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West Dulwich Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 25 June 2015 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.

West Dulwich Dental is located in the London Borough of Lambeth. The premises consist of one treatment room, a dedicated decontamination room, waiting room with reception area and toilet.

The practice provides private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), a dental nurse and a receptionist.

The practice is open Monday, Tuesday and Thursday from 9.00am to 5.30pm and on Wednesday from 1.00pm to 8.00pm.

A new provider took over the practice in April 2014 and registered with the Care Quality Commission (CQC) at that time. We carried out an announced, comprehensive inspection on 25 June 2015. The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

30 people provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Summary of findings

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and patient practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings.
- Monitoring arrangements were however, not effective in improving the quality and maintaining the safety of the service
- Medicines required for the management of medical emergencies had recently expired and needed replacing.

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

- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- Review availability of medicines to manage medical emergencies giving due regard to guidelines issued by the British National Formulary.

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

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

- Ensure that all staff are up to date with training requirements including X-ray and basic life support training.
- Disseminate information contained within the Control of Substances Hazardous to Health (COSHH) file to ensure that all staff understand how to minimise risks associated with these substances.
- Carry out a practice-wide risk assessment in relation to Legionella in order to identify any changes or monitoring practices which need to be implemented.
- Ensure audits such as those related to infection control, X-rays and dental care records are undertaken at regular intervals to assess and improve the quality of service.

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 policies and protocols related to the safe running of the service. Staff were aware of these and were following them. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had systems in place for the management of infection control and waste disposal, incident reporting, staff recruitment and dental radiography.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment.

The practice maintained appropriate medical records and details were updated appropriately The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Clinical staff generally worked towards meeting professional standards and completing continuing professional development (CPD) standards set by the General Dental Council (GDC). However, the dentist needed to renew some training, for example in relation to taking X-rays and responding to emergencies.

Are services caring?

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

We received feedback from patients through comment cards and interviews that they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that patient records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The dentist took a flexible approach to meeting the needs of patients which included making themselves available via phone when the surgery was closed.

The needs of people with disabilities had been considered in terms of accessing the service, but the lay out of the premises was such that it had not been reasonably possible to provide wheelchair access.

Patients were invited to provide feedback via a satisfaction survey, and a suggestions box situated in the waiting area. There was a clear complaints procedure although no complaints had been received in the past year.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Summary of findings

There were some governance arrangements in place to guide the management of the practice. These included having appropriate policies and procedures and staff meetings.

However, we found that there was lack of an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. These included those arising from out-of-date medicines to manage medical emergencies, the management of Control of Substances Hazardous to Health (COSHH) and Legionella bacteria.

Additionally no audits had been carried out to monitor and improve the quality of care. For example, there had been no audits of the effectiveness of infection control protocols, X-rays or quality of clinical recording keeping.

West Dulwich Dental

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 25 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the local Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with three members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

30 people provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents. There was a policy in place which described the actions that staff needed to take in the event that something went wrong or there was a 'near miss'. The policy confirmed that if patients were affected by something that went wrong, they would be given an apology and informed of any actions taken as a result.

There had been two minor incidents reported in the past year. These both related to patients feeling temporarily unwell following dental treatment. We saw that the practice had kept notes of actions taken at the time. These demonstrated they had acted promptly to resolve the issues and supported patients appropriately.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission.

The registered manager, who was also the principal dentist, was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed safeguarding training and were able to describe potential signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

There was a whistleblowing policy which staff could follow if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager.

The practice had carried out some risk assessments and subsequently implemented protocols with a view to keeping staff and patients safe. For example, risk assessments had been carried out in relation to fire safety and the safe use of sharps (needles and sharp instruments). We saw evidence that these risk assessments and protocols were reviewed on an annually in January. The dentist described actions taken in relation to some issues identified by these risk assessments with a view to improving safety on site. For example, the fire safety risk assessment had identified that emergency lights needed to be installed and we observed that this had been done.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments. 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.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. Staff had received training in emergency resuscitation and basic life support, although we noted that the dentist's training was now overdue for renewal by four months. The staff we spoke with were aware of the practice protocols for responding to an emergency.

The practice had emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines and oxygen and an automated external defibrillator (AED). (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). There were face masks of different sizes for adults and children. The oxygen cylinder was in date and the AED was functioning. However, the oxygen cylinder and AED were not being routinely checked for effectiveness and there were no records for these types of tests.

