Mr. Christopher Wenham

Norton Village Dental

Inspection Report

Also known as High Street Dental Centre
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Overall summary

We carried out an announced comprehensive inspection on 30 June 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

The practice offers both NHS and private treatments. The NHS contract only extended to children. The staff structure at the practice includes the principal dentist (male) two fully qualified dental nurses, and a dental therapist/hygienist (all female). There is also a practice manager, who also covers the reception duties.

The practice is open from 9.00am to 6.30pm Monday, Tuesdays to Thursday from 9.00am to 5.30pm and on Friday 9.00am to 5.00 pm. One Saturday per month the practice is open10.00 am to1.00pm. The practice is closed each day for lunch.

The practice is housed in a converted residential property and across two floors. There are two treatment rooms, both on the first floor along with a dedicated decontamination room and patient toilet. The reception and waiting area are on the ground floor. The practice is not accessible to patients with restricted mobility. The practice offers domiciliary visits to these patients and also offers treatment in the waiting area when the practice is closed. The practice will also refer patients to neighbouring practices for treatments that have disabled access.

The principle dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. 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 spoke with seven patients on the day of our inspection and reviewed seven CQC comment cards that had been completed by patients they reflected positive views about the care and treatment they had received. Patients felt the dentist, nurses and hygienist took a lot of time to explain care and treatment options in a way they understood. Common themes were patients felt they received excellent care and they were provided with personal and compassionate services. All patients commented positively about the care and treatment they had received and the friendly, polite and professional staff.

We found this practice was providing safe, effective, caring, and responsive care in accordance with the relevant regulations. We found concerns in the area of providing well led services in relation to leadership.

Our findings were:

Summary of findings

- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).
- There was a system in place for when mistakes might be made, patients would receive an apology and would be informed of any actions taken following an investigation.
- There was promotion of patient education to ensure good oral health.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice had an accessible and visible leadership team. Staff on duty told us they felt supported by the leadership team.
- The practice sought feedback from staff and patients about the services they provided.
- The practice maintained appropriate dental care records and patients' clinical details were updated appropriately.
- Governance systems were not effective.
- Audits were being undertaken but action plans were not established follow these.
- Infection control was not being maintained.
- Employment checks did not follow the recruitment policy.

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

- Review their infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- Review governance arrangements including the effective use of risk assessments, audits, such as those for infection control, radiographs and dental care records
- Record staff meetings for monitoring and improving the quality of the care received.
- Review the suitability of all areas of the premises and the fixtures and fittings in the treatment room.
- Ensure medicines that require storage in a fridge follow national guidance.
- Ensure all areas of the practice are kept clear of clutter.

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.

The practice had systems in place for the management of infection control, clinical waste segregation and disposal, management of medical emergencies and dental radiography. However some systems required improvement. Staff had received training in safeguarding and whistleblowing and knew the signs of abuse and who to report them to. We found the equipment used in the practice was well maintained and in line with current guidelines. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The staffing levels were safe for the provision of care and treatment.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies.

Are services effective?

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

Consultations were carried out in line with best practice guidance such as those from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs including a review of their medical history. The dentists ensured patients were given sufficient information about their proposed treatment to enable them to give informed consent.

The staff kept their training up-to-date and received professional development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC) said they were supported by the practice in continuing their professional development (CPD). We saw evidence they were meeting the requirements of their professional registration. Staff understood the Mental Capacity Act and offered support when necessary. Staff were aware of Gillick competency in relation to children under the age of 16.

Health education for patients was provided by the dentist, dental nurses and dental therapist/hygienist. They provided patients with advice to improve and maintain good oral health. We received feedback from patients who told us they found their treatment was successful and effective.

Are services caring?

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

Patients were complimentary about the practice and how the staff were caring and sensitive to their needs. Patients commented positively on how caring and compassionate staff were, describing them as approachable, understanding and professional. We observed the staff to be caring, compassionate and committed to their work. Staff spoke with passion about their work and were proud of what they did.

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 time was kept to a minimum. Staff told us all patients who requested an urgent appointment would be seen within 24 hours. They would see any patient in pain, extending their working day if necessary. Patients told us through comment cards and interviews the practice staff were very responsive in supporting those patients who were particularly anxious or nervous to feel calm and reassured.

