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Milk Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 March 2016 to ask the practice the following key questions; are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Milk Dental is situated close to the centre of Liverpool in a busy residential locality. The practice is located in a converted residential property, and comprises a reception and waiting room, two treatment rooms situated on the ground floor, a decontamination room and storage and staff rooms. Parking is available on nearby streets. The practice is accessible to people with impaired mobility but not to wheelchair users.

The practice provides general dental treatment to predominantly NHS patients of all ages with private treatment options available, and is open Monday, Wednesday and Friday 8.45am to 5.15pm, and Tuesday and Thursday 8.45am to 7.00pm. The practice is closed for lunch between 1.00pm and 2.00pm.

The practice is staffed by a dentist and three trainee dental nurses at various stages of their training. Two of the nurses share practice manager responsibilities and all three carry out reception duties in addition to nursing.

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

We received feedback from 13 patients about the service. The 13 CQC comment cards seen reflected positive comments about the staff and the service provided.

Summary of findings

Patients commented that they found the staff caring, friendly and professional. They had trust and confidence in the dental treatments and said information and explanations from staff were clear and understandable.

Our key findings were:

- The practice recorded and analysed significant events and incidents and received and acted on safety alerts.
- Staff had received some safeguarding training and knew the process to follow to raise any concerns.
- There was an adequate number of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies, however some items of emergency equipment were unavailable.
- Premises and equipment were clean, secure and properly maintained, but improvements were needed to the infection prevention and control procedures.
- Patients' needs were assessed and care and treatment were delivered in accordance with current legislation, standards and guidance.
- Patients received explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Staff were supported to deliver effective care, and opportunities for training and learning were available, but the practice lacked a structured training plan.
- Patients were treated with dignity and respect and their confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Services were planned and delivered to meet the needs of patients and reasonable adjustments were made to enable patients to receive their care and treatment.
- The practice took into account patient feedback but no formal system for obtaining feedback from patients or staff was in place.
- Staff were supervised and felt involved and worked as a team.

We identified a regulation that was not being met and the provider must**:**

- Ensure the risks to the health, safety and welfare of patients, staff and others are mitigated by providing adequate equipment to manage medical emergencies, having due regard to guidelines issued by the British National Formulary, the Resuscitation Council UK, and the General Dental Council standards for the dental team.
- Ensure systems are established and operated effectively in relation to the recruitment process to ensure the necessary employment checks are in place for all staff, and the required specified information in respect of persons employed by the practice is retained, in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Ensure the storage of records relating to people employed is in accordance with current legislation and guidance.
- Ensure infection control audits have documented learning points and improvements can be demonstrated as part of the process of assessing, monitoring and improving the quality and safety of the services provided.

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

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

- Review the practice's safeguarding training and ensure all staff are trained to an appropriate level for their role.
- Review staff awareness of the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the storage of products identified under Control of Substances Hazardous to Health Regulations 2002 to ensure they are stored securely.
- Review the practice's infection control procedures and protocols having 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.
- Review the current legionella risk assessment in relation to the required actions including the monitoring and recording of water temperatures, having due regard to the guidelines issued by the Department of Health - Health Technical

Summary of findings

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.

- Review the systems in place to monitor and track the use of prescriptions.
- Review the practice's legal obligations under the Ionising Radiation Regulations 1999 to notify the Health and Safety Executive.
- Review the training, learning and development needs of staff at appropriate intervals.
- Review the practice's website to ensure details of the complaints procedure are displayed, and ensure details are provided in the practice leaflet as to the steps people can take should they be dis-satisfied with the outcome of their complaint.
- Review the systems in place for obtaining, analysing and acting on feedback from patients, staff and stakeholders about the quality of care provided.

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 a system in place to record accidents and incidents and staff were aware of their responsibilities to report incidents. We saw that accidents were recorded and procedures were in place for recording and analysing significant events. Safety alerts were received by the practice and there was evidence of action taken in response to these alerts.

The practice had a policy in place for safeguarding children and vulnerable adults. We did not see certificates of training for staff in safeguarding vulnerable adults and children, within the time period specified in current guidelines, however staff told us there were regular safeguarding updates in staff meetings and staff were aware of their responsibilities regarding safeguarding children and vulnerable adults.

There were adequate numbers of suitably qualified staff working at the practice. The practice had a recruitment policy in place which did not reflect current regulations to ensure staff were recruited in line with requirements relating to workers' suitability for their role. Staff recruitment records we reviewed did not contain all the required information. We saw evidence of inductions for staff and regular reviews and appraisals.

