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Dairyground Dental Practice

Inspection Report

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Overall summary

We carried out this unannounced inspection on 4 October 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

Dairyground Dental Practice is in the village of Bramhall, close to Stockport, Cheshire, and provides NHS and some private treatment for adults and children.

The practice is approached through the front door which leads to two flights of stairs. This means it is not accessible for people who use wheelchairs and those with pushchairs. Car parking spaces, are available outside the practice, where the waiting time is limited to 90 minutes.

Summary of findings

The dental team includes four dentists, one permanently employed dental nurse, a locum dental nurse and two part-time receptionists. A practice manager works at the practice one day each week. The practice has two treatment rooms.

The practice is owned by an individual who is the principal dentist at a sister practice. 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.

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

We were able to speak with one patient following their treatment. They told us the standard of treatment was good and that they were pleased with the service provided.

The practice is open from 8.30 to 1pm and from 2pm to 5.30pm Monday to Thursday. On Friday the practice is open from 8.30am to 1pm.

Our key findings were:

- The standard of record keeping in respect of patient records was good.
- The practice did not appear clean or well maintained.
- The provider could not demonstrate that infection control procedures reflected published guidance.
- Staff knew how to deal with medical emergencies.
- Some medicines and life-saving equipment were available; items marked as being present in emergency equipment bags were missing.
- The practice did not have adequate systems in place to help them manage risk to patients and staff.
- Staff demonstrated that they understood their responsibilities for safeguarding vulnerable adults and children, but did not have access to supporting protocols to refer to when required.
- The provider did not have thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect.
- More care was required to protect their privacy and personal information of patients in handling post to the practice.
- We saw evidence from the dentist we spoke with that the practice was providing preventive care and supporting patients to ensure better oral health.
- The appointment system met patients' needs.
- The practice leadership was ineffective. There was no focus on issues that required addressing, or culture of continuous improvement.
- Some staff we spoke with did not feel involved and supported.
- Staff and patients were asked for feedback about the services provided. We saw limited evidence of this, or that when feedback was provided, it was acted on.
- There was no evidence available to demonstrate that the provider dealt with any complaints positively and efficiently.
- Information governance arrangements required improvement.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Ensure specified information is available regarding each person employed.

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 and procedures for the use of X-ray equipment in compliance with The Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017 and taking into account the guidance for Dental Practitioners on the Safe Use of X-ray Equipment. In particular, making the required declaration to the Health and Safety Executive to confirm all radiation equipment is used in compliance with applicable regulations.

Summary of findings

- Review operational procedures for taking X-ray images, including the use of rectangular collimators as recommended in recognised guidance.
- Review the practice's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Enforcement action 

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 and Enforcement Actions section at the end of this report

- The practice did not have effective systems and processes to provide safe care and treatment.
- The practice was unable to demonstrate that all staff had received training in safeguarding children and vulnerable adults. There were no protocols in place, or policies with details of local authority safeguarding contacts in place for them to refer to when required.
- The standard of record keeping in respect of patient records was good.
- Staff were qualified for their roles. When we reviewed recruitment records, the provider could not demonstrate that they conducted essential recruitment checks.
- The premises were visibly dirty in places. Some equipment was at the end of its suitability for use. There were no measures in place to address this.
- There was no radiation protection file in place for staff to refer to and the appropriate declaration to the Health and Safety Executive to confirm all radiation equipment is used in compliance with applicable regulations, had not been made.
- The practice processes for cleaning, sterilising and storing dental instruments did not reflect national guidance.
- Appropriate personal protective equipment for staff was not available.
- Clinical waste was bagged and kept in the small kitchen which also served as the decontamination room, which could make working conditions difficult.
- Some recommendations made in a practice Legionella risk assessment had not been actioned.
- The practice had arrangements for dealing with medical and other emergencies. When we checked the equipment available, we found some items marked as being present were not, and some items had passed their use by date.

Are services effective?