Summary of findings

The treatment rooms and the patient toilet were on the first floor. The staff toilet was on the ground floor and not easily accessible to patients who had restricted mobility. The practice had put in place systems to accommodate patients with disabilities. The complaints information was readily available for patients to read in the reception area and on the practice website.

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 at the end of this report).

The practice had poor governance arrangements. We saw that audits had been completed. However action plans had not been developed to assess, monitor and drive improvement in the quality and safety of the services provided.

We found the staff areas of the practice to be cluttered and infection control was not always maintained to safeguard the risk of infection. Records of safety checks were not kept to demonstrate all equipment was maintained over a period of time.

We found that the recruitment policy had not been followed and pre-employment checks had not been undertaken for the recently employed member of staff.

Patients' comments in reviews and surveys were positive and there was evidence that the practice listened to the views of patients and made improvements.

Staff felt supported and there was a culture of openness in the practice. Staff told us they were supported to complete training for the benefit of patient care and for their continuous professional development.

Norton Village Dental

Detailed findings

Background to this inspection

The inspection took place on 30 June 2015. The inspection team included one CQC inspector and a specialist advisor.

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.

Prior to the inspection we asked the practice to send us some information which we reviewed. The information reviewed did not highlight any significant areas of risk across the five key question areas. On the day of our inspection we looked at practice policies and protocols, clinical patient records and other records relating to the management of the service. We spoke to the practice owner who was also the provider, the dental therapist and hygienist, two dental nurses, and the practice manager. We also reviewed seven CQC comments cards completed by patients and spoke with seven patients.

We reviewed the information we held about the practice. We informed NHS England area team / Health watch that we were inspecting the practice; we did not receive any information of concern from them.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice maintained clear records of significant events and complaints. Staff were aware of the reporting procedures in place and encouraged to bring safety issues to the attention of the dentist or the practice manager. The dentist and staff spoken with had a clear understanding of their responsibilities in Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and had the appropriate recording forms available.

The practice responded to national patient safety and medicines alert that were relevant to the dental profession. These were received in a dedicated email address and actioned by the dentist and practice manager. Medical history records were updated to reflect any issues resulting from the alerts.

Records we reviewed reflected the practice had undertaken a risk assessment in relation to the control of substances hazardous to health (COSHH). Each type of substance used at the practice that had a potential risk was recorded and graded as to the risk to staff and patients. Measures were clearly identified to reduce such risks including the wearing of personal protective equipment and safe storage.

Reliable safety systems and processes (including safeguarding)

All staff at the practice were trained in safeguarding and the dentist was the identified lead for safeguarding. Staff we spoke with were aware of the different types of abuse and who to report them to if they came across a situation they felt required reporting. This was confirmed by their continuing professional development files. A policy was in place for staff to refer to. The policy did not contain telephone numbers of who to contact outside of the practice if there was a need. However when we spoke with staff they were aware of who to contact and told us they would update the policy.

Care and treatment of patients was planned and delivered in a way which ensured their safety and welfare. Patients told us and we saw dental care records which confirmed new patients were asked to complete a medical history; these were reviewed at each appointment. The dentist was aware of any health or medication issues which could affect the planning of a patient's treatment. These included any underlying allergy, the patient's reaction to local anaesthetic or their smoking status. All health alerts were recorded on the front of the patient's dental care record.

The dentist at the practice ensured clinical practices reflected current guidance in relation to safety. The dentist does not routinely undertake procedures that require the use of a rubber dam however the practice kept one on site should a procedure be undertaken that required this to maintain their safety and to increase the effectiveness of treatment. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. These ensured patients were not able to swallow solutions or instruments used in the procedure and to ensure the operative site was free from moisture contamination.