The practice had most, but not all, the recommended emergency medicines and equipment. Staff did not have access to an automated external defibrillator (AED) on the premises, in line with current guidance, and the provider had not undertaken and documented a risk assessment as regards its unavailability. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. Staff were carrying out regular checks on the medicines and equipment.

The practice had identified and assessed a number of risks and put actions in place to minimise these, however some risk assessments did not identify risks or actions. The practice was not regularly reviewing the risk assessments to ensure they reflected current legislation and guidance. The practice had arrangements in place to ensure continuing care for patients during holidays and service disruptions.

The practice was clean and tidy and there was a cleaning schedule in place. Infection prevention and control policies and procedures were in place and staff were largely following these. One of the staff had a lead role for infection control. The practice had carried out a recent infection control audit but no actions were identified in it. No documented evidence of staff training in infection control was seen, although the dental nurses assured us this was provided in the external dental nurse qualification course they were currently undertaking.

The practice had testing arrangements in place for the equipment used in the practice and we saw that equipment was regularly serviced.

We saw evidence that X-rays were justified, reported on and quality assured, and evidence of auditing of the quality of the X-ray images, which demonstrated the practice was protecting patients and staff from unnecessary exposure to radiation.

Are services effective?

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

Summary of findings

Patients received an assessment of their dental needs which included assessing and recording their medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were fully explained and consented to. The practice kept detailed dental records of oral health assessments and treatment carried out, and monitored any changes in the patients' oral health. The practice provided regular oral health advice and guidance to patients.

The dentist followed current guidelines in the delivery of dental care and treatment for patients. The treatment provided for patients was evidence based and focussed on the needs of the individual. Patients were referred to other services where necessary, in a timely manner.

Qualified staff were registered with their professional body, the General Dental Council, (GDC). Staff received some training, development and support appropriate to their roles and learning needs, but the practice did not have an overall training plan in place to ensure staff were supported in meeting the GDC core subjects, for example, infection control, or to ensure staff were trained and updated in areas specifically relating to a dental practice, for example, fire safety training.

Staff were supervised and supported by the provider and their colleagues.

Are services caring?

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

Patients commented that the staff were caring, polite, and friendly. They told us that they were treated with respect and that they were happy with the care and treatment given.

We found that treatment was clearly explained and patients were provided with information regarding their treatment and oral health. Patients commented that the staff were informative and that information given to them about options for treatment was helpful.

Are services responsive to people's needs?

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

The practice tailored appointment lengths to patients' individual needs and patients could choose from morning or afternoon, or early evening appointments. Patients could request appointments by email, telephone or in person. Patients were able to access urgent appointments in a timely manner when required. The practice opening hours and out of hours appointment information was in the patient leaflet and on the website. Waiting times and delays were kept to a minimum and we were told that patients were kept informed of any delay.

The practice captured social and lifestyle information on the medical history forms completed by patients. This helped the dentist to identify patients' specific needs and helped them direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records, which helped them treat patients individually.

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. The practice was accessible to people with disabilities and impaired mobility but was unable to accommodate wheelchair users. A treatment room and an accessible toilet were located on the ground floor. The practice was able to refer patients who were wheelchair users to a practice nearby which was accessible for wheelchairs.

Staff had access to interpreter services where patients required these.

Summary of findings

The practice had a complaints policy in place which was displayed in the waiting room and outlined in the practice leaflet but not on the practice's 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 Notice at the end of this report).

The practice had a management structure in place and staff were aware of their roles and responsibilities. Staff had lead roles and the provider told us that the team approach to leadership encouraged the staff to reach their full potential.

The provider did not have effective systems and processes in place for monitoring and improving services, for example, the recruitment process was not effective and feedback from patients and staff was not actively sought.

The practice had a number of policies and procedures in place, however several were not regularly reviewed and some did not reflect current guidelines, for example, the staff recruitment policy.

The provider carried out some audits effectively, such as record cards and X-rays. We saw evidence to show that these auditing processes were functioning well as actions were clearly identified and followed up to monitor improvement. The auditing process for infection control was not functioning effectively.

We were given examples of some feedback from patients but no formal system was in place to actively seek the views of, and obtain feedback from patients, staff and stakeholders.

The provider had a number of risk assessments in place; however there was no evidence of regular review to ensure they were up to date with relevant regulations and guidance. Staff had a good understanding of risks.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete and accurate.