No action

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

- From patient records we reviewed, we established that the dentists assessed patients' needs and provided care and treatment in line with recognised guidance.
- Patients who comment verbally when leaving the practice following treatment, described the treatment they received as good.

Summary of findings

- The dentist discussed treatment with patients so they could give informed consent and recorded this in their records. Clinical staff we spoke with confirmed they had not received training in the Mental Capacity Act, which is linked to patient consent.
- The practice had arrangements in place for when patients needed to be referred to other dental or health care professionals.
- The practice had limited arrangements to support staff to complete training relevant to their roles and did not have systems in place to help them monitor this.

Are services caring?

No action 

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

- One patient who commented verbally when leaving the practice, described their treatment as being good.
- On the day of inspection, we observed reception staff were friendly and warm towards patients.

We saw that reception staff protected patients' privacy in the reception area and were aware of the importance of confidentiality. On the day we visited the practice, we found post had not been collected by staff and had been left on the floor of the entrance to the practice. Some of this was patient specific correspondence from secondary care providers.

Are services responsive to people's needs?

No action 

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

- The practice's appointment system was efficient and met patients' needs. Patients could secure an appointment quickly if in pain.
- Patients were seen quickly following arrival; phones were answered promptly.
- There was no evidence that the practice considered patients' different needs. For example, there was no access for disabled patients and those who had small children in prams and pushchairs. No disability access audit had been carried out and there were no plans in place to do this.
- The practice staff had access to telephone interpreter services if required.
- There was no hearing loop available at the practice. There were no signs in the practice to say that information was available in other formats, such as large print and alternative languages. These were communication aids were not available to staff.
- The practice took patients views seriously. However, evidence available to us on the day of inspection showed that any attempts to gather patient views were not followed up.

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 Enforcement Actions section at the end of this report

- Some managerial staff at the practice could not explain or identify the recognised guidance for the safe processing and management of reusable dental instruments. When prompted they could not tell us about guidance that applied to this area of work.
- Management, governance and oversight of processes in the practice, including cleaning, management of the decontamination room and other areas were either absent or ineffective.
- There was no lead in the practice for infection control.
- The facilities to process dental instruments for each surgery required improvement. There was no effective plan in place to address this.
- Staff did not have access to running hot water, for example, for environmental cleaning. Staff told us that this had been the situation for a number of years.
- There was no system of continuous improvement in place at the practice; audit was limited to infection prevention and control. This had not picked up the issues identified in our inspection.
- The practice team kept complete patient dental care records which were stored securely.

Enforcement action 

Are services safe?

Our findings

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

The practice did not have clear systems to keep patients safe.

Staff understood their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice did not have a safeguarding policy in place, or protocols for staff to follow to make a safeguarding referral. Staff confirmed they had not received safeguarding training whilst with the practice. Staff knew about the signs and symptoms of abuse and neglect but had no guidance on how to report concerns locally or to CQC.

There was a system to highlight vulnerable patients on dental care records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication. Staff told us they knew how to use this feature of the electronic records system. We did not see evidence that it had been used effectively to alert clinicians to patients who may be vulnerable.

The practice did not have a whistleblowing policy. Staff could raise concerns; we did not see any evidence that staff concerns had been responded to.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was documented in the dental care record.

We reviewed staff recruitment records. The practice did not have a recruitment policy and procedure to help them employ suitable staff. Checks that are required to be in place for all staff, including for locum staff, could not be evidenced on the day of inspection.

We looked at five staff recruitment records. We asked for recruitment records for all staff working at the practice. The practice was unable to do this. From the five recruitment records we did look at, we saw that all essential recruitment checks had not been completed for those staff. For example, for one staff member, there was no evidence of references having been taken, no evidence of Disclosure and Barring Service (DBS) check, no evidence of immunity to blood borne viruses, for example, Hepatitis B, no identity checks, no qualifications or evidence of professional indemnity cover. The practice staff confirmed that they used locum dental nurses, who provided cover for a staff member on a period of leave. Staff confirmed they had not asked for, or received, confirmation that all required checks on locum staff had been carried out.

