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Gosport Smile Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 14 September 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 providing well-led care in accordance with the relevant regulations

Background

Gosport Smile Clinic is a mixed dental practice providing mainly NHS and some private treatment and caters for both adults and children. The practice is situated in a converted residential property. The practice has three dental treatment rooms and a separate decontamination room for cleaning, sterilising and packing dental instruments and a reception and waiting area. Some facilities were on the ground floor enabling disabled access.

The practice has one full time dentist, a locum, a part-time dental hygienist and a dental nurse. Supporting the clinical staff were a full time practice manager, who is also a dental nurse, two reception staff and a decontamination technician. The practice also had one dental nurse from an agency on the day of our visit. The practice's opening hours are 8:00am – 5:30pm Mondays to Fridays.

The Provider is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We

Summary of findings

collected 15 completed cards and spoke to two patients. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

We carried out an announced comprehensive inspection on 14th September 2015 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- Staff had been trained to handle emergencies and appropriate medicines and emergency equipment were readily available in accordance with current guidelines.
- Patients' needs were assessed and care was planned and delivered in line with current professional guidelines.
- All equipment used in the practice was well maintained in accordance with the manufacturer's instructions.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had enough staff to deliver the service.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Staff felt well supported by the practice manager and were committed to providing a quality service to their patients.
- Information from 15 completed CQC comment cards gave us a positive picture of a friendly, professional service.
- All complaints were dealt with in an open and transparent way by the practice manager if a mistake had been made.
- The practice had a programme of clinical audit in place.

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

- Re-sterilise equipment that has passed it's expiry date for sterilisation or remove it from use, provide bins for the disposal of hazardous waste that can be operated using a foot pedal and remove materials that are passed their expiry date.
- Provide a policy on safeguarding adults and review policies, recording the date of review on the policy.
- Provide all staff with appraisals at least annually.
- Review records for the Control of Substances Hazardous to Health and update them in line with new products brought into use.
- Record the distribution of alerts from the Medicines and Healthcare Regulatory Agency and record any actions taken as a result of these alerts.

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 care which was safe in accordance with the relevant regulations.

The practice had robust arrangements for essential topics such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children. The practice had a policy of safeguarding children but there was no policy regarding the safeguarding of vulnerable adults.

Are services effective?

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

The dental care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We collected 15 completed cards. These provided an overwhelmingly positive view of the service, we also spoke to two patients who reflected these findings. All of the patients commented that the quality of care was very good. Results from the friends and family test indicated that all of the patient s who responded to the test in July and August said that they would be extremely likely or likely to recommend the practice to their friends and family. Patients were able to make suggestions to improve the practice and patients suggestions had been implemented in order to make improvements to the practice facilities.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took these into account in running the practice. Patients could access treatment and urgent care when required. The practice provided patients with written information and had access to telephone interpreter services when required. Some practice facilities were all on the ground floor enabling ease of access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

We found that this practice was providing care which was well led in accordance with the relevant regulations. The practice had a Business Continuity plan in place and policies and procedures were in place to support the effective running of the practice. However some policies and procedures, although contained current information, did not have a date written on them to identify that they had been reviewed. Staff had not received appraisals.

Gosport Smile Clinic

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 14th September 2015.The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

We informed NHS England area team that we were inspecting the practice.

During our inspection visit, we reviewed policy documents and staff records. We spoke with seven members of staff, including the practice manager. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed the decontamination technician carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area. We reviewed comment cards completed by patients and spoke with two patients. Patients gave a positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were systems in place for recording and reporting accidents and incidents and staff that we spoke with were aware of the procedure for reporting significant events. We reviewed the records for six significant events that had occurred in the last 12 months and found that they had been investigated and action taken as a result of the events had been recorded. Learning from significant events was shared with staff.