Medical emergencies

There were arrangements in place to deal with foreseeable medical emergencies. We saw the practice had emergency medicines and oxygen available, in accordance with guidance issued by the Resuscitation Council UK and the British National Formulary (BNF), which may be needed to deal with any medical emergencies should they arise. All staff had been trained in basic life support including the use of the defibrillator and were able to respond to a medical emergency. All emergency equipment was readily available and staff knew how to access it. We checked the emergency medicines and found that they were of the recommended type and were all in date. A system was in place to monitor stock control and expiry dates. However we found orophangeal airways had expired in 2011. A new recording system was being introduced to improve the monitoring.

Staff recruitment

The practice had a recruitment policy. This described the processes involved when employing new staff. It included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, references and whether a Disclosure and Barring Service check was necessary. We looked at two staff files including the file of the last person to be employed and found that this policy was not being followed. The file did not contain a pre-employment checks, job description, application form, references, employment history or record of the interview process. Both staff files contained a record

Are services safe?

of qualifications, including registration details and Disclosure and Barring Service (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

All qualified staff were registered with the General Dental Council GDC. There were copies of current registration certificates and personal indemnity insurance. (Insurance professionals are required to have in place to cover their working practice).

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records that demonstrated staffing levels and skill mix were in line with planned staffing requirements.

Monitoring health & safety and responding to risks

The practice had carried out a practice risk assessment in 2015 which included fire safety. There was guidance for patients about fire safety and the actions to take. However stored underneath the stairs in a store cupboard we found paint and other consumable which could present a fire risk. The staff areas of the ground floor were also cluttered which could present a fire risk.

Staff were aware of their responsibilities in relation to the control of substances hazardous to health (COSHH), there had been a COSHH risk assessment done for certain materials used at the practice to ensure staff knew how to manage these substances safely.

The practice had minimised risks in relation to used sharps (needles and other sharp objects which may be contaminated) by ensuring sharps bins, were stored appropriately in the treatment rooms.

Infection control

The premises appeared clean and tidy. The practice had a cleaning policy and contract in place with a cleaner. The cleaning schedule covered all areas of the premises and detailed what and where equipment should be used. However we saw that national guidance on colour coding of equipment to prevent the risk of infection spread was not evident. We saw that cleaning equipment and damp cloths were stored in the staff toilet which also acted as a store room. The patient toilet did not have a towel or toilet roll dispenser these were placed on top of the toilet cistern presenting a risk of contamination. We did not see a record of checks to ensure all areas continued to be clean and guidance was followed.

During the inspection we found that the treatment rooms contained soft furnishings and fans. Both dental chairs had small tears in them which could increase the risk of infection and rusting around the base of the chairs. We saw dental instruments in one surgery had been prepared and left uncovered during the lunch time period which increased the risk of infection.

During our visit we spoke with the dental nurse, who was the designated person in the decontamination room. They were able to demonstrate they were aware of the safe practices required to meet the essential standards published by the Department of Health -'Health Technical Memorandum 01-05 Decontamination in primary care dental practices' (HTM 01-05).

The equipment used for cleaning and sterilising dental instruments were maintained and serviced as set out by the manufacturers. Daily, weekly and records were kept of decontamination cycles and tests and when we checked those records it was evident the equipment was in good working order and being effectively maintained.

Decontamination of dental instruments was carried out in a separate decontamination room. A dental nurse demonstrated to us the process; from taking the dirty instruments out of the dental surgery through to clean and ready for use again. We observed dirty instruments did not contaminate clean processed instruments. The process of cleaning, disinfection, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty to clean. However we saw that household gloves used in this process were only changed every fortnight, the guidance recommends changing on a weekly basis.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. (Legionella, a particular bacteria which can contaminate water systems in buildings). Flushing of the water lines was carried out in accordance with current guidelines and supported by a practice protocol. A

Are services safe?

Legionella risk assessment had been carried out by an appropriate contractor. This ensured that patients and staff were protected from the risk of infection due to growth of the Legionella bacteria in the water systems.

The segregation of dental waste was in line with current guidelines laid down by the Department of Health. The treatment of sharps and sharps waste was in accordance with the current European Union directive with respect to safe sharp guidelines; this mitigated the risks to staff against infection. We observed sharps containers were correctly maintained and labelled. The practice used an appropriate contractor to remove dental waste from the practice and waste consignment notices were available for us to view.

