Mrs Karen Lesley Archer

@155

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 January 2017 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

The dental practice @155 is located in ground floor premises situated to the west of Derby city centre. There are two treatment rooms, both of which are located on the ground floor. The practice provides solely private dental treatment. The practice has its own car park for patients to the rear of the premises.

The practice provides regulated dental services to both children and adults. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatments. Services also include specialist oral surgery procedures including placement of implants

The practice's opening hours are – Monday: 8 am to 6 pm; Tuesday: 8 am to 1pm; Wednesday: 8:30 am to 4 pm; Thursday: 8 am to 5 pm; Friday: 8 am to 1 pm

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual registered person. 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.

The practice has one dentist; one oral surgery specialist, one therapist/ hygienist; two qualified dental nurses; and one receptionist.

Summary of findings

Before the inspection we sent CQC comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received responses from six patients through comment cards and by speaking with them during the inspection. Those patients provided positive feedback about the services the practice provides.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- There were systems to record accidents, significant events and complaints. Learning points from these were recorded and used to make improvements.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice did not have an automated external defibrillator (AED). A risk assessment regarding the AED sent to CQC after the inspection did not identify alternative arrangements to access an AED from another provider in an emergency situation.
- There were effective systems at the practice related to the Control of Substance Hazardous to Health (COSHH) Regulations 2002.
- Patients said they had no problem getting an appointment that suited their needs.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect.
- Patients' confidentiality was protected within the practice.
- The practice did not always follow the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns about a colleague's practice.
- The practice did not have the necessary equipment for staff to deal with medical emergencies, or a risk assessment identifying any alternative arrangements.

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

Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment. The provider should consider the guidance issued by the British Endodontic Society when carrying out root canal treatments.
- Review availability of equipment such as an AED to manage medical emergencies taking into account guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. The provider must ensure a suitable risk assessment is undertaken if a decision is made to not have an AED on-site.

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?

No action

There were systems for recording accidents, incidents and complaints.

All staff had received training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns.

There were effective systems at the practice related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

X-ray equipment was regularly serviced to make sure it was safe for use.

The provider did not have access to an automated external defibrillator (AED) in the event of an emergency occurring. The risk assessment provided to CQC did not identify the alternative arrangements to use an AED in an emergency situation.

Recruitment checks were completed on all new members of staff.

Dental instruments were not cleaned in line with published guidance, and not all of the equipment necessary to check cleaning had been effective was in place.

Staff said that regular audits of the decontamination process were completed, however documentary evidence was not seen to demonstrate this was as recommended by the current guidance.

Are services effective?

No action

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

All patients were clinically assessed by a dentist before any treatment began. The practice used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

Discussions with patients about their treatment options were recorded in dental care records.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

The practice had systems in place for making referrals to other dental professionals when it was clinically necessary.

Are services caring?

No action

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

Summary of findings

Patients' confidentiality was maintained and electronic dental care records were password protected.

Feedback from patients identified staff were friendly, and treated them with care and concern. Patients also said they were treated with dignity and respect.

There were systems for patients to express their views and opinions.

Are services responsive to people's needs?

No action

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

Patients who were in pain or in need of urgent treatment could usually get an appointment the same day. There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays

Patient areas including two treatment rooms were located on the ground floor which allowed easy access for patients with restricted mobility. A disabled access audit in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility. The practice had an induction hearing loop to assist patients who used a hearing aid.

A company providing interpreters was available for patients who could not speak English.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

Requirements notice 

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).

Governance arrangements in place were not robust. Staff were not following the practice's own policies and protocols when cleaning and sterilising of dental instruments.

Risks to patient safety had not been adequately risk assessed as was demonstrated by the lack of risk assessment for the non-use of rubber dams during endodontic (root canal) treatments and the lack of alternatives identified in the risk assessment submitted to CQC regarding the use of the automated external defibrillator (AED).

Systems and processes at the practice to monitor the regulated activity were not effective as some items were out of date and had not been identified as such.

Summary of findings

The practice had a system for carrying out audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. However, the records to demonstrate that regular six monthly audits of the infection control processes had been completed were not available for inspection.