The culture of the practice encouraged openness and honesty. Staff told us they could speak with the dentist or colleagues if they had any concerns and felt their concerns would be listened to and appropriate action taken.

Staff we spoke to told us that as the practice team was small they communicated daily to share information and learning. We observed numerous examples of this taking place during the inspection. The practice held staff meetings frequently and these were used to share information to inform and improve future practice.

Staff reported they were happy in their roles and felt well supported by their colleagues and the provider. Staff commented that the managers were approachable and helpful and took account of their views.

Milk Dental

Detailed findings

Background to this inspection

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

The inspection took place on 8 March 2016 and was led by a CQC inspector who had access to remote advice from a specialist advisor.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included details of complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members including their qualifications and proof of registration with their professional body.

We also reviewed information we held about the practice. During the inspection we spoke to the dentist and dental nurses. We reviewed policies, procedures and other documents and observed procedures. We reviewed 13 CQC comment cards that we had sent prior to the inspection, for patients to complete about the services provided at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to report, analyse and learn from accidents and incidents. The provider told us staff had recently been trained in what constitutes a significant event in relation to a dental practice. Staff had started to log significant events and analyse them, recording the urgency of action required and the action taken. Staff showed us the log and discussed examples they had recorded. The provider also discussed an example with us and we saw that the provider had closely adhered to the reporting procedure, recorded the incident, reviewed current practice and put in place actions as a result of learning from the event. The practice maintained a record of accidents and incidents. Included in the records were photographs of the hazards where relevant. A description as to the type of risk and why this constituted a risk was also included. Staff were encouraged to bring safety issues and concerns to the attention of the dentist.

Staff had an understanding of the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 and were aware of how and when to report. Staff had an understanding of their responsibilities under the Duty of Candour. Duty of Candour means relevant people are told when a notifiable safety incident occurs and in accordance with the statutory duty are given an apology and informed of any actions taken as a result. The provider knew when and how to notify CQC of incidents which could cause harm.

The provider received alerts from the Medicines and Healthcare products Regulatory Agency and Department of Health. These alerts identify problems or concerns relating to a medicine or piece of medical or dental equipment, or detail protocols to follow, for example, in the event of an outbreak of pandemic influenza. Staff were able to discuss examples of these and confirmed that alerts were discussed at staff meetings.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place in relation to the protection of children and vulnerable adults, but no evidence of review arrangements in place. The practice had local safeguarding authority's contact details and guidance available, and flowcharts containing this information were clearly displayed for staff to refer to. The provider was identified as the lead for safeguarding to oversee safeguarding procedures within the practice. We did not see any documented evidence of training for staff in safeguarding vulnerable adults and children, within the time period specified in current guidelines, but staff confirmed there were regular safeguarding updates in staff meetings and the practice watched training videos on safeguarding, as a team. Staff we spoke to were aware of how to raise concerns and were aware of the reporting process. The practice had a system for alerting them to children and vulnerable adults who failed dental and referral appointments and these patients were followed up.

We observed that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records were maintained on paper and electronically. Records contained a medical history which was completed or updated by the patient and reviewed by the dentist, prior to the commencement of dental treatment and at regular intervals of care. The clinical records we saw were all well structured and contained sufficient detail to demonstrate what treatment had been prescribed and completed, what was due to be carried out next and details of possible alternatives.

Computers were password protected and data regularly backed up to secure storage. Screens at reception were not overlooked which ensured patients' confidential information could not be viewed at reception.

Medical emergencies

The provider had procedures in place for staff to follow in the event of a medical emergency and these procedures were clearly displayed in the treatment rooms for staff to refer to. All staff received basic life support training annually as a team. We saw certificated evidence of this for three of the four staff. Staff told us they had regular updates at staff meetings. Staff we spoke to were able to describe how they would deal with medical emergencies.

The practice had most emergency medicines and equipment available in accordance with the Resuscitation Council UK and British National Formulary guidelines but did not have some of the recommended equipment, for example, oropharyngeal airways. Staff did not have access to an automated external defibrillator (AED) on the premises, in line with Resuscitation Council UK guidance and the General Dental Council standards for the dental

team and the provider had not undertaken and documented a risk assessment as regards its unavailability. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. We saw records to show that the medicines and equipment were checked monthly. All medicines were within their expiry date.