Equipment and medicines

The practice manager had a method that ensured tests of machinery were carried out at the right time and all records of service histories were seen. This ensured the equipment used in the practice was maintained in accordance with the manufacturer's instructions, this included the equipment used to sterilise the instruments, the x-ray sets and the compressor. This confirmed to us that all the equipment was functioning correctly.

Medicines in use at the practice were stored and disposed of in line with published guidance. A recording system was in place for the prescribing and recording of the medicines and drugs used in clinical practice. The systems we viewed were complete, provided an account of medicines prescribed, and demonstrated that patients were given their medicines as prescribed. The batch numbers and expiry dates for local anaesthetics were always recorded.

We saw that regular temperature checks of the medicine fridge used by the practice were not undertaken by the practice. The practice were not aware of the need for this to be undertaken daily. We saw that the fridge had an ice box which was in need of defrosting and the fridge did not feel cold.

We found the prescription pads were stored securely. This would help to prevent any possible mis-use of the prescription pads.

Radiography (X-rays)

We checked the provider's radiation protection file as X-rays were taken and developed at the practice. We also looked at X-ray equipment at the practice and talked with staff about its use. We found there were suitable arrangements in place to ensure the safety of the equipment and we saw local rules relating to each X-ray machine was displayed. We found procedures and equipment had been assessed by an independent expert within the recommended timescales.

The practice provided documentation demonstrating that the X-ray equipment in use had been serviced at recommended intervals. Records we viewed demonstrated that the X-ray equipment was regularly tested serviced and repairs undertaken when necessary.

Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays. This included identifying where patients might be pregnant.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dental assessments were carried out in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment.

Patients told us they always felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment. The comments received on CQC comment cards reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and their outcomes.

Health promotion & prevention

The dentist provided patients with advice to improve and maintain good oral health. Patients said they were well informed about the use of fluoride paste and the effects of smoking on oral health. The practice promoted the maintenance of good oral health as part of their overall philosophy and had considered the Department of Health publication 'Delivering Better Oral Health; a toolkit for prevention' when providing preventive oral health care and advice to patients. Staff spoken with were aware of the importance of promoting good oral health care.

Information leaflets on oral health were given out by staff. There was an assortment of different information leaflets available in patient areas.

Staffing

The practice had systems in place to support staff to be suitably skilled to meet patients' needs. They were aware of the training their staff had completed. Staff kept a record of all training they had attended; this ensured that staff had the right skills to carry out their work. All clinical staff carried out annual medical emergencies and basic life support training. They trained together to ensure they knew their roles and responsibilities should an emergency arise.

Records showed staff were up to date with their continuing professional development (CPD). (All people registered with the General Dental Council (GDC) have to carry out a specified number of hours of CPD to maintain their registration.) Staff records showed professional registration was up to date for all staff and they were all covered by personal indemnity insurance.

Dental nurses were flexible in their ability to cover their colleagues at times of sickness and holidays. We were told there had been no instances of the dentist working without appropriate support from a dental nurse.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice, for example orthodontic treatment.

The practice referred patients for secondary (hospital) care when necessary. For example for assessment or treatment by oral surgeons. Referral letters contained detailed information regarding the patient's medical and dental history.

The dentist explained the system and route they would follow for urgent referrals if they detected any unidentifiable lesions during the examination of a patient's soft tissues.

Consent to care and treatment

The practice ensured patients were given sufficient information about their proposed treatment to enable them to give informed consent. Staff told us how they discussed treatment options with their patients including the risks and benefits of each option. Patients said the dentists were exceptionally good at explaining their treatment. However in the records we looked at we saw that improvements could be made in the recording of treatment options discussed. Patients told us they were provided with a treatment plan for every treatment this included information about the financial and time commitment of their treatment.

Staff spoken with on the day of the inspection were aware of the requirements of the Mental Capacity Act 2005. We saw that the staff had completed recent training in this area. The dentist told us how they would manage a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient's family

Are services effective?

(for example, treatment is effective)

and other professionals involved in the care of the patient to ensure that the best interests of the patient were met. They had not as yet needed to obtain professional help for a patient. Where patients did not have the capacity to consent, the dentist acted in their best interests and all patients were treated with dignity and respect.