Patients were able to express their views and provide comments about the dental service.

@155

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.

We carried out an announced, comprehensive inspection on 10 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked for information to be sent to us, this included the complaints the practice had received in the last 12 months; the practice's latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies.

We reviewed the information we held about the practice and found there were no concerns.

We reviewed policies, procedures and other documents. We received feedback from six patients about the dental service.

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 systems for recording and investigating accidents, significant events and complaints. The practice had an accident book to record any accidents to patients or staff. The last recorded accident had been some years previously. Staff said there had been no accidents since the practice changed ownership in 2014.

The practice had not needed to make any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they were aware how to make these reports. The accident book contained guidance on making RIDDOR reports.

The records identified there had been no significant events in the twelve months leading up to this inspection. There was a book in the practice for recording any significant events and recording learning points.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by e mail and information was shared with staff when appropriate.

Following the inspection the practice sent a copy of their new Duty of Candour policy. Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Discussions with the practice owner identified they were aware of the regulation and understood their responsibilities as result. The practice owner said there had been no examples of duty of candour needing to be put into action. Discussions identified they were aware of when and how to notify CQC of incidents which caused harm.

Reliable safety systems and processes (including safeguarding)

The practice had policies for both safeguarding vulnerable adults and children. Both policies had been reviewed in August 2016. The child protection policy had been identified for discussion at a staff meeting in February 2017. The policies identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers were available for staff within the policy. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The practice owner said there had been no safeguarding referrals made by the practice.

The practice owner was the identified lead for safeguarding in the practice. They had received enhanced training in child protection to level three during 2016. We saw evidence that all staff had completed safeguarding training to level two during 2016.

The practice had guidance for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The COSHH policy formed part of the overall health and safety policy. There were risk assessments for all products and there were copies of manufacturers' product data sheets. Data sheets provided information on how to deal will spillages or accidental contact with chemicals and advised what protective clothing to wear.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 23 February 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a policy for dealing with sharps injuries which had been reviewed in August 2016. It was practice policy that only the dentist handled needles and these were not re-sheathed. There were devices to allow this to be completed safely. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were located in treatment rooms where they were accessible to dentists but not to patients.

We asked the dentist how they prevented patients from swallowing or inhaling root canal instruments during root canal treatment. They explained that they did not use a rubber dam to prevent this from happening but used irrigation during treatment instead. (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 and protect the airway. Rubber dams should be used when

endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.) We asked whether the practice had any rubber dam kits available and were told they did not.

Medical emergencies

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice also had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and medical oxygen we saw were all in date and stored in a central location known to all staff.

We did note that the practice did not have access to an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Following the inspection, we were sent a risk assessment detailing the practice's position regarding an AED. However, this did not suitably identify what arrangements were in place to access an AED from another source. We also noted that several items in the practice first aid kit had passed their expiry date.

During the inspection, a replacement first aid box was ordered to replace the existing box and contents.

Staff recruitment

The practice had a staff recruitment policy which had been reviewed in August 2016. We looked at the staff recruitment files for four staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files.

We saw that staff recruitment files had most of the information required by the regulations and all staff had received a Disclosure and Barring Service (DBS) check. We discussed the records that should be held in the recruitment files with the practice owner.

Monitoring health & safety and responding to risks

The practice had a general health and safety policy which had been reviewed in August 2016 and identified the practice owner as the lead person who had responsibility within the practice for different areas of health and safety. As part of this policy each area of the practice had been risk assessed to identify potential hazards and identify the measures taken to reduce or remove them.

Records showed that fire extinguishers had been serviced in February 2016. The practice had a fire risk assessment which identified the steps to take to reduce the risk of fire. The risk assessment had been produced in January 2014 and most recently reviewed in August 2016. We saw there was an automatic fire alarm system installed with emergency lighting and smoke alarms throughout the practice. Fire evacuation notices were displayed for staff and patients outlining the action to take if a fire occurred. Records showed the practice held a fire drill six monthly with the last one completed on 17 August 2016.

The practice had a health and safety law poster on display in the office and behind reception. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available. The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance identifies how infection control relates to the regulations within the Act.