We reviewed the contents of the emergency medicines kit. We found that the medicines had recently expired and needed to be replaced. Two items recommended by the Resuscitation Council UK were not present (midazolam and dispersible aspirin). We discussed this with the dentist. They told us they relied on an external company to send a reminder when medicines needed renewing. They agreed that this system had not been working and assured us that the medicines would be replaced as soon as possible.

Staff recruitment

Are services safe?

The practice staffing consisted of a principal dentist, a dental nurse and a receptionist. The principal dentist was the owner and the receptionist was the owner's wife. The dental nurse had worked at the practice for a number of years prior to the new owner taking over the business. Therefore, the practice had not recruited any new members of staff since the change in ownership in April 2014.

There was an appropriate recruitment policy in place which stated that appropriate checks would be carried out to ensure new staff were suitable and competent for their role. This included the use of interview notes, a review of employment and medical history, checking of qualifications, identification and references. The dentist told us they would also carry out checks with the Disclosure and Barring Service (DBS).

The practice was in the process of recruiting an additional dental nurse who could also work as a receptionist. We reviewed the notes kept in relation to this process and saw that the practice was following its recruitment policy.

We reviewed the staff files for the dentist and dental nurse. We saw that appropriate checks of registration with the General Dental Council (GDC) had been carried out.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were some arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file which described the regulations and the need to assess risks to patients, staff and visitors associated with hazardous substances. However, at the time of the inspection, this file was incomplete. Some substances, such as the use of amalgam, had been risk assessed. However, other potential hazardous substances had not been considered or listed in the COSHH file. We discussed this with the dentist who assured us there was a recently updated COSHH file on a home computer, but this had yet to be included in the practice documents. The contents of this file were subsequently sent via email for us to review. We noted that this information had not yet been disseminated amongst staff so that they could follow the actions required to minimise risks associated with these substances.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts arrived via email to the dentist who then disseminated these alerts to the other staff, where appropriate.

The practice had a business continuity plan in place to ensure continuity of care in the event that the practice's premises could not be used for any reason. However, this had not been updated since the refurbishment of the premises in December 2014 and was under review by the dentist at the time of the inspection.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The dentist was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms, the decontamination room and the toilet.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room with a clear flow from 'dirty' to 'clean.' The dental nurse demonstrated how they used the room and showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. Items were manually cleaned before being place in an

Are services safe?

ultrasonic cleaner. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp was used. We noted that the date stamp indicated the day of the sterilisation instead of how long items could be stored for before the sterilisation became ineffective.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well. However, the ultrasonic cleaner was not being checked with an appropriate 'foil' test with the results recorded.

The practice had not carried out any infection control audits since the new provider took over the practice in April 2014. Therefore the practice was not monitoring the effectiveness of the infection control protocols.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. Staff demonstrated they understood how to dispose of single-use items appropriately.

Records showed that a test for the presence of Legionella in the water system was carried out annually. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). We saw evidence that dental water lines were being flushed in accordance with current guidance in order to prevent the growth of Legionella. However, a risk assessment to identify and minimise wider risks associated with Legionella had not been carried out. Therefore, some protocols, such as the regular testing of water temperature had not been put in place.

The premises appeared clean and tidy. The practice had a cleaning schedule that covered all areas of the premises. However, we found that a cleaner was only employed to carry out the environmental cleaning of the premises twice a week. The cleaning equipment also did not take account of national guidance on colour coding to prevent the risk of infection spread.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely in the administrative office.

Medicines were stored securely and appropriately. Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed in clinical areas where X-rays were used. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales. The dentist was the radiation protection supervisor (RPS). X-rays were graded as they were taken.

The nurse had completed some online radiation training within the past year. The dentist's radiation training had expired in March 2015 and was now due to be renewed. We discussed this with the dentist who was aware of the issue and assured us they would be booking on to a new training course as soon as possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records with the dentist. We found that the dentist regularly assessed patient's gum health and soft tissues (including lips, tongue and palate). The dentist took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening

tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action.

The receptionist gave all new patients a medical history form to complete prior to seeing the dentist for the first time. The dentist's notes showed that this history was reviewed at each subsequent appointment. This kept the dentist reliably informed of any changes in people's physical health which might affect the type of care they received.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients. The dentist was also aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there were a range of health promotion materials displayed in the waiting area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. There was also advice on smoking cessation. A range of toothpastes, toothbrushes and oral hygiene aids were available for purchase.