We saw that clinical staff were qualified and registered with the General Dental Council (GDC). The practice staff were asked to provide evidence of indemnity insurance for clinical staff. They were unable to show us this and did not forward copies of this to us in the days following the inspection. Further requests were made by the inspector, following inspection. On 19 October 2018, we received evidence on indemnity for the practice hygienist, a locum dental nurse, an associate dentist and the principal dentist. The evidence of indemnity for the other three associate dentists who work at the practice has not been provided.

The practice staff told us that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. When we visited the decontamination room we saw that the autoclave in use leaked and when serviced by a contractor, was described as being at the end of its serviceable life. Practice staff could not show us evidence of an electrical safety certificate for the premises. We saw that the air compressor was maintained and in good working order.

There were no records available to us, or that could be produced by the practice, that showed that fire detection equipment, such as smoke detectors and emergency lighting, were regularly tested. Our visual checks confirmed that firefighting equipment, such as fire extinguishers, were regularly serviced. The fire risk assessment for the practice was undertaken in September 2013 and was marked as being due for review in September 2014. The risk assessment had not been reviewed since 2013.

The practice had some arrangements to ensure the safety of the X-ray equipment. They had local rules in place although these required updating. There was no radiation protection file kept by the practice, or documents with pertinent information on the safe operation of equipment. The practice staff showed us certificates, which referred to

the servicing of the X-ray equipment, specifically mechanical servicing and routine testing which was being performed annually. The certificate for 2018 was missing. Staff were not using rectangular collimators when taking X-ray images, as recommended in recognised guidance. There was no evidence available that the provider had made the required declaration to The Health and Safety Executive, that they were operating all X-ray equipment in accordance with regulations.

We saw evidence that the dentists justified, graded and reported on the radiographs they took. When we asked, staff could not show us any evidence of radiography audits. There was no evidence of radiograph audit for the practice. The dentist had not seen or completed any radiograph audits for work undertaken at the practice.

Risks to patients

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

The practice manager showed us sections from a staff handbook that referred to the practice health and safety policy. This outlined the responsibilities of staff in relation to health and safety matters and was present in some staff recruitment files, but was not generally available to staff in the practice location. Staff could not provide protocols, procedures and risk assessments in relation to health and safety, to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. A sharps risk assessment had not been undertaken. Staff confirmed they had not seen a sharps risk assessment for the practice. We noted a sharps bin was present on the floor of the decontamination room, indicating that nurses were dismantling sharps. This was not placed and secured to a wall, in line with recognised guidance.

The provider did not have an effective 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. We saw a sharps injury had been reported in an accident book. This staff member was advised to ensure the full course of hepatitis B immunisation was completed. There was no evidence available that this recommendation had been followed.

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

Emergency equipment and medicines were available. Some items described in recognised guidance were missing from this equipment, for example, there was no self-inflating air bag available or airway management available. A GTN spray was out of date as of May 2018. We did note that glucagon, held in the emergency medicines kit, was not marked with an adjusted date due to it not being stored in a refrigerator. We saw that the defibrillator was connected to defibrillator pads, which were out of date. The regular checks on the equipment had failed to identify this. A spare set of pads was available in another part of the case for the defibrillator, which were in date. Staff recorded checks on the equipment, but these had not identified any of the issues highlighted by our inspection.

A dental nurse worked with the dentists when they treated patients, in line with GDC Standards for the Dental Team. We found that this was not the case at all times. On occasions when locum nurses had not arrived to work at the practice, a dentist had worked alone. The dental hygienist worked alone and there was no risk assessment in place to support this arrangement. The practice staff could not show us evidence that locum staff received an induction to ensure they were familiar with the practice's procedures.

There were no suitable risk assessments in place to minimise the risk that can be caused from substances that are hazardous to health. For example, the practice receptionists cleaned the practice and they could not show us or refer to any risk assessments in place for the use of cleaning products. The receptionist had not received any training on the control of substances hazardous to health. (COSHH).