The practice stored emergency medicines and equipment centrally in the practice in kits relating to emergencies by type, which were immediately accessible to staff. Staff were able to tell us where they were located.

Staff recruitment

The practice had a recruitment policy in place which did not reflect current regulations to ensure staff were recruited in line with requirements relating to workers' suitability for their role. We did not see evidence that this policy was regularly reviewed. Staff recruitment records we reviewed did not contain all the prescribed information. The provider told us that the dental nurses' external training provider carried out recruitment checks when they applied for the course. We did not see evidence of a Disclosure and Barring Service, (DBS), check or risk assessment for any of the clinical staff. Following the inspection the practice manager provided us with evidence of a recent DBS for one of the nurses which had been carried out by the nurse's external training provider. We saw evidence of qualifications and of registration with the professional body, the General Dental Council, (GDC), for the provider. The three dental nurses were not yet qualified and therefore not required to be registered with the GDC. We saw evidence of indemnity insurance for the provider. The provider told us that the clinical staff were covered by the practice indemnity but we did not see documented evidence of this. We observed that staff recruitment information was not held in individual files but was retained collectively and was accessible to unauthorised people.

There were sufficient numbers of staff working at the practice, and the provider was always assisted by a dental nurse. The practice was staffed by three trainee dental nurses, who were at various stages in their training; one was due to qualify in two months, another in eight months and the third in approximately a year.

The practice had an induction programme in place. The dental nurses confirmed to us that they had received an induction when they started work at the practice. Staff showed us their individual induction packs which contained information relevant to their job role and a range of policies and procedures.

Monitoring health and safety and responding to risks

The practice had an overarching health and safety policy in place, underpinned by several specific policies and risk specific assessments.

A range of other policies, procedures and protocols were in place to inform and guide staff in the performance of their duties and to manage risks at the practice. We did not see evidence that all policies, procedures and risk assessments were regularly and consistently reviewed.

The risk assessments, for example, in relation to the control of substances hazardous to health and sharps, detailed arrangements to identify, record and manage risks with a view to keeping staff and patients safe. A fire risk assessment had been carried out by the provider but it was not dated and we were not assured independent advice had been sought in carrying out the assessment.

The practice had carried out a recent Legionella risk assessment to determine if there were any risks associated with the premises. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

The practice had procedures in place to assess the risks from substances in accordance with the Control of Substances Hazardous to Health Regulations 2002, and maintained a file containing details of products in use at the practice, for example, chemicals used for dental treatment. The practice retained the manufacturers' data sheets to inform staff what action to take in the event of a chemical spillage, accidental swallowing or contact with the skin. Measures were identified to reduce risks and included, for example, the use of personal protective equipment for staff and patients. The practice was not storing hazardous materials and gas cylinders securely.

The practice had a business continuity plan in place in order to minimise the risks associated with, and to be able to respond to and manage, disruptions and developments. Staff were able to discuss examples of disruptions, for

example, the lead for infection control explained to us the procedure should the autoclave fail, and staff showed us documented evidence of the practice's evacuation plan which would be used in the event of fire.

The practice had arrangements in place with a local practice to ensure continuing care for patients during the dentist's absence. Staff provided cover for each other during absences.

Infection control

The practice was visibly clean, tidy and uncluttered. The practice had an overarching infection control policy in place and supporting policies and procedures which detailed decontamination and cleaning. Procedures were clearly displayed in appropriate areas such as the decontamination room and treatment rooms for staff to refer to.

One of the nurses had a lead role for infection control and decontamination. We saw that the practice had undertaken a recent infection control audit which identified that the practice was not fully compliant with infection control overall. The audit did not detail actions to be taken to improve this compliance. Infection control audits were undertaken regularly but we observed that a number of the same issues were regularly noted as non compliances, for example the Hepatitis B documentation was not available in the last four audits.

We observed that there were adequate hand washing facilities available in each of the treatment rooms, the decontamination room, and in the toilet facilities. Hand washing protocols were displayed appropriately near hand washing sinks.

We observed the decontamination process and found it to be largely in accordance with the Department of Health's guidance, Health Technical Memorandum 01- 05 Decontamination in primary care dental practices, (HTM 01-05), however there were some deviations from the guidance, for example no cleaning solution was used for scrubbing the instruments. The practice had a dedicated decontamination room which was not accessible to patients. The decontamination room and treatment rooms had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff used sealed boxes to transfer used instruments from the treatment rooms to the decontamination room. Staff used a process of manual cleaning to clean the instruments. Instruments were then examined using an illuminated magnifying glass to enable closer inspection of them. Instruments were then sterilised in a validated autoclave. At the end of the sterilising process the instruments were packaged, sealed, dated with an expiry date and stored. Staff wore appropriate personal protective equipment during the process.