We identified several examples where the guidance in HTM 01-05 and the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. were not being followed, and there were no suitable alternatives in place. For example: the use of personal protective equipment (PPE), manual cleaning techniques and the use of an illuminated magnifying glass.

Are services safe?

The practice had an infection control policy which had been reviewed in August 2016. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

The guidance HTM 01-05 recommends six monthly infection control audits. Discussions with staff identified that six monthly audits had been completed. However, the documented evidence to support this was not available.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury and a bodily fluids spillage kit both of which were in date.

There was one decontamination room where dental instruments were cleaned and sterilised and then bagged, date stamped and stored. A dental nurse demonstrated the decontamination process. However, we noted that the nurse did not wear an apron or a mask. This was not as recommended in the national guidance HTM 01-05. We asked the dental nurse about the use of aprons and masks but she was unable to locate any. Aprons and masks formed part of the personal protective equipment (PPE) used during the process to protect staff from contamination and injury. Other items of PPE would include the use of heavy duty gloves, latex free gloves and protective eye wear which were being used.

The practice used manual cleaning techniques to clean dental instruments before they were sterilised. We saw that the manual cleaning techniques used were not as recommended in the guidance HTM 01-05 (section 16). The temperature of the water was not checked during the process we observed and there were no records to show that water temperatures were routinely checked and recorded. We saw that a nail brush was used to clean the dental instruments."

After cleaning, instruments were rinsed. However, we noted there was no illuminated magnifying glass available for examining the instruments.

Finally the instruments were sterilised in one of the practice's two autoclaves (a device for sterilising dental and medical instruments). At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

We saw that matrix bands (cylindrical metal bands with a special clamp or holder used to surround a tooth while filling material is used to fill a prepared hole in that tooth) were a single use item. A dental nurse explained that used matrix bands were squashed out of shape to identify them as being contaminated. However, we saw matrix bands on a tray ready to be autoclaved, and on closer inspection we saw there was debris on the inside which identified the matrix band as having been used. We also saw matrix bands in treatment rooms which were identified as ready to use, which were visibly stained and had debris attached.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There was a data logger for one autoclave and nursing staff said data was downloaded once a month. However, staff were not able to locate the records. Nursing staff were also unable to locate records to demonstrate that autoclaves were checked on a daily basis to ensure they were working correctly.

The practice had a policy for dealing with blood borne viruses dated December 2016. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received boosters when required. Records showed that blood tests to check the effectiveness of the inoculation had been taken. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The risks associated with Legionella had been assessed. This assessment had been completed by an external contractor in November 2014 and was due for review in November 2017. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had taken steps to reduce the risks associated with Legionella with regular flushing of dental water lines as identified in the relevant guidance. We saw documentary evidence to identify that quarterly dip slide

tests had been completed. Dip slide tests are a means of testing the microbial content (bacteria) in a liquid through dipping a sterile carrier into that liquid and monitoring any bacterial growth.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing had been completed on electrical equipment at the practice in September 2015. The gas supply had been checked and the practice had a landlord's gas safety certificate dated 3 December 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in March 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced and validated in July 2016.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).

This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs, Health and Safety Executive notification and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured.

We did note that none of the intraoral X-ray machines were fitted with rectangular collimation (a specialised metal barrier attached to the head of the X-ray machine used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient receives). However, the practice used digital X-rays, which relied on lower doses of radiation. This therefore reduced the risks to both patients and staff.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment. The care records showed a thorough examination had been completed, and identified any risk factors such as smoking and diet for each patient.

New patients at the practice completed a medical history form which was scanned into their electronic dental records. Returning patients updated their information which was reviewed with the dentist in the treatment room. The patients' medical histories included any health conditions, medicines being taken, whether the patient might be pregnant or had any allergies.

The dental care records showed the dentist assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentist used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw the dentist used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentist was following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had one waiting room for patients. There were leaflets and posters to encourage good oral hygiene. There were free samples of toothpaste for patients available in the practice.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. The use of fluoride varnish was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health.

We were shown several examples in patients' dental care records that the dentist had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, the dentist had particularly highlighted the risk of dental disease and oral cancer. The dental care records contained an oral cancer risk assessment. In some dental care records we saw the risk assessments for caries (tooth decay) and periodontal disease (gum disease) were also recorded.