Reliable safety systems and processes (including safeguarding)

We spoke with the practice manager about the prevention of needle stick injuries. She explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice had developed a series of risk assessments around potential sharps injuries from contaminated dental drill bits and matrix bands. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A single use delivery system was used to deliver local anaesthetics to patients. The lead dental nurse was also able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked how the practice treated the use of instruments which were used during root canal treatment. A dentist we spoke with explained that these instruments were single use only. He explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

The practice had a policy for safeguarding children but there was no policy for safeguarding vulnerable adults. The dentist was the lead for safeguarding and contact information was available for local adult and children safeguarding organisations. The practice had a separate whistleblowing policy, that was current but there was no date for review on the policy. We discussed with the dentist about the different types of abuse and who to report them to if they came across a vulnerable child or adult. The dentist was able to describe in detail the types of behaviour a child would display that would alert him if there were possible signs of abuse or neglect. The practice had also introduced a bespoke custom screen on the computerised patient records system for safeguarding vulnerable children. The screen contained four mandatory questions which were completed for every patient. Any question that was answered by a yes triggers a discussion with another colleague in the practice which may result in local safeguarding procedures being implemented.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had access to an automated external defibrillator (AED). This was situated on the external aspect of the practice and was available for both the dental practice and local community use. An AED is 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. Staff received team annual training in how to use this. The last training session was carried out in October 2014. The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Oxygen and other related items such as manual breathing aids and portable suction were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff behind the reception area.

The expiry dates of medicines and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. The practice manager was the named first aider and had completed training in this role. Staff could identify the named first aider.

Staff recruitment

We reviewed staff files for three permanent members of staff and one temporary staff member and found that they contained evidence of checks that had been carried out to ensure that staff working at the practice were suitable for

Are services safe?

their role. All clinical staff had received a check by the Disclosure and Barring Service (DBS) in line with the practice policy (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 other children or adults who may be vulnerable). Other checks included checks on registration with the General Dental Council, proof of identification and Hepatitis B immunisation status of staff. The practice did not have references available for staff that had been employed at the practice for many years and there were no references for a member of staff that had recently been employed from outside of the United Kingdom, who was a relative of another staff member.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice had a Health and Safety Policy that had been reviewed in December 2014 and the practice had fire safety, health and safety, radiation and water quality risk assessments in place. Fire safety equipment had been tested in May 2015 and fire evacuation drills had been completed.

The practice compressor was stored in a locked cupboard and had been serviced in the past 12 months and there was a schedule of testing for other equipment, for example, portable appliance testing was completed in November 2014.

Staff were aware of their responsibilities in relation to the Control of Substances Hazardous to Health (COSHH) and a COSHH file was available. COSHH assessments had been reviewed. A new product had been introduced and the safety data sheet was available for staff but there was no COSHH assessment for this product.

We were advised that alerts were received from the Medicines and Healthcare Products Regulatory Agency and alerts were available to staff. However there was no record to identify then actions taken in response to alerts or to confirm that they had been reviewed by all clinical staff.

The practice had a detailed emergency evacuation plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. An infection control policy was in place supported by written protocols for various stages of the decontamination process. This was reviewed regularly with the last review having been carried out in January 2015. The practice had recruited a dedicated decontamination technician to undertake the initial cleaning of contaminated dental instruments, sterilisation procedures and the packaging of processed instruments. The technician was also responsible for carrying out the routine validation tests of the ultrasonic cleaning baths and the autoclaves (devices for sterilising cleaned instruments). It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. It was observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines. The practice had completed six monthly infection control audits in line with the requirements of HTM01-05 and the last audit had been completed in March 2015.

