Nationwide Healthcare

Clay Cross Family Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 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 providing well-led care in accordance with the relevant regulations.

Background

Clay Cross Family Dental Centre is located over two floors of a building close to the centre of Clay cross. The practice was registered with the Care Quality Commission (CQC) in October 2011. The practice provides an NHS dental service. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are: Monday to Friday: 9 am to 1pm and 2 pm to 6 pm. The practice is closed at the weekends.

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

One of the partners is registered with the Care Quality Commission (CQC). 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.

Summary of findings

The practice has three dentists; three trainee dental nurses; one receptionist and one practice manager.

We received positive feedback from 40 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

Our key findings were:

- Patients spoke positively about the dental practice with several saying they received good treatment and were treated with dignity and respect.
- There were systems in place to record accidents, significant events and complaints, and where learning was identified this was shared with staff.
- There was a whistleblowing policy staff were aware of this and how to use it. All staff had access to the whistleblowing policy.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included oxygen and emergency medicines.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Dentists involved patients in discussions about the care and treatment on offer at the practice. Patient recall intervals were in line with National Institute for Health and Care Excellence (NICE) guidance.

Governance arrangements were in place for the smooth running of the practice, with regular audits of different aspects of the quality of the 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.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

The practice had emergency medicines and equipment available. This included oxygen and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely.

X-ray equipment was serviced and tested as identified in the manufacturer's guidance, although dentists were not always recording a written justification for taking X-rays in the patients' dental care records.

Are services effective?

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. This included completing a health questionnaire. The practice used a recognised assessment process to identify any potential areas of concern in patients' mouths, jaws and neck, including their soft tissues (gums, cheeks and tongue).

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, wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Staff were able to demonstrate that referrals had been made in a timely way when necessary.

Are services caring?

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

There were systems in place to help maintain patient confidentiality. Staff were able to demonstrate how they achieved this in both the reception area and the treatment rooms.

Patients said they were well treated, and staff were professional, approachable and caring. Feedback identified that the practice treated patients with dignity and respect.

Patients said they received good dental treatment and they were involved in discussions about their dental care.

Patients said they were able to express their views and opinions.

Summary of findings

Are services responsive to people's needs?

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

Patients said they were able to get an appointment. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The patient areas of the practice were mostly located on the ground floor. There was good access for patients with restricted mobility.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, and in the practice leaflet.

The practice had completed an Equality Act (2010) access audit, and had a hearing loop, to assist patients who used a hearing aid.

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?

We found that this practice was providing well-led care in accordance with the relevant regulations.

There was a clear management structure. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

Regular audits were carried out at the practice to review the quality and efficiency of the systems and processes.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them. Regular feedback was given to patients following surveys to gather patients' views.

Staff said the practice was a friendly place to work, and they could speak with the dentists if they had any concerns.

Clay Cross Family Dental Centre

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 22 March 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

We also reviewed the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with four members of staff. We reviewed policies, procedures and other documents. We received feedback from 40 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 maintained records and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in February 2016 this being a minor injury to a member of staff. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had a policy for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) which had been updated in July 2015. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although they were aware how to make these on-line. The accident policy had details of how to make a RIDDOR report together with a flow chart for ease of reference.

The practice recorded significant events. The records showed there had been seven significant events during this calendar year. The last recorded significant event had been when the heating had failed at the practice. We saw that the significant event had been analysed and discussed in a staff meeting.

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 the practice manager. The alerts were analysed and information shared with staff if and when relevant. The practice manager showed us the most recent alert which had been received in December 2015 and related to problems with fire door closers. On this occasion this had not affected the practice, but the information had been kept on file for information. The practice manager said if the information was relevant, it was discussed at the daily team meeting.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. Both policies had been reviewed in February 2016. The policies identified how to respond to any concerns and how to escalate those concerns. 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 relevant contact telephone numbers were on display in the staff room and in the safeguarding file. Safeguarding contact details were also in the patient information folder in the waiting room.

The practice had an identified lead for safeguarding in the practice and this was one of the dentists. The lead had received enhanced training in child protection to support them in fulfilling that role. We saw the practice had a safeguarding file which contained all of the relevant information and the action plan should the practice have any concerns relating to safeguarding.

Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children on 20 June 2015

There was a policy and risk assessment to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. This policy had been updated in February 2016. Staff were directed to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin. A review of the COSHH data showed that the file was in need of updating. We discussed this with the practice manager who demonstrated they had begun the process, and were working through the data to update it.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 23 November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which directed staff how to handle sharps (particularly needles and sharp dental

instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We discussed the use of safer sharps with a dentist who outlined the steps taken to reduce the risks of sharps injuries. 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 bins were attached to the wall and out of reach of small children. The guidance indicated sharps bins should ideally be fixed to the wall. The arrangements at the practice followed the Health and Safety Executive (HSE) guidance: 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'.

Copies of the practice's sharps policy and how to deal with sharps injuries were displayed in the clinical areas of the practice.

We were assured that dentists always used rubber dams when carrying out root canal treatments (endodontic treatments). Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We saw the practice had the equipment required to use rubber dams with patients.

Medical emergencies

The dental practice had a supply of equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Two dentists had completed a first aid at work course. The dentists were the designated first aiders for the dental practice, and a poster in the reception area informed patients of this.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Resuscitation Council UK guidelines suggest the minimum equipment required and includes an AED and oxygen which should be immediately available. Staff at the practice had completed basic life support and resuscitation training in October 2015. Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Additional emergency equipment available at the practice included: airways to support breathing, manual resuscitation equipment (a bag valve mask) and portable suction.

Staff recruitment

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 (schedule 3) identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all members of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the practice manager, and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in February 2016. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example: risk assessments for the use of the autoclave and using electrical equipment in the practice.

Are services safe?

Records showed that firefighting equipment such as fire extinguishers had been serviced by an external company within the last year. Records showed the last fire drill for staff had been on 14 March 2016.

The practice had a health and safety law poster. However, this was not on display as it had been taken down during a recent refurbishment. 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. The practice manager said the poster would be put back on display when the maintenance person visited the practice the following day.

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 practice had an infection control policy which had been reviewed in February 2016. The policy was readily available to staff working in the practice. 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.

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit had been on 9 March 2016. The practice scored 100% on this audit.

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 spillage kits for both mercury and bodily fluids. Both spillage kits were in date.

There was a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had dirty and clean areas, and there was a clear flow between to reduce the risk of cross contamination and infection. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy.

The practice had a washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. 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, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate the decontamination processes and to ensure that equipment was working correctly. Records showed that the equipment was in good working order and being effectively maintained.

We examined a sample of dental instruments that had been cleaned and sterilised using the illuminated magnifying glass. We found the instruments to be clean and undamaged.

The saw records to demonstrate that staff had received inoculations against Hepatitis B and had received regular blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting this blood borne infection.

The practice did not have any hot water at the premises. This reduced the risk of Legionella developing in water systems at the practice. Legionella is a bacterium found in the environment which can contaminate water systems in buildings.

The practice was flushing the dental unit water lines used in the treatment rooms. This was done for two minutes at

the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing in the dental unit water lines. This followed the published guidance for reducing risks of Legionella developing in dental water lines.

Equipment and medicines

The practice maintained a file of records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice during September 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

The practice had all of the medicines needed for an emergency situation, as identified in the current guidance. Medicines were stored securely and there were sufficient stocks available for use. Medicines used at the practice were stored and disposed of in line with published guidance.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Radiography (X-rays)

The dental practice had a radiation protection file which contained all of the information related to the X-ray machines and their use within the practice.

There were three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull. The OPG machine was not working and had been taken out of service. We saw that X-rays were carried out in line with the local rules that were relevant to the practice and each specific piece of X-ray equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The radiation protection file identified the practice had appointed a radiation protection supervisor (RPS) this was one of the dentists. There was also a radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Records showed the X-ray equipment had last been serviced in March 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Patients' dental care records showed that information related to X-rays was not always recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. We saw some examples where the grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings were not recorded. This highlighted the need for an audit of X-ray records to ensure the Faculty of General Dental Practice (FGDP UK) guidelines: 'selection criteria for dental radiography' (2013) were being followed. Following the inspection we were informed this had been discussed at a peer group meeting with all the dentists at the Clay Cross Family Dental Centre. As a result after this meeting the grading of X-rays, views taken, justification for taking the X-ray and the clinical findings were recorded in dental care records every time.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held dental care records for each patient. We saw a small number of dental care records to confirm information we had gathered during the inspection. The dental care records contained information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and included examination of the soft tissues including the tongue and the jaw and neck.