Staffing

The practice had one dentist; one oral surgery specialist, one therapist/ hygienist; two qualified dental nurses; and one receptionist. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

Records within the practice showed there were sufficient numbers of staff to meet the needs of patients attending the practice for treatment.

We looked at staff training records for clinical staff to identify that they were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. We saw the training records for clinical staff and saw copies of training certificates and CPD details for relevant staff during the inspection. Examples of training completed included: radiography (X-rays) and medical emergencies.

Records at the practice showed that all staff had received an annual appraisal. This was completed with the practice owner. We saw evidence the practice had an induction programme for new members of staff.

Working with other services

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. We saw the practice referred to other local dental services and for minor oral surgery when this could not be completed within the practice. The practice had recently appointed a new oral surgeon and an internal system for referrals was being developed.

Are services effective?

(for example, treatment is effective)

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. Children or patients with special needs who required more specialist dental care were referred to the community dental service.

Referrals were made to the Maxillofacial department at the local hospital or a local dental practice with a contract for minor oral surgery for wisdom tooth removal if this could not be completed at the practice. For patients with suspicious lesions (suspected cancer) referrals were sent through to the hospital within the two week referral window identified for suspected cancer.

Consent to care and treatment

We saw how consent was recorded in the patients' dental care records. The dentist had recorded the treatment options and recorded these had been discussed with the patients. This led the patients concerned to make informed choices about their treatment and give valid consent. We discussed the Mental Capacity Act 2005 (MCA) with the dentist. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. We saw the dentist had a good understanding of the MCA and how it would apply to dentistry.

We talked with the dentist about their awareness of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. We saw that the dentist understood the principals that underpinned Gillick competency.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed staff speaking with patients. We saw that staff were professional, polite, and had a welcoming manner. We saw that staff spoke with patients with due regard to dignity and respect.

The reception desk was located away from the waiting room. We asked reception staff how patient confidentiality was maintained at reception. Staff said that details of patients' individual treatment were never discussed at the reception desk. In addition if it was necessary to discuss a confidential matter, there were areas of the practice where this could happen such as an unused treatment room.

We saw examples that showed patient confidentiality was maintained at the practice. For example we saw that computer screens could not be overlooked at the reception desk. Patients' dental care records were held securely and computer password protected.

Involvement in decisions about care and treatment

We received positive feedback from six patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection, and by speaking to patients in the practice during the inspection. The practice owner did not make the comment box supplied by CQC available to patients and did not provide an alternative. This resulted in patients leaving their completed comment cards on the reception desk where they could be seen by the staff. The purpose of the comment card box is to ensure confidentiality of patient feedback.

The practice offered only private treatments and the costs were available at reception and given out with welcome packs for new patients. If patients were receiving treatment they were given a treatment plan which included the costs.

We spoke with the practice owner who was the principal dentist about how patients had their diagnosis and dental treatment discussed with them. Patients were given a written copy of the treatment plan which included the costs.

Where necessary the dentist gave patients information about preventing dental decay and gum disease. In particular the dentist had highlighted the risks associated with smoking and diet, and we saw examples of this recorded in the dental care records. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The patient areas of the practice were located on the ground floor. There was parking including disabled parking close to the dental practice.

The practice had separate staff and patient areas, to assist with confidentiality and security.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To manage this the practice made specific appointment slots available for patients who were in pain or required emergency treatment.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The appointment book also identified where patients were being seen in an emergency.

Tackling inequity and promoting equality

There were two treatment rooms in use for dentistry, both of which were situated on the ground floor. Both treatment rooms were accessible for wheelchair users. This allowed patients with restricted mobility easy access to treatment at the practice. Wheelchair access was via the rear entrance and there were designated disabled parking spaces in the car park The ground floor treatment rooms were large enough for patients to manoeuvre a wheelchair into the room.

The practice had reviewed and recorded the arrangements for access for people with a disability in August 2016.

There was a lower section of the reception desk which meant patients who were using a wheelchair could speak with the receptionist and were able to make eye contact.