It was noted that the three dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

We inspected the drawers in two treatment rooms. These were well stocked, clean, well ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) and staff described the methods they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice in November 2013 with regular reviews carried out

by a company specialising in legionella control, the current assessment is due to be reassessed in November 2015. The recommended procedures contained in the report namely sentinel water temperature testing were being carried out and logged appropriately. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice utilised a separate decontamination room for instrument processing. This room was well organised and was very clean, tidy and clutter free. Displayed on the wall were protocols to remind staff of the processes to be followed at each stage of the decontamination process. Dedicated hand washing facilities were available in this room. The decontamination technician demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing instruments and an ultrasonic cleaning bath for the initial cleaning process, following inspection instruments were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized they were pouched and stored appropriately until required. Pouches were dated with an expiry date in accordance with current guidelines. We found a small quantity of instruments that had passed their expiry date and we were told that these were no longer used. The technician also demonstrated that systems were in place to ensure that the autoclaves and ultrasonic cleaning baths used in the decontamination process were working effectively. These included the automatic control test and steam penetration tests. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always completed and up to date. Essential checks for the ultrasonic cleaning baths including protein tests and soil test were carried out and were available for inspection.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The foot pedal on one waste bin was broken and could not be operated. The practice used an appropriate contractor to remove dental waste from the practice and waste was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. We noted that the practice used an electronic 'metal detector' device to scan each clinical waste bag to detect any metal dental instruments that were inadvertently thrown away by staff. This not only helped prevent needle stick injuries to waste control contractors but prevented the loss of valuable equipment such as dental hand pieces. Waste consignment notices were available for inspection. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste. A mercury spillage kit was available.

The practice was cleaned using staff from an externally contracted company. Cleaning equipment was stored in the practice and cleaning staff followed a schedule of cleaning. There were records of audits to monitor the quality of cleaning completed. Cleaning equipment and materials were stored in a cupboard but this was not locked.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, both of the autoclaves had been serviced and calibrated in August 2015 and the pressure vessels testing certificates were available for the compressors and autoclaves. These were all within the recommended 26 month time frame between inspections. The practices' had three X-ray machines that had been serviced and calibrated in April 2015. The practice had sufficient quantities of dental instruments to ensure that treatments did not have to be interrupted or cancelled due to a shortage of instruments. We spoke with a locum dentist and another temporary member of staff who told us that they had sufficient instruments to carry out the scheduled treatments on patients.

There was clear guidance in place regarding the prescribing, recording, dispensing, use and stock control of the medicines used in clinical practice. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored safely for the protection of patients. We noted that the practice carried out an on going audit of prescribing medicines. When a medicine was prescribed, the dentists completed a log sheet detailing the date of prescription, patient name, dentist, drug prescribed and the NHS

prescription number. This helped to prevent misuse and loss of prescriptions, the prescription pads and log sheets were locked away at the end of each clinical day. We found a small quantity of materials, such as tooth whitening materials that had passed their expiry date and were told that these were no longer in use.

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, a copy of the local rules and a copy of the notification to the Health and Safety Executive. The maintenance logs were within the current recommended interval of three years and the file contained a complete history dating back to 2009.

The local rules for the safe use of ionising radiation were displayed in each surgery to provide staff with guidance on the safe use of radiography and staff confirmed that only qualified members of the team took X-rays. Staff had completed training in Radiation Protection line with the continuous professional development (CPD) requirements that were set by the General Dental Council.

A copy of the most recent radiological audit from June 2015 was available for inspection this demonstrated that a very high percentage of radiographs were of grade one standard. A sample of dental care records where X-rays had been taken showed that when dental X-rays were taken they were justified, reported on and quality assured. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist we spoke to described to us how he carried out a patient assessment. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination reviewing the condition of a patient's teeth and gums and reviewing soft tissues for the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was discussed and treatment options were explained to patients.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as brushing techniques or recommended tooth care products and advice leaflets. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

The practice used the 111 service to provide emergency treatment out of hours to patients and information was displayed about how to contact this service. Patients who required treatment in an emergency during the working day were either given an appointment that day or advised to attend the practice and wait to be seen.

The practice used a computerised system for maintaining patients clinical records which was password protected. Wherever possible written medical history forms and update forms, referral letters, laboratory documents and treatment plans with costs were scanned into the computer system. A review of a sample of dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out where appropriate during a dental health assessment. The dentist we spoke to was fully conversant with guidance from the National Institute for Health and Care Excellence in relation to antibiotic prophylaxis and the management of wisdom teeth. The practice also used a risk based approach to dental recall intervals.