Patients said they always felt fully informed about their treatment and they were given time to consider their options before giving their consent to treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received feedback from seven patients who had completed the CQC card and spoke with a further seven patients about their care and treatment. All patients commented positively about the caring and compassionate staff, describing them as friendly, understanding and professional. We spoke with a number of patients who told us they travelled from outside the area to receive treatment at this dental practice. Patients told us they found all the staff friendly, polite, cheerful and the welcoming. Some patients told us they had previously felt anxious about visiting a dentist but found this practice relaxed and supportive in their approach.

A data protection and confidentiality policy was in place which staff were aware of. This covered disclosure of patient information and the secure handling of patient information. We observed the inter action between staff and patients and found that confidentiality was being maintained. Records in the practice were held securely.

We were told by staff that if they were concerned about a particular patient after receiving treatment, they always contacted them the same or the next day, to check on their welfare.

Patients told us they felt listened to by all staff. We observed reception staff interacting with patients before and after their treatment and speaking with patients on the telephone. Although we were able to hear appointment arrangements being made we did not hear any personal information discussed during our observations in the waiting room. Reception staff were polite and friendly in all situations. We saw that the dentist came down to the waiting room to greet patients and escort them to the treatment rooms.

Involvement in decisions about care and treatment

There was information about fees, displayed in the waiting rooms and on the patient information leaflet.

We looked at some examples of written treatment plans and found that they explained the treatment required and outlined the costs involved. The dentist told us that they rarely carried out treatment the same day unless it was considered urgent. This allowed patients to consider the options, risks, benefits and costs before making a decision to proceed.

Patients told us they felt involved at every stage with the planning of their treatment and also during treatment. They all felt very confident in the treatment, care and advice they were given.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback direct from patient suggestions. An example of this was improving access to appointments by providing a Saturday morning service once a month.

Appointment times and availability met the needs of patients. The practice was open from 9.00am Tuesday to Thursdays to 5.00 pm. and was open later until 6.30pm on a Monday. On Fridays the practice closed at 5.00pm. The Saturday monthly appointments were from 10.00am until 1.00pm. Patients with emergencies were assessed and seen the same day if treatment was urgent.

Staff told us that the practice scheduled enough time to assess and undertake patients' care and treatment needs. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Tackling inequity and promoting equality

The treatment rooms at the practice were on the first floor, the waiting room was on the ground floor. The patient toilets were on the first floor. The practice building did not accommodate patients with mobility problems and the structure of the building made it not possible to adapt to provide disabled access. The practice offered domiciliary visits at no extra charge.

Staff we spoke with explained to us how they supported patients with additional needs such as a learning disability. They ensured patients were supported by their carer and that there was sufficient time to explain fully the care and treatment they were providing in a way the patient understood.

Access to the service

Patients could access care and treatment in a timely way and the appointment system met the needs of patients. Where treatment was urgent patients would be seen within 24 hours or sooner if possible. The practice opening hours were Tuesday to Thursday 9.00am to 5.00pm, Monday they opened until 6.30pm and Friday they closed at 5.00pm. Outside these hours the practice answer phone directed patients to call the emergency telephone number, if they had a dental emergency.

Concerns & complaints

We arranged for a Care Quality Commission (CQC) comments box to be placed in the waiting area of the practice several days before our visit and seven patients chose to comment. All of the comment cards completed were complimentary about the service provided.

We saw information was available to help patients understand the complaints system in the waiting area, in the practice leaflet and the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. There had not been any complaints since registering with the CQC.

Are services well-led?

Our findings

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at these policies and procedures and staff spoken with were able to clearly relate to policies and this indicated to us that they had read and understood them. However not all of the policies we looked at had been reviewed recently and there was no date, named author or confirmation the policy had been approved.

There were five members of staff employed in the service. The practice had identified named members of staff in lead roles. An example was a dental nurse for infection control and the practice owner was the lead for safeguarding. The principle dentist and practice manager were responsible for information governance and data protection.