Patients at the practice completed a medical history form, or updated their details. The forms were then checked by the dentist to identify if there had been any changes to the patients' health or medicines which could affect the dental treatment. The medical history was added to the dental care record. The medical history forms included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that comprehensive assessment of the periodontal tissues (the gums) and soft tissues of the mouth had been undertaken. The dentists 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 dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Discussions with 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 wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

The costs for NHS treatments were on display in the practice, private fees were available on request.

Health promotion & prevention

The practice had a large waiting room, and information for patients was on display in the waiting room and the reception area. There was assorted literature about the services offered at the practice, as well as health promotion advice.

Discussions with a dentist and a dental nurse identified that the practice made patients aware of the risks associated with oral cancer. Posters and leaflets to inform patients of the risks associated with oral cancer were available. There was also information relating to the use of fluoride; healthy gums and body and stopping smoking available to patients.

A dentist explained that children seen at the practice were assessed on an individual basis to check their risk of dental decay. This resulted in children routinely provided fluoride application varnish and fluoride toothpaste to all children identified as being at risk.

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet with regard to oral health. With regard to smoking dentists had particularly highlighted the risk of dental disease and oral cancer.

The Department of Health had produced guidance called: 'Delivering better oral health: an evidence-based toolkit for prevention'. The practice were aware of the guidance and the dentists were following the guidelines contained within it.

Staffing

The practice had three dentists; three trainee dental nurses; one receptionist and one practice manager. The trainee dental nurses were supervised by a qualified dental nurse who was based part-time at a nearby dental practice. 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.

We looked at staff training records and these identified that staff 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

Are services effective?

(for example, treatment is effective)

ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays), medical emergencies, and safeguarding.

Records at the practice showed that appraisals had been completed for all staff. We saw evidence in four staff files that appraisals had taken place. We also saw evidence of new members of staff having an induction programme. We spoke with three members of staff who said they had received an annual appraisal.

Working with other services

Staff at the practice said that referrals to other dental professionals were made when it was clinically indicated that a referral should be made, or when the practice was unable to offer the required treatment. For example: for sedation services or for orthodontic treatment.

Patients' dental care records within the practice identified that referral for patients with suspected oral cancer had been made in a timely manner and these were tracked to ensure they had been received and the patient seen.

Consent to care and treatment

The practice had a consent policy which had been reviewed in February 2016. The policy made reference to capacity and the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

The practice recorded consent directly into the patients' dental care record. This was by the use of a digital signature. The dentist was able to discuss the treatment plan in the treatment room and gain the patient's consent. A large display screen in the treatment room allowed the patient to see their treatment plan, and dental care record. Patients were given a copy of the treatment plan including the costs.

Discussions with dentists showed they were aware of and understood the use of Gillick to record competency for young persons. Gillick competence 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff throughout the inspection to see staff spoke with patients and how patients were treated. We saw that staff were welcoming, friendly and polite. Our observations showed that patients were treated with dignity and respect throughout the dental practice.

The reception desk was located outside the waiting room. We discussed the need for confidentiality with reception staff who explained how this was achieved. Staff said if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen. There was often an unused treatment room available, or the manager's office on the first floor. Staff said all details of patients' individual treatment was discussed in the privacy of the treatment rooms.

We observed staff speaking with patients throughout the day. We found that confidentiality was mostly being maintained at the reception desk. We did highlight one issue which we discussed with the practice manager. Steps were taken to address this issue straight away. We saw that patients' dental care records were held securely.

Involvement in decisions about care and treatment

We received feedback from 40 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback was wholly positive with patients saying the staff were professional and friendly. Patients also spoke positively about the dental care they had received. The CQC comment cards identified that patients who responded thought the dentist involved them in decisions about their dental care and treatment. Several patients said the dentists explained the treatment and gave an opportunity to ask questions.

The practice offered mostly NHS dental treatments. The costs of NHS treatment were displayed within the practice. Private fees were available on request.

We spoke with two dentists, and two dental nurses who explained that each patient had their diagnosis and dental treatment discussed with them. The different treatment options and the costs were explained before treatment started. Patients were given a written copy of the treatment plan which included the costs.