Health promotion & prevention

A dental hygienist worked at the practice part-time. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was also given to them. Fluoride treatments were available. The sample of dental care records we observed all demonstrated that dentists and dental hygienist had given oral health advice to patients.

The waiting room and reception area at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. Oral health products were available for patients to purchase.

Staffing

The practice had systems in place to support staff to be suitably skilled to meet patients' needs. Records showed that staff completed continuous professional development (CPD) in line with General Dental Council (GDC) requirements. All staff had completed CPD training covering recommended subjects such as medical emergencies, infection controls and complaints management. New staff had received a documented and thorough induction and had been supported to attend additional training that was relevant to their role. For example, the decontamination technician had attended training in testing and validation equipment used as part of the infection control process.

All staff attended practice meetings that were usually held on a monthly basis and were minuted. We were told that

Are services effective?

(for example, treatment is effective)

meetings had not been held during the last month due to staff being on holiday but there was a notice indicating the date of the next meeting and inviting staff to contribute to the meeting by providing agenda items.

Staffing levels were monitored and staff absences were planned to ensure that the service was uninterrupted. There was a staff rota available to ensure that each dentist was supported by a trained dental nurse but the dental hygienist was not supported by a dental nurse. There was one member of staff who was absent on the day of our visit and the practice used agency staff and locum dentists to maintain staffing levels. All staff had a current job description but staff had not received appraisals in the last 12 months.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals when required were made to other dental specialists and patients were referred to hospital for treatment if required. We noted the record of one such referral and saw that scanned into the patients record was the referral letter, letter of acknowledgement from the specialist along with the letter explaining the treatment carried out and copies of appropriate dental X-rays. The practice used registered dental laboratories to manufacture dental appliances such as dentures and crowns for patient's treatment. Items that were sent to the dental laboratory were recorded in the patient records and patients had their next appointment scheduled in advance to ensure that they treatment was completed.

Consent to care and treatment

We spoke to two dentists on duty on the day of our visit they all had a clear understanding of managing patients consent. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. The written costed treatment plans were always scanned into the patients dental care records. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options, allowing them to give informed consent. The owner of the practice explained how he used an intra-oral camera to take photographs of important findings in a patient's mouth. This included the condition of teeth requiring treatment, the appearance of the gums and of the soft tissues. These were scanned into the patients' treatment record and provided a means of patient education as well as preventing medico-legal problems in cases where patients could dispute the dentist's findings. Patients that we spoke with on the day of our visit confirmed that they were aware of which treatment was being provided on a private basis and which treatment was being provided by the NHS.

The dentists we spoke with on the day of our visit explained how they would obtain consent from a patient who suffered with any mental impairment which may meant that they might not be unable to fully understand the implications of their treatment. The dentists explained if there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They explained that they would involve relatives and carers to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. The Gillick competency test was discussed and staff indicated that they understood how this test was applied (The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During our visit we spoke with two patients about their care and treatment and we reviewed 15 Care Quality Commission comments cards. Patients commented positively about the care and treatment they received and the professional and caring attitude shown by staff. Patients who were nervous commented that staff were sympathetic to their fear, friendly and put them at ease.

Surgeries were situated away from the main waiting area and we saw that doors were closed at all times during consultation and treatments. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up and paper records were stored in a secure area in the practice. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients which detailed possible management options and indicative costs. A poster detailing NHS costs was displayed in the waiting area which gave details of the cost of treatment and entitlements under NHS regulations. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Patients completed the friends and family survey and all of the patients who completed the survey in July and August indicated that they would be likely to recommend the practice to their friends and family.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours, emergency 'out of hours' contact details and arrangements. Patient information leaflets were available in the waiting area and treatment rooms. These gave information about caring for teeth and gums, smoking and oral health and specific treatments such as root canal treatment. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. The practice referred patients to other dentists with the appropriate qualifications and experience for some other specialist treatments and referred patient to hospital if required. The dentist was supported by a part-time dental hygienist and could refer patients to the dental hygienist if they needed treatment and support to maintain good oral health.