We found that areas of the practice were not monitored regularly to maintain all aspects of patient safety. The practice staffing areas were cluttered, good infection control was not maintained and staff had a lack of knowledge of some regulations. An example of this was the correct storage of cleaning equipment, the requirements for monitoring of fridges used to store medicines that require refrigeration. Although the practice told us they monitored health and safety we saw that some areas presented a safety risk. We found potential fire risk with the storage of combustible materials such as paint and oxygen stored under a wooden stairs case (the only stair case to the first floor). All of the staffing areas including the staff toilet were cluttered. We saw a potential tripping hazard in the staff area were the carpet was frayed.

Daily, weekly and records were kept of decontamination cycles and tests to ensure the equipment was in good working order and being effectively maintained. However we found that records of safety checks carried out were not kept by the practice in a log book to provide evidence of effective sterilisation over a period of time.

We were told that the practice held regular lunch time meetings and teaching sessions. We saw the minutes from some meetings. However detailed minutes were not always kept of discussions and plans agreed by the practice. Staff told us there was an open culture within the practice and they had the opportunity and were confident to raise issues at any time.

The practice staff told us they were clear about what decisions they were required to make, knew what they were responsible for as well as being clear about the limits to their authority. However there was a lack of awareness of some national guidance relating to safety and risk. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The leadership in the practice did not provide regular monitoring of all aspects of safety for staff and patients.

Leadership, openness and transparency

The registered manager who was the principal dentist provided clinical leadership to all staff. The dentist held responsibility as the clinical lead for identified areas such as for example safeguarding, X-rays and auditing. The practice manager with the dentist were also responsible for human resources, policies, procedures and risk assessments. We found that policies, procedures and risk assessments were in place to support the running of the service. However we found that many of these risk assessments did not identify areas of concern raised by the inspection team. The policies were not regularly reviewed and it was unclear when they were updated. We spoke with the practice manager who had a clear understanding of their role and responsibilities. They told us they had been supported by the dentist and that standards had been set for them to follow.

The dentist was responsible for the day to day running of the service. They led on the individual aspects of governance such as risk management and audits within the practice. There were some systems in place to monitor the quality of the service. We found that there were a number of clinical and non-clinical audits taking place at the practice. These included audits of infection control, and X-ray. However there were no structured assessments, nor action plans developed to drive improvement following audit. We identified many areas of concern which were not identified in the infection control audit and there appeared to be a lack of awareness about the importance of some aspects of infection control. An example of these were soft furnishings in the treatment rooms and the staff toilet used to store a range of equipment including old notes. There was no monitoring of clinical practice or record keeping which could be used to make improvements to the service.

Practice staff were clear about what decisions they were required to make, knew what they were responsible for as

Are services well-led?

well as being clear about the limits to their authority. It was clear who was responsible for making specific decisions, especially decisions about the provision, safety and adequacy of the dental care provided at the practice and this was aligned to risk. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We reviewed information on risk assessments which did not cover all aspects of health and safety within the practice. Examples of these were fire and infection control.

Management lead through learning and improvement

The management of the practice was focused on achieving high standards of clinical excellence. Staff at the practice were all working towards a common goal to deliver high quality care and treatment.

Staff spoken with on the day of the inspection felt they always received all relevant information and were kept updated about all changes in the practice.

Staff appraisals were used to identify training and development needs that would provide staff with additional skills and to improve the experience of patients at the practice. We were told that until recently appraisals in the practice had been informal and not documented. However we saw that the practice had introduced a more formal approach to appraisal.

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

Patients who used the service had been asked for their views about their care and treatment. The practice sought patient feedback and conducted patient satisfaction surveys. The most recent survey was conducted in March 2015 the previous survey was Oct 2011. We saw that 56 patients had completed questionnaires in the 2015 survey. However a full analysis was not available at the time of the inspection. We saw that comments from the 2015 and the previous surveys had been positive. The practice also monitored comments about the practice received via social media which were positive.

There had not been any formal complaints received in the practice in the past 12 months. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate.

Staff we spoke with told us their views were sought informally and there was regular discussions where staff views were sought. They told us their views were listened to, ideas adopted and that they felt part of a team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have effective systems in place to; Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2) (a, b, d and f)