Where necessary dentists gave patients information about preventing dental decay. This included discussions about smoking and diet on the patient's teeth, gums and mouth. Details of these discussions were recorded in the patients' dental care records. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. Information posters for patients regarding the frequency of dental visits and the NICE guidelines were displayed within the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was situated in a building on a main road, with a bus stop nearby. There was car parking available at the rear of the practice, and further parking directly opposite. There were three ground floor treatment rooms.

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.

We spoke with two patients during the inspection. Patients said they had found getting an appointment easy, and there had been no unreasonable delay. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist.

Tackling inequity and promoting equality

The practice was located in a two storey building with designated disabled parking to the rear of the practice. All of the treatment rooms and patient areas were on the ground floor and had level access for patients with restricted mobility.

The practice had completed an Equality Act (2010) access audit. This demonstrated the practice had formally considered the needs of patients with restricted mobility. Particularly in respect of them accessing the service and meeting their dental needs. The practice had a portable hearing induction loop. The Equality Act requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

We spoke with patients during the inspection who said they were usually seen on time, and making an appointment was easy, as the reception staff were friendly and efficient.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language.

There was an equality and diversity policy in place and we saw that this had been discussed with all staff at a practice meeting.

Access to the service

The practice's opening hours were: Monday to Friday: 9 am to 1pm and 2 pm to 6 pm. The practice was closed at the weekends.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Or by telephoning the 111 NHS emergency helpline.

Patients were sent a text reminder and a telephone call to remind them that their appointment was due the following day.

Concerns & complaints

The practice had a complaints procedure which had been reviewed regularly. The procedure explained the process to follow for making complaints or raising concerns. This included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included NHS England and the Parliamentary and Health Service Ombudsman.

Information about how to make a complaint was displayed in the practice and on the practice website.

From information received before the inspection we saw that there had been one complaint received in the 12 months up to this inspection. The practice had recorded the action taken and the outcome, including any learning from the complaint. We saw from documentation in the practice that complaints had been addressed in a timely way, and apologies had been given for the distress caused.

Are services well-led?

Our findings

Governance arrangements

We reviewed a number of policies and procedures at the practice and saw that they had been reviewed and where relevant updated during February 2016.

We spoke with several members of staff who said they understood their roles. Staff also said they could speak with the practice manager or a dentist if they had any concerns. We spoke with three members of staff who said they were happy working at the practice, and there was good team working.

We were shown a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw suggested there was a need for a clinical audit with regard to record keeping in relation to X-rays.

Leadership, openness and transparency

There was a practice manager in post who had a diploma in business management.

The practice held monthly staff meetings throughout the year. We saw that staff meetings were minuted, and the minutes were shared with all staff.

We saw there was a clear management structure within the organisation. This included several different staff members with lead roles for various areas of activity. We spoke with several different grades of staff at the practice. We were staff were able to voice their views, and raise concerns. Managers or dentists were available to discuss any concerns and there was support available regarding clinical issues. Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had an employee handbook. This contained selected policies and procedures and offered staff guidance around key areas of the practice.

The practice had a whistleblowing policy. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with two dental nurses who were able to describe the purpose of the procedures, and when and how to use them. The policy was available on the staff room notice board, on any computer in the practice and in the employee handbook.

Learning and improvement

The practice carried out regular audits to assess the quality of the service and drive improvements. We saw a number of completed audits and ow information was analysed and improvements made. For example we saw patients dental care records were audited; an audit of antibiotic prescribing had been completed in October 2015; and X-rays had been audited between December 2015 and January 2016.

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 need to complete 150 hours over the same period. The practice manager was monitoring clinical staff members' CPD on behalf of the organisation.

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

The practice had an NHS Friends and Family (FFT) comment box which was located on the reception desk. The responses within the boxes were analysed on a monthly basis. Feedback from patients by means of the FFT box was good, with 165 responses recorded. All but a very small amount of the responses were positive with respondents saying they would recommend the practice to their family and friends.

The practice completed its own patient survey with 'your opinion counts' comment cards in the waiting room. The comment card gave patients the option to leave a compliment, and idea, a comment or a concern. Additionally the patients could pose a question or request information.

The practice also had a patient satisfaction survey which were analysed on a three monthly basis. Copies of the satisfaction survey form were available in the waiting room. Results had been positive, with patients overwhelmingly of the view they had received good dental care at the practice.