents.

The practice had completed a several audits including a number of infection control related audits and audits of dental X-rays. There were no records to show that had been shared with the team.

The principal dentist had considered development plans for the service and this included upgrading the decontamination room.

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

The practice were using the NHS Family and Friends Test on a regular basis but received a low number of responses. During October 2016 6 patients had given feedback that they were extremely likely to recommend the service. There were no other formal systems for seeking patient feedback.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p data-bbox="815 656 1385 725">Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p data-bbox="815 748 1490 965">The registered person did not have effective systems in place to ensure that the regulated activities at The Cambridge Street Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <ul data-bbox="815 987 1506 1995" style="list-style-type: none"><li data-bbox="815 987 1506 1133">• There was no process to monitor the work environment in relation to infection control in the treatment and decontamination rooms or to monitor general cleaning of the practice.<li data-bbox="815 1155 1506 1267">• The emergency medical equipment and the temperature of the fridge used to store emergency medicines were not checked on a regular basis.<li data-bbox="815 1290 1506 1435">• There was no effective process to share information with staff about quality issues on a regular basis to promote learning and improvement. This included the sharing of patient safety alerts.<li data-bbox="815 1458 1506 1570">• Systems for recording the investigation of accidents, significant events and incidents were not effective to help promote learning and improvement.<li data-bbox="815 1592 1506 1738">• There were no systems to monitor the training, learning and development needs of staff members at appropriate intervals including induction and annual appraisal<li data-bbox="815 1760 1506 1827">• There were no systems to track the use of prescriptions.<li data-bbox="815 1850 1506 1995">• Systems to manage health and safety risks, including sharps handling procedures in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, were not fully effective. <p data-bbox="815 2018 1023 2051">Regulation 17 (1)</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider had not ensured that a recruitment policy was followed to ensure the pre-employment checks were completed and that appropriate records of persons employed by the practice were held.

Regulation 19 (1)