Staff were not aware if there was an infection prevention and control policy. The practice manager was not aware of the guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. The practice manager did not know if the staff were following the guidance. Several staff had not completed infection prevention and control training or received updates as required.

Are services safe?

The practice's arrangements for transporting, cleaning, checking, sterilising and storing instruments required improvement. Current arrangements did not reflect guidance provided in HTM01-05. The practice used the kitchen as a decontamination room. There was no access to running hot water anywhere in the practice; staff were using water boiled in a kettle for cleaning of instruments. There was no thermometer available to indicate the temperature of the water used was appropriate, when manually cleaning dental instruments. Staff were washing their hands in cold water; there was no handwashing gel or soap in the decontamination room. The decontamination room was cluttered, and in parts, visibly dirty.

When clinical waste bags were full, they were tied at the neck and left in the decontamination room. Collection of this waste was fortnightly, and usually consisted of 10 bags. The storage of clinical waste in this room, which was small and cramped, made working in it very difficult for staff. In the decontamination room we saw dirty cups stacked in a washing-up bowl, at the side of the sink, with a drainer balanced on top. A small, plastic box used to carry the instruments from the surgery to the decontamination room was placed in the sink and filled with water to manually scrub dental instruments. There was an autoclave with a magnifying glass placed on top. We could see that the magnifier was not being used by staff to check instruments following cleaning, for any remaining debris. Staff confirmed this was the case.

The autoclave in use was rusting and leaked water during cycles. A recent service report stated that the appliance was at the end of its serviceable life. Staff were not aware of any plans to replace this appliance.

There was a bucket of dirty water, with a mop, head down, in the water. The mop was not identified for use in a particular area of the practice. The dental nurse could describe a system of colour coded mops, but this system was not being used at the practice. The only other mop we found was in a cupboard and was completely dry, dirty and dusty.

The sink in the decontamination room was in front of a window, which staff confirmed was open in the warm weather. There was insufficient airflow in this room. There was a lack of recommended personal protective equipment available in the decontamination room, for example, there were no heavy-duty gloves, visors or aprons available for staff carrying out decontamination work. Staff confirmed that they washed cups and food dishes in a washing up bowl, in the sink in the decontamination room. The infection prevention and control audit we were shown, carried out in May 2018, referred to a system of checks in place in the decontamination room. We found the audit did not reflect or findings during the inspection.

There was no oversight of the duties performed by dental nurses in the decontamination room. Our review of records available showed there was no oversight of cleaning of the two dental surgeries, and inconsistent evidence of processes being completed.

The practice staff showed us the procedures in place to reduce the possibility of Legionella or other bacteria developing in the water systems. When we reviewed the risk assessment, we saw that some recommendations had not been actioned. We looked at records of water testing and found water temperatures to be outside the recommended safe range for management of Legionella.

There were no cleaning schedules for the non- clinical areas of the premises and we observed the practice was visibly dirty. There was one fridge in the practice which was dirty and had a large patch of mould inside. Staff confirmed that dental work was stored in the fridge, as well as foods and drinks.

The infection prevention and control audit referred to COSHH records and assessments. Staff were unaware of these and had not received training in the control of substances hazardous to health (COSHH).

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 several dental care records to confirm our findings and noted that individual dental care records were written and managed in a way that kept patients safe. Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation (GDPR) requirements.

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

Are services safe?

Safe and appropriate use of medicines

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

The stock control system for medicines which were held on site, required improvement. This system was not effective in that we found some medicines for use had passed their expiry date, and replacement items were not available. We did note that glucagon, held in the emergency medicines kit, was not marked with an adjusted date due to it not being stored in a refrigerator. We also noted that a GTN spray in the emergency medicines kit was out of date, having an expiry date of May 2018.

Arrangements for storage and management of NHS prescriptions did not reflect national guidance. Prescriptions were not kept in a lockable cabinet and there was no system in place to allow the tracing of prescriptions issued by each dentist.

The dentist demonstrated they were aware of current guidance with regards to prescribing medicines.