Patients commented that the dentist explained about the importance of oral hygiene when they attended for appointments. One of the patients we spoke with told us the dentist had supported their child to learn about effective tooth brushing and had given their child a new toothbrush.

Staffing

Staff told us they received appropriate professional development and training. The practice had a clear training policy which allowed staff paid time to complete the mandatory requirements for registration issued by the General Dental Council (GDC).

We reviewed the staff files for the dentist and the dental nurse. We found that the nurse was up to date with their training and had recently completed online training in relation to topics such as radiography, responding to emergencies and infection control. However, we noted that the dentist was now due to renew their radiography and basic life support training. We discussed this with the dentist who noted that they had recently completed a five-year continuing professional development (CPD) cycle for the GDC. The training which needed renewing had only recently expired within the past three months and they understood the need to renew this as soon as possible.

The dental nurse had recently been engaged in an appraisal process with a view to identifying their personal development needs, including training and career aspirations. We examined the notes kept from this appraisal and discussed these with the nurse. The nurse was keen to pursue further development goals in the taking of dental impressions and implants. The dentist was supportive of this and had offered to subsidise any training. The dentist was also in the process of training in implants and was being appropriately supported by an external mentor.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. The dentist used a system of onward referral to other providers, for example, for oral surgery, orthodontics or advanced conservation. The practice completed referral forms or letters to ensure the specialist service had all of the require information about each patient. The dental care records we reviewed showed that details about referrals and their outcomes were stored appropriately so that the dentist could review the patient's progress when they next attended at the practice.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments such as tooth extraction.

Staff were aware of the Mental Capacity Act (2005). They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all commented positively on staff's caring and helpful attitude. Patients who reported some anxiety about visiting the dentist noted that the dental staff were good about providing them with reassurance. Parents were pleased with the level of care their children received.

We observed staff were welcoming and helpful when patients arrived for their appointment. The receptionist told us they placed a high value on ensuring that all patients felt comfortable and welcome as they arrived; they often played classical music as a means of relaxing and distracting anxious patients.

The practice obtained feedback from patients via a satisfaction survey and through the use of a suggestions box in the waiting area. We noted that the overwhelming majority of feedback about staff was positive and corroborated our own findings regarding staff's caring attitude.

Patients indicated to us they were treated with dignity and respect at all times. Although the door to the treatment room was sometimes left open, we noted that there was an additional screen to ensure that patients could not be overseen during treatment in order to protect people's privacy and dignity

Patient records were stored electronically and in a paper-based format. Computer records were password protected and regularly backed up. Paper records were stored in securely locked filing cabinets. Staff understood the importance of data protection and confidentiality. There was an information governance policy in place which staff had all signed after reading.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the private dental charges or fees. Children under six years of age were offered free treatment. Patients commented that the dentist was open and clear about discussing fees prior to treatment and that they were content with the explanations given.

One of the suggestions received via the feedback box in the waiting area had asked if itemised bills could be produced. The dentist had now implemented this system in order to increase the clarity around dental charging.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. There was a range of information leaflets in the waiting area which described the different types of dental treatments available. The patient feedback we received via discussions and comments cards confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The dental nurse gave a clear description about which types of treatment or reviews would require longer appointments. The dentist could manage their time according to their own preference and schedule longer or shorter appointments depending on the level of care and support each patient needed.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist. The receptionist told us that patients could book as many weeks in advance as they wanted and that there were generally new appointments available within the next few days. We reviewed the appointments book and saw that the next available appointment was in three working days' time.

The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment. They told us the practice sent them a reminder letter when their appointment was due or when they needed to be recalled to see the dentist.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The dentist spoke two languages fluently; the receptionist told us this generally met the needs of the local population and that patients who did not speak English as a first language were usually accompanied by a relative who could translate for them. We spoke with one patient who told us that the dentist was careful to check they had understood the explanations given about treatment because English was not their first language.

The dentist provided written information for people who were hard of hearing and large print documents for patients with some visual impairment.

A disability discrimination audit had been carried out in 2003 before the new provider took over the practice. The provider told us this information had been reviewed at the time of purchase to determine if any further action could be taken. The premises were not wheelchair accessible. The practice is located in a converted, residential building with steps to the front and steps down to a toilet. The audit had explored the possibility of installing a suitable ramp, but the provider is not the freeholder for the premises and has thus far been unable to secure support for the necessary alterations. Currently patients with mobility issues are asked if they can manage the steps and if not they are referred to another local practice which has level access to the treatment rooms.