The autoclave had options for two types of sterilisation and staff had a clear understanding of the correct use and procedure for each option.

We observed that instruments were stored in drawers in the treatment rooms. We looked at the packaged instruments in the treatment rooms and found that most were marked with an expiry date which was within the recommendations of the Department of Health.

The dental nurse showed us the systems in place to ensure the decontamination equipment was tested and maintained in accordance with the manufacturer's instructions and HTM 01 05, and we saw records of this for the autoclave.

Staff changing facilities were available and staff were aware of the uniform policy. Staff were well presented and wore uniforms inside the practice only.

The practice had had a recent Legionella risk assessment carried out to determine if there were any risks associated with the premises. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). Actions were identified in the assessment which had mostly been carried out. We saw records of checks and testing, for example, on water outlet temperatures, which assists in monitoring the risk from Legionella. Some of the results of the tests identified that further action may be required as to the temperature of the hot water.

The dental water lines and suction unit were cleaned and disinfected daily, in accordance with guidance to prevent the growth and spread of Legionella bacteria, but filters from the suction unit were disinfected weekly which was not in line with guidance.

The treatment rooms had sufficient supplies of personal protective equipment for staff and patient use.

The practice had a policy and a procedure for dealing with sharps injuries. We saw documented evidence demonstrating that three of the four clinical staff had received a vaccination to protect them against the

Are services safe?

Hepatitis B virus, but no evidence relating to the effectiveness of this vaccination and no risk assessment in relation to these staff undertaking clinical duties. People who are likely to come into contact with blood products and are at increased risk of injuries from sharp instruments should receive these vaccinations to minimise the risks of acquiring blood borne infections.

The practice staff were responsible for cleaning all areas of the practice. The practice had a cleaning policy and cleaning schedule in place identifying tasks to be completed, and used a colour coding system to assist with cleaning risk identification in accordance with National specifications for cleanliness : primary medical and dental practices, issued by the National Patient Safety Agency. We observed that the cleaning equipment was stored inappropriately and not in accordance with current guidance. Responsibility for cleaning the clinical areas in between patient treatments was identified as a role for the dental nurses.

The segregation, storage and disposal of dental waste was in accordance with current guidelines laid down by the Department of Health in the Health Technical Memorandum 07-01 Safe management of healthcare waste. We observed that clinical waste awaiting collection was stored securely. The practice had arrangements for all types of dental waste to be removed from the practice by a contractor. We observed during the inspection that sharps bins were suitably located in the clinical areas.

Equipment and medicines

Staff showed us contracts for the maintenance of equipment, and recent test certificates for the decontamination equipment and the air compressor.

The practice had a current portable appliance test certificate, (PAT). PAT is the name of a process under which electrical appliances are routinely checked for safety.

We saw records to demonstrate that some fire detection and fire-fighting equipment such as fire extinguishers were checked by staff. The provider told us this equipment was regularly maintained by an external contractor, but we did not see documented evidence of this.

The practice had a sharps policy in place and the practice had implemented a safer sharps system to dispose of used needles. The policy and procedures were displayed in the treatment rooms. Staff were fully familiar with the policy and able to describe the action they would take should they sustain an injury. Staff told us that only the dentist disposed of used needles. We saw recorded evidence of one sharps injury to a member of staff. Action taken was in line with the policy and recognised guidance. The practice used single use disposable instruments where possible to minimise the risk of injury.

We saw evidence that the practice was storing NHS prescription pads securely in accordance with current guidance. Staff were not maintaining a prescription log to ensure all prescriptions were accounted for, including void prescriptions. Private prescriptions were printed out when required following assessment of the patient.

Radiography (X-rays)

The practice maintained a radiation protection file which contained most of the required information.

The provider had appointed a Radiation Protection Advisor and the dentist was the Radiation Protection Supervisor.

We did not see evidence that the Health and Safety Executive had been notified of the use of X- ray equipment on the premises.

We saw critical examination packs for each X-ray machine. Routine testing and servicing of the X-ray machines had been carried out in accordance with the current recommended maximum interval of three years.

We observed that local rules were displayed in areas where X-rays were carried out. These included specific working instructions for staff using the X-ray equipment.