There was no evidence of antimicrobial prescribing audits. The dentist demonstrated their understanding of current guidelines on the use of antibiotics. They confirmed that there was no policy for the practice.

Track record on safety

The staff, including the practice manager, could not describe what a significant event was. There was no form used to record any significant events. Significant events were not discussed at practice meetings. There had been some needlestick injuries experienced by dental nurses. These were recorded in the accident book. There was no follow-up on these incidents to identify any learning, or to share this to prevent similar incidents happening again.

There were some risk assessments in relation to safety issues, for example, in respect of Legionella. There was no evidence the practice monitored and reviewed incidents.

Lessons learned and improvements

There was no evidence available to us that the practice learned and made improvements when things went wrong.

The staff were not aware of the Serious Incident Framework. When we discussed one accident that had been reported in the accident book, there was no evidence that recommendations made were acted on.

There was no clearly defined system for receiving and acting on safety alerts. For example, dentists were signed up themselves to receiving alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) and for updates from National Institute for Health and Care Excellence (NICE). These were not routinely shared and discussed at practice meetings, and there was no recording system in place for staff to confirm they had been made aware of these alerts and updates.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dentists had their own systems to keep up to date with current evidence-based practice. We saw no evidence that this was shared with the rest of the staff. We saw that the dentist assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance, and could identify local clinical pathways and protocols.

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 dentists prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for patients, based on an assessment of the risk of tooth decay.

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

The practice dentist we spoke with and the practice dental nurses, were 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 outcomes for patients with gum disease. This involved providing patients preventative advice, taking plaque and gum bleeding scores and recording 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 dentists gave patients information about treatment options and the risks and benefits of these so they could make informed decisions.

The practice did not have a consent policy. The dentist had not received training on the Mental Capacity Act. The dentist was aware of Gillick competence, which is applied when seeking to confirm that a child under the age of 16 years of age can give consent for themselves.

There was no evidence of training on the Mental Capacity Act for any of the staff at the practice.

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

Monitoring care and treatment

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

Effective staffing

Staffing of the practice was not effective. The provider had been relying on the services of locum nurses, to cover the equivalent of one full time dental nurse post. On occasions when a locum nurse had not turned up as planned, a dentist had worked on their own. This had happened on several occasions.

When we checked training records available we noted significant gaps in training for all staff. For example, staff had not received training on safeguarding, information governance, consent or mental capacity training.

Staff new to the practice had a period of induction based on a structured programme. The dentist and dental nurse confirmed they had completed the continuing professional development required for their registration with the General Dental Council. This had included refresher training on basic life support.

Staff had not had annual appraisals or performance reviews. The practice manager confirmed they had not had any performance review since starting at the practice in 2015. There was little opportunity for staff to speak with managers to discuss their on-going career development or any performance issues.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

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

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

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

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

The practice monitored all referrals to make sure they were dealt with promptly. During our inspection, patient specific correspondence had been left lying in the entrance to the practice. There was no secure post box at the practice. There was no process in place to ensure post was held securely until collected by staff.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. We spent time in the reception area throughout the inspection day and observed that all patients were being seen in a timely manner. If there was any delay, patients were advised of this.

We saw that staff treated patients respectfully, appropriately and kindly, and were friendly towards patients at the reception desk and over the telephone.

Staff told us patients could choose whether they saw a male or female dentist.

Privacy and dignity

Our observations on the day of inspection, showed the practice respected and promoted patients' privacy and dignity.

Staff said they aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided some privacy when reception staff were dealing with patients. If a patient asked for more privacy, other than the surgeries, there was no other area that patients could be seen in to have a more private conversation. The reception computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it.

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

Involving people in decisions about care and treatment

Staff could demonstrate how they helped patients be involved in decisions about their care. When we asked, staff could not explain the Accessible Information Standards and the requirements under the Equality Act. The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given.

- Interpreter services via telephone were available for patients who did not have English as a first language. We did not see any notices in the reception areas, written in English or other languages, informing patients translation service were available.
- Staff communicated with patients in a way that they could understand. There were no other communication aids or easy read materials available.
- Staff could help patients and their carers find further information and access community and advocacy services, using information available in leaflets.