Access to the service

The practice was open Monday, Tuesday and Thursday from 9.00am to 5.30pm and on Wednesday from 1.00pm to 8.00pm. The practice displayed its opening hours on their premises and on the practice website.

We asked the receptionist and dentist about access to the service in an emergency or outside of normal opening hours. They told us that if a patient called outside of the usual opening hours the call was forwarded to the dentist's mobile. The dentist spoke with patients directly to assess the urgency of their need and would either arrange for an emergency appointment at the surgery or direct the patient to local emergency dental resources at an NHS foundation trust hospital. The dentist occasionally visited people in their own homes to assess their needs prior to treating them at the surgery or referring them for emergency treatment elsewhere.

The receptionist told us that the dentist would always arrange to see patients who needed emergency care either during a lunch hour or after usual opening times. This meant that patients who needed to be seen, for example, because they were experiencing dental pain, could be accommodated. Patients told us that they could get an appointment in good time and some people noted that they had been seen promptly on the day they presented with an urgent issue.

The practice had a policy which described how emergency patients could be prioritised. We noted that this policy also gave a clear priority for emergency appointments for children who required urgent care.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a complaints policy

Are services responsive to people's needs?

(for example, to feedback?)

describing how the practice would handle formal and informal complaints from patients. However, no complaints had yet been received by the practice. The complaints policy specified that the dentist was responsible for leading investigations following any complaints. The practice would respond to complaints within three days and contact details were also provided for the dental complaints service and Ombudsman. The patients we spoke with told us they could approach the receptionist or the dentist directly if they wanted to make a complaint.

Are services well-led?

Our findings

Governance arrangements

The practice had some governance arrangements and a management structure. There were also relevant policies and procedures in place. Staff were aware of these policies and procedures and acted in line with them.

However, there were limited arrangements for identifying, recording and managing risks through the use of risk assessments, audits, and monitoring tools. For example, we found that the medicines needed for managing medical emergencies had not been monitored. They were now out of date and needed to be replaced. Not all of the expected assessments and audits had been carried out and others were incomplete. For example there had been no infection control audit within the past year. Typically infection control audits are completed every six months in order to monitor the effectiveness of infection control protocols with a view to keeping staff and patients safe. There was a COSHH file at the time of the inspection, but this was not held at the practice meaning that the actions needed to minimise the risks associated with hazardous substances had not been disseminated effectively amongst staff. A Legionella risk assessment had not been carried out and we therefore found that some protocols, such as the regular testing of water temperature, were not in use. Some equipment, including those used in an emergency and the ultrasonic cleaner, were not being regularly checked for effectiveness.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff told us they were comfortable about raising concerns with the dentist. They felt they were listened to and responded to when they did so. Staff told us they enjoyed their work and were well supported by the management team.

We spoke with the principal dentist who outlined the practice's ethos for providing good care for patients. They had a clear ethos about providing high quality and patient-centred care. The other members of the staff team shared and understood this philosophy.

There was a system of staff appraisals in place which identified staff member's career goals and aspirations. For example, the dental nurse had expressed interest in taking further training in relation to implants; the dentist supported this goal and had offered to subsidise some of the expense of the training course.

Management lead through learning and improvement

The staffing policies set out support for meeting professional standards and completing continuing professional development (CPD) standards set by the General Dental Council (GDC). The clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by GDC. However, some of the dentist's required training courses had now expired and needed renewing. These included training courses in the carrying out of X-rays and responding to emergencies.

Audits were not being carried out to monitor the quality of the service or to drive improvements. For example, the grades of X-rays were being recorded, but X-rays had not been systematically reviewed to identify any other quality issues. The dentist had also not carried out an audit of their record keeping and no infection control audits had been carried out in the past year.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey and a suggestions box. The majority of feedback had been positive. The dentist showed us an example of how they had acted on feedback regarding the implementation of itemised billing.

Staff feedback was obtained on an ad hoc basis at weekly meetings. A more formal staff meeting was also carried out on an approximately yearly basis, with the last one having taken place in April 2014. This provided staff with an opportunity to review the practice's performance and suggest improvements to the smooth running of the practice.

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 practice did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2) (a, b and f)