We saw evidence of regular auditing of the quality of the X-ray images which demonstrated the practice was acting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and patients and staff were protected from unnecessary exposure to radiation.

Dental care records confirmed that X-rays were justified, reported on and quality assured in accordance with IR(ME)R, current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines.

We saw evidence of recent radiology training for the relevant staff in accordance with IR(ME)R requirements.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with current National Institute for Health and Care Excellence guidelines, Faculty of General Dental Practice, (FGDP), guidelines, the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' and General Dental Council guidelines. The dentist described to us how examinations and assessments were carried out. Patients completed a medical history questionnaire which included detailing any health conditions, medicines being taken and allergies, as well as details of their dental and social history. The dentist then carried out a detailed examination. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was discussed with the patient and treatment options and costs explained in detail.

Details of the treatments carried out were documented and specific details of medicines used in the dental treatment were recorded. This would enable a specific batch of medicine to be traced to the patient in the event of a safety recall or alert in relation to a medicine.

Patients were monitored in follow-up appointments which were scheduled to individual requirements.

We checked dental care records to confirm what was described to us and found that the records were complete, clear and contained sufficient detail about each patient's dental treatment. The dental care records adhered to the FGDP guidance. We saw patients' signed treatment plans containing details of treatment and associated costs. The dentist confirmed to us that appointment lengths could be adjusted to allow more time, for example, when treating an anxious patient.

We saw evidence that the dentists used current National Institute for Health and Care Excellence Dental checks: intervals between oral health reviews, guidelines to assess each patient's risks and needs and to determine how frequently to recall them.

Health promotion and prevention

The dentist explained to us that there was a high incidence of dental caries in the local population and the practice therefore adhered closely to guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is used by dental teams for the prevention of dental disease in primary and secondary care settings. Tailored preventive dental advice and information was given in order to improve oral health outcomes for the patient. This included dietary advice and advice on general dental hygiene procedures. Where appropriate, dental fluoride treatments were prescribed. Adults and children attending the practice were advised during their consultation of steps to take to maintain good oral health. Tooth brushing techniques were explained to them in a way they understood. The sample of dental care records we observed confirmed this. Information in leaflet form was also available in the waiting room in relation to improving oral health and lifestyles, for example, smoking cessation. A number of oral hygiene products were available for sale in reception.

Staffing

All qualified dental care professionals are required to be registered with the General Dental Council, (GDC), in order to practice dentistry. To be included on the register dental care professionals must be appropriately qualified and meet the GDC requirements relating to continuing professional development, (CPD). We saw evidence that the provider was registered with the GDC. The dental care professionals employed at the practice were currently undergoing training and were not as yet required to register.

The GDC highly recommends certain core subjects for CPD, including cardio pulmonary resuscitation, (CPR), safeguarding, infection control and radiology. We saw documented evidence of CPR for all staff. We did not see documented evidence of training for staff in safeguarding vulnerable adults and children, within the time period specified in current guidelines, but staff confirmed there were regular safeguarding updates in staff meetings and the practice watched training videos on safeguarding as a team. We did not see documented evidence of infection control training for all staff, one of whom was the lead for infection control, but we were told by the dental nurses that infection control training was part of their external training course for qualification as a dental nurse.

Are services effective?

(for example, treatment is effective)

The dental nurse trainees were regularly assessed on their knowledge and practical skills as part of their external dental nurse qualification course. The provider also carried out practical training and oversaw the dental nurses work. We observed examples of this supervision during the inspection. The dental nurses supervised those nurses less experienced than themselves, and all the dental nurses were aware of their own competencies and limits. We observed the provider discussing issues which arose in the daily running of a dental practice with the nurses and using this as a learning opportunity for them. The nurses were encouraged to discuss the matters and identify solutions and were supported by the provider to reach their own action plan. Staff maintained an actions book and actions were recorded as they arose.

We did not see evidence of a practice training plan to ensure all staff received training in topics such as all the GDC core subjects, health and safety, and fire safety. The provider told us all staff had attended a presentation on fire safety delivered by the agency contracted to maintain the fire extinguishers, but we did not see any evidence of fire safety training on a regular basis.

The practice manager informed us that staff appraisals were carried out annually and we saw evidence that these were a two way process, and were used to identify training needs, for example, one of the dental nurses currently sharing the practice manager role expressed an interest in completing a practice manager's course. Additional personal development reviews were carried out quarterly for all staff.