The practice gave patients clear information to help them make informed choices about their treatment. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's information leaflet provided patients with 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 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.

Reception staff were aware of those patients who were nervous when visiting the dentist and offered appointments at the start of clinics, to keep any waiting time to a minimum.

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

The practice had not carried out any disability access audit on the premises, and there were no plans to do so. The practice was not accessible for wheelchair users, those with mobility issues and those people with prams and pushchairs. There was nothing displayed which explained any provision in place for those patients who could not physically access the practice, for example, onward referral to another, accessible practice nearby. There was no action plan formulated in order to continually improve access for patients.

Timely access to services

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

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

The practice had an efficient appointment system to respond to patients' needs. Patients who requested an urgent appointment were seen the same day. Patients 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 and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. From appointment availability, we could see that patients could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice had not received any complaints within the last 24 months. They told us they took complaints and concerns seriously and responded to them appropriately to improve the quality of care. During our inspection, we saw a customer comments and suggestions box with one customer feedback form inside. This had not been reviewed. The box was visibly dusty and it had not been checked for some time.

The practice manager could not show us a policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint. The practice manager was responsible for dealing with these. Staff would tell the practice manager about any formal or informal comments or concerns straight away so patients received a quick response.

Information was not available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders did not demonstrate they had the capacity and skills to deliver high-quality, sustainable care. They did not demonstrate an awareness of issues within the practice, or that they were listening to feedback from staff, and the challenges they faced.

Staff had told us that one practice manager had been working between the two sites. As a result of this, the time the practice manager had spent each week at the practice had declined and was usually part of one day each week. Staff said that this had been difficult for them and they did not feel supported.

There was no system in place to develop leadership capacity and skills, or any planning for the future leadership of the practice.

Culture

Staff were committed to providing the best service possible, within the limitations imposed by the facilities at the practice. The dentist and dental nurse were motivated to work to a high standard. The lack of input from management in terms of training, communication, opportunities for advancement and the feeling of team spirit, had impacted on the morale of some staff.

The practice focused on the needs of patients.

There was no system in place to address performance issues or poor working practice. For example, we were made aware of several occasions when one dentist had worked alone, due to staffing issues. This was not adequately addressed by leaders.

The dentist demonstrated they were aware of the requirements of the Duty of Candour. Due to the lack of complaints received, or incidents recorded, we were unable to corroborate this

Staff were able to raise concerns but evidence provided on the day of inspection showed that these were not always heard and responded to. Staff did not have confidence that issues would be addressed.

Governance and management

Overall, there was a lack of governance, management and oversight of working processes in the practice. Staff understood their responsibilities, and we saw evidence of job descriptions for dental nurses. There were limited systems of accountability in support of governance. We saw checking systems in place which were failing; for example, checks on the emergency medicines and kit were ineffective. We saw infection control audits that had not highlighted any of the issues we found on the day of inspection. Staff who had environmental cleaning duties, had no cleaning schedule to work with, and no COSHH training or COSHH risk assessments to refer to. There was no radiation protection file in place for staff to refer to.

The governance in place was limited, and did not extend to policies, protocols and procedures that were accessible to all members of staff, which were reviewed on a regular basis. For example, safeguarding, whistleblowing, consent policies.

There was a lack of effective processes for managing risks, issues and performance. The fire risk assessment for the practice was done in 2013, with advice to review in 2014. There was no evidence of review. There were no performance reviews in place for staff. The practice manager could not show us evidence of professional indemnity for the dentists and nurses.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

There was no quality and operational information available for us to review, to demonstrate the practice took steps to ensure and improve performance. There was no effective system in place for gathering patient feedback. The practice did not use the Friends and Family Test, or carry out patient surveys.

Engagement with patients, the public, staff and external partners

There was limited evidence of engagement with the public, patients or staff, to gain their views on how services could be improved. We saw one example of patient feedback, which had not been acted on.