The practice had two ground floor toilets. One for patients to use which was compliant with the Equality Act (2010) being fitted with support bars and grab handles, an emergency pull cord and lever operated taps.

The practice had a hearing induction loop built into the reception desk to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

Staff said the practice had access to an interpreter service through a recognised company. However, staff could not recall needing to use the service.

Access to the service

The practice's opening hours were – Monday: 8 am to 6 pm; Tuesday: 8 am to 1pm; Wednesday: 8:30 am to 4 pm; Thursday: 8 am to 5 pm; Friday: 8 am to 1 pm

The practice had a website: www.155unr.co.uk. This allowed patients to access the latest information or check opening times or treatment options on-line.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message.

The practice operated a text message reminder service for patients who had appointments with the dentist 24 hours before their appointment was due. Patients also received an e mail reminder and telephone call 24 hours before their appointment as due.

Concerns & complaints

The practice had a complaints policy which was dated June 2013 and had been reviewed in August 2016. The policy explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the complaints policy.

Information about how to complain was displayed in the patient information file in the waiting room.

From information reviewed in the practice we saw that there had been three formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient when required.

Are services well-led?

Our findings

Governance arrangements

During our inspection we found that the systems and processes within the practice had not always been operated effectively and we identified that some systems for monitoring infection control procedures were not robust. For example: single use matrix bands were being re-used. The manual cleaning techniques used in the practice were not following published guidance and records to demonstrate the processes were robust were not available. Staff were unable to locate records that would have demonstrated that six monthly infection control audits had been completed. Risk assessments to guide staff in maintaining patient safety were not robust. The risk assessment provided to CQC in respect of there being no automated external defibrillator (AED) at the practice did not identify alternatives to keep patients safe.

We found that guidance issued by the Department of Health (HTM 01-05), the British Endodontic Society, the Resuscitation Council UK and the General Dental Council (GDC) was not being followed. We identified examples where systems and processes to protect patient safety within the practice were not effective as a result of the guidance not being followed.

We saw a number of policies and procedures at the practice these had been reviewed during the year before this inspection.

We spoke with staff who said they understood the structure of the practice. Staff said if they had any concerns they would raise these with the practice owner. We spoke with two members of staff who said they liked working at the practice.

Leadership, openness and transparency

There was a management structure at the practice with clear lines of accountability. Staff were aware of the structure and said they would talk to the dentist and practice owner if they had any concerns. We saw that there were regular staff meetings at this practice and meetings were minuted and minutes were available to all staff.

Discussions with staff showed there was a good understanding of how the practice worked.

The principal dentist sent a copy of the new policy relating to the Duty of Candour to CQC after the inspection. The policy directed staff to be open, honest and to offer apologies when things had gone wrong. Discussions with the practice owner showed they understood the principles behind the duty of candour. There had been no examples where the Duty of Candour policy had been used.

The practice had a whistleblowing policy which identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. This was both internally and with identified external agencies. A copy of the policy was available on any computer in the practice.

Learning and improvement

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Radiography (X-rays) which had been audited in August 2016. The radiography audits checked the quality of the X-rays including the justification (reason) for taking the X-ray and the clinical findings which had been recorded in the dental care records. The practice had audited their dental care records. The dentist said the radiography audit was due to be repeated. We asked a dental nurse if six monthly infection control audits were being completed. They said they were, but were unable to locate the documentary evidence.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

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

Are services well-led?

The practice invited feedback from patients and several testimonials were published on the practice website. We discussed how the practice gathered formal feedback and saw that patients were able to leave written feedback on an on-going basis.

The practice had a social media page. This was used to give positive messages regarding oral health and also gave patients the opportunity to provide feedback about the services.

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 **Regulation 17 HCSA 2008 Regulations 2014** **Good governance** The registered person did not have effective systems in place to ensure that the regulated activities at 155 Uttoxeter Road Dental Practice were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider did not have in place systems to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. Infection control procedures were not in line with current national guidance as personal protective equipment such as aprons was not being used by staff while cleaning and decontaminating used dental instruments. Single use instruments such as matrix bands were being re-used. **Regulation 17(1)**