Working with other services

The provider had carried out a recent review of referral protocols, and the practice had effective arrangements in place for external referrals. The practice referred patients to a variety of secondary care and specialist options where necessary, for example for orthodontic treatment. The dentist was aware of their own competencies and knew when to refer patients requiring treatment outwith their competencies. Urgent referrals were made in line with current guidelines. Information was shared appropriately when patients were referred to other health care providers.

Consent to care and treatment

The dentist described how they obtained valid informed consent from patients by explaining their findings to them and keeping records of the discussions. Patients were given a treatment plan following the initial consultations and assessments, and prior to commencing dental treatment.

The patient's dental care records were updated with the proposed treatment once this was finalised and agreed with the patient. The signed treatment plan and consent form were retained in the patients' dental care records. The form and discussions with the dentist made it clear that a patient could withdraw consent at any time and that they had received an explanation of the type of treatment, including the alternative options, risks, benefits and costs. The dentist described how they obtained verbal consent at each subsequent treatment appointment.

The dentist explained that they would not normally provide treatment to patients on their first appointment unless they were in pain or their presenting condition dictated otherwise. The dentist told us they allowed patients time to think about the treatment options presented to them.

The dentist told us they would generally only see children under 16 who were accompanied by a parent or guardian to ensure consent was obtained before treatment was undertaken but the dentist demonstrated an understanding of Gillick competency. (Gillick competency is a term used in medical law to decide whether a child of 16 years or under is able to consent to their own treatment).

The Mental Capacity Act 2005, (MCA), provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. The provider and staff had not received any training on the MCA and had a limited awareness of the MCA. The provider was aware the whole practice needed training in the MCA and was planning to arrange this.

NHS and private fee lists were displayed in the waiting room but not on the practice website.

Information on dental treatments was available in the waiting room and on the practice website to assist patients with treatment choices.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback given by patients on CQC comment cards demonstrated that patients felt they were always treated with kindness and respect, and staff were friendly, caring and helpful. The practice had a separate room available should patients wish to speak in private. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were with the dentist. Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment.

Involvement in decisions about care and treatment

The dentist discussed treatment options with patients and allowed time for patients to decide before treatment was commenced. We saw this documented in the dental care records. Patient's comment cards we reviewed told us care and treatments were always explained in a language they could understand. Patients commented that they were listened to. Patients confirmed that treatment options, risks and benefits were discussed with them and that they were provided with helpful information to assist them in making an informed choice.

Patients commented that the staff were open, honest and informative, and that they had confidence in the dental treatments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice tailored appointment lengths to patients' individual needs and patients could choose from morning, afternoon and evening appointments. Patients could request appointments by email, telephone or in person.

The provider told us patient surveys were carried out to gather the views of patients but we did not see any formal, documented system in place for this. Staff told us that patients were always able to provide feedback. Staff showed us patient information letters which detailed actions taken by the practice in response to patient feedback, for example, a reminder service for appointments was put into place, and a staff and patient focus group designed and chose uniforms and waiting areas colours. The NHS Family and Friends Test was used by the practice and forms were available in the waiting room for patients to indicate how likely they were to recommend the practice.

The practice captured social and lifestyle information on the medical history forms completed by patients. This enabled the dentist to identify any specific needs of patients and helped to direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records, which helped them treat patients individually, for example, assistance with mobility or interpreter services.

Tackling inequity and promoting equality

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. The practice was located in a listed building and was constrained by this as to alterations which could be made. There were a few steps at the front entrance to the practice with railings either side. One of the treatment rooms was situated on the ground floor near the front entrance and there were ground floor toilet facilities, which were accessible to people with disabilities and impaired mobility. Parking was located on nearby streets.

The practice leaflet explained that individual suitable arrangements would be put in place for patients with disabilities.

The practice was able to refer patients who were wheelchair users to a practice nearby which was accessible for wheelchairs.

Access information was provided in the practice leaflet but not on the practice website.

Staff told us they offered interpretation services to patients whose first language was not English and patients with impaired hearing.

The practice made provision for patients to arrange appointments by email, telephone or in person.

Where patients failed to attend their dental appointments staff contacted them to re-arrange appointments where possible and to establish if the practice could assist by providing adjustments to enable patients to receive their treatment.

Access to the service

The practice opening hours and out of hours appointment information were not displayed at the entrance to the practice but were provided in the practice leaflet and on the website. Emergency appointments were available daily. Waiting times and delays were kept to a minimum and we were told that patients were kept informed of any delay.