There were no mechanisms in place in the practice to gather feedback from staff, for example, through meetings, surveys, and informal discussions. Staff were not encouraged to offer suggestions for improvements to the service.

Are services well-led?

Continuous improvement and innovation

There were no systems and processes in place for learning, continuous improvement and innovation.

The practice had a lack of quality assurance processes to encourage learning and continuous improvement. There were no audits of dental care records or radiographs. Infection prevention and control audits in place were ineffective in that they had not highlighted any of the concerns raised by our inspection.

There was no evidence of commitment to learning and improvement by the provider, and no indication that the contributions made to the team by individual members of staff, were valued.

The was no appraisal or performance review in place for staff. This, with the lack of regular practice meetings, meant staff had limited opportunity to meet with the provider to discuss their learning needs and career development.

Staff had completed some of the 'highly recommended' training as per General Dental Council professional standards, for example undertaking medical emergencies and basic life support training annually.

The General Dental Council also requires clinical staff to complete continuing professional development. There was no evidence available to us on the day of inspection, of support in place for associate dentists and dental nursing staff to complete professional development activity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular: 1. The provider did not have a safeguarding policy for the practice, which was available for staff to refer to. 2. Some staff had not received safeguarding training. Regulation 13(2)

This section is primarily information for the provider

Enforcement actions

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 **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. The practice did not appear clean or well maintained. 2. Hot water was not available at the practice for environmental cleaning. 3. A fridge used for storage of food and drink, as well as dental work, required cleaning. 4. The staff could not demonstrate infection control procedures which reflected published guidance. 5. Staff did not have access to appropriate PPE, for example, heavy duty gloves, aprons and visors. 6. Items of medical emergency kit were not available. 7. There was no evidence of checks made to confirm the immunity status for Hepatitis B for staff members A, C, E,G, H and I. 8. No action had been taken when recorded temperatures, monitored for the control of risk of Legionella, fell outside of specified range. Regulation 12 (1)(2)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

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. There was no system of checks and oversight in place to ensure that all required tasks were being carried out to the required standard, for example, in cleaning of the surgeries at the end of the day, on the processes within the decontamination room, and cleaning tasks in respect of environmental cleaning.

2. Staff were not aware of recognised guidance for running and maintaining a decontamination room, for example, HTM01-05.

3. Prescriptions were not held securely. There was no log in place to effectively monitor their use, and to track and trace prescriptions issued.

4. The system to check medical emergency drugs and equipment was ineffective.

5. There was a lack of policies, procedures and protocols, and access to these, for staff to refer to and follow. For example, in respect of infection control, COSHH, safeguarding of vulnerable adults and children, lone working, consent and sharps handling.

6. There was no radiation protection file available for staff to refer to. Local rules for X-ray equipment required updating.

7. The practice had not carried out audits of radiography. Infection control audits that had been carried out were ineffective.

8. There were no effective systems in place to ensure all required recruitment checks were carried out before staff commenced employment. There was no system in place to confirm that all required checks on locum staff had been carried out, before locum staff commenced work at the practice.

This section is primarily information for the provider

Enforcement actions

9. Systems to monitor that staff were up to date with and had received, appropriate training and development in line with the General Dental Council were ineffective.

10. The provider had not submitted a Statement of Purpose to CQC.

Regulation 17(1)

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

How the regulation was not being met:

Recruitment procedures were not established or operated effectively. The information specified in Schedule 3 was not available for each person employed.

1. There was no evidence of confirmation of checks carried out on locum staff working at the practice.
2. No staff recruitment records or staff files could be produced for clinical staff members G, H and I.
3. For staff member A, there was no record of any recruitment checks. We were later sent evidence of medical indemnity cover only.
4. For staff member B, there was no Disclosure Barring Service (DBS) check, no references available or evidence that these had been taken up.
5. For staff member C, there was no DBS check, no references or evidence that these had been taken up. We were later sent evidence of medical indemnity cover.
6. For staff member D, there were no references or evidence that these had been taken up.

Regulation 19(2)(3)