We saw that the next available appointment for a new patient was a week and a half ahead.

Concerns and complaints

The practice had a complaints policy which was displayed in the waiting room and outlined in the practice leaflet, but was not on the practice's website. No details were provided in the practice leaflet as to the steps people could take should they be dis-satisfied with the outcome of their complaint.

The practice had a complaints procedure and we saw that the one complaint received by the practice in the last 12 months had been thoroughly investigated and issues arising from it had been used to inform future practice. The patient had been given an explanation and an apology and informed of action taken.

Are services well-led?

Our findings

Governance arrangements

The provider was a member of the British Dental Association, (BDA), and was able to use the services of the BDA for advice and guidance on issues relating to dental practice.

The practice had a management structure in place. Staff had lead roles, and staff we spoke to were aware of their roles and responsibilities within the practice. Staff reported that the managers were approachable and helpful and we observed this during the inspection.

The provider did not have effective governance arrangements in place for monitoring and improving the services provided for patients. There were some established systems and processes in place for the smooth running of the practice which were largely operating effectively, however the recruitment system was not operating effectively.

There were a number of policies and procedures in place at the practice, which were accessible to staff. These included health and safety, safeguarding children and adults, and infection control. Some of these were not regularly reviewed. The recruitment policy did not reflect current legislation and was not operating effectively. Policies and procedures were not audited for their effectiveness.

The provider had an approach for identifying where quality or safety was being compromised, for example, via the implementation of an audit programme. Practice staff audited record cards, infection control and X-rays.

The provider had a number of risk assessments in place and practical measures were in place for staff reference, for example, the risk assessment scenarios book. Not all risk assessments were effective, for example the fire risk assessment, and not all were consistently and regularly reviewed to ensure they were current and up to date with relevant regulations and guidance.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete and accurate. They were maintained electronically and on paper and securely stored. All computers were password protected and the computer was backed up daily.

Leadership, openness and transparency

Staff told us that there were clear lines of responsibility and accountability within the practice, and that there was a no blame culture. Two of the dental nurses shared the practice manager role. One of these nurses was the lead for clinical issues and the other for administration issues. The provider told us that the team approach to leadership encouraged the staff to reach their full potential.

The culture of the practice encouraged openness and honesty. Staff told us they could speak with the dentist or colleagues if they had any concerns and felt their concerns would be listened to and appropriate action taken.

Staff we spoke to told us that as the practice team was small staff communicated daily to share information and learning. We observed numerous examples of this taking place during the inspection. The practice held staff meetings frequently and these were used to share information to inform and improve future practice. We saw recorded minutes of these meetings and items discussed included, for example, staffing issues, contract activity, practice maintenance, incidents and training updates.

Learning and improvement

We saw evidence to demonstrate that the auditing processes for record cards and X-rays, were functioning well as actions were identified and followed up, and re-auditing was carried out to monitor continuous improvement. Infection control audits were being carried out but we did not see evidence showing actions identified. We saw evidence to show that information resulting from record card and X-ray audits was used to improve the quality and safety of the service.

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

There was no formal method for actively seeking the views of patients, staff and stakeholders but staff told us that information was gathered by the practice from patients to assist in evaluating and improving the current service. We did not see evidence of the documentation of feedback but staff showed us examples of improvements made in response to patient feedback. Patients were informed of the improvements in the patient information letter. We saw evidence of learning implemented from written complaints.

Are services well-led?

Staff told us that that they were encouraged to report any concerns, and that as the practice was a small team concerns were sorted out quickly and not allowed to escalate.

Staff reported they were happy in their roles, and managers took account of their views. Staff commented that they were well supported by managers and colleagues and always able to seek clarification and assistance if they were unsure of any of their duties.

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 had not established an effective system or process to ensure compliance with the Regulations for staff recruitment. • The provider was not assessing, monitoring and improving the quality and safety of the services in that the infection control audits the provider had carried out had no actions identified in them, and no analyses. • The provider was not assessing, monitoring and mitigating the risks relating to the health, safety and welfare of patients and others in that items of recommended emergency equipment were unavailable, namely an automated external defibrillator and oropharyngeal airways. • The provider was not maintaining securely records necessary to be kept in relation to persons employed in the carrying on of the service, in that not all the prescribed information was available in staff recruitment records, and staff recruitment information was stored collectively. **Regulation 17 (1), (2) (a), (b), (d)**