Tackling inequity and promoting equality

The practice had a surgery and toilet facilities that were accessible to patients with mobility difficulties and these could be accessed using a separate entrance to the practice. The reception and other facilities were on a separate level and were also accessible to patients with mobility problems using the main entrance. The practice was in the process of installing a handrail to improve access for patients and we were told that patients who could not use the stairs were still able to see the clinician of their choice and this was arranged in the accessible surgery. A telephone translation service was available for patients who did not speak English as a first language.

Access to the service

The practice leaflet advertised surgery opening hours and opening hours were advertised on the outside of the practice. The practice was open between 8am and 5.30pm Monday to Thursday and between 8am and 4pm on a Friday. The practice did not offer any extended opening hours to meet the needs of patients who were at work during the day. Appointments were available during the working day for patients to be seen in an emergency and we were told that dentists would see patients that required urgent treatment in addition to appointments that were scheduled. The procedure for obtaining emergency treatment out of routine opening hours using the 111 service was available on the telephone answer machine which was switched on when the practice was closed.

Concerns & complaints

The practice had a complaints procedure that was displayed to patients and information about how to complain was available to patients in the practice information leaflet. The practice had procedures in place, for acknowledging, recording and investigating complaints and suggestions should they be made by patients. The summary of complaints showed that the practice had received four complaints within the last twelve months. The practice had responded to patients in order to resolve their complaints. Learning from incidents and complaints was discussed with staff. For example, we reviewed a complaint where a patient had complained about being unable to access emergency treatment as the dentist was unavailable and the patients had paid for treatment at another practice as they had not been advised of the procedure for obtaining emergency treatment. The patient had received an apology and the complaint was finalised in a timely manner. Reception staff had been given further training in booking emergency appointments to reduce the likelihood of the situation recurring.

Are services well-led?

Our findings

Governance arrangements

The provider is the responsible individual. A responsible individual is a person who is registered with the Care Quality Commission as the registered person who is responsible for the service. 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 manager had put systems in place to manage the service. The practice manager was responsible for the day to day management at the service.

Policies and procedure had been reviewed and contained current information and policies had a date of review identified. There were systems in place to manage risk and risk assessments such as those for managing health and safety were updated but the practice had not updated COSHH assessments for all new materials that were in use. The practice had dedicated leads for infection control and safeguarding. Audits were completed to monitor the quality of the service provision and included audits on record keeping, infection control and X-rays.

The practice had a Business Continuity Plan that had been completed in place that included action to be taken to manage the service in the event of an unavoidable failure of systems or events such as flooding.

Leadership, openness and transparency

The practice manager was in day to day charge at the location and was well supported by staff within the practice. The responsible individual retained responsibility for some key areas such as safeguarding and staff within the practice supported each other to carry out their roles. A communal staff room was available and staff met daily to discuss key matters as they arose. The practice had regular meeting and we saw that the date of the next meeting was advertised and staff were invited to contribute to the agenda.

Learning and improvement

Staff told us they had access to training and training records were available as part of staff files. Staff were supported to undertake continuous professional development as required by the General Dental Council. Staff had not received annual appraisals but told us that they felt supported within the practice. We spoke to a member of staff who was working temporarily at the practice and they told us that they had received a short induction and sufficient information to enable them to carry out their role safely and effectively.

We found that there was a programme of clinical and non-clinical audits taking place at the practice. These included important areas such as infection prevention control, clinical record keeping and X-ray quality. All of these audit topics were current during 2015. The record keeping and X-ray quality audits were well written up. We saw how the record keeping audit had led to the improvement of the quality of dental treatment records. Prior to the last audit it was noted that improvements could be made to the process for updating a patient's medical history at subsequent appointments. As a result of the audit, the practice now prints off the computerised medical history questionnaire which the patient then amends where required, signs and dates the amended history which is then re-scanned into the patient's records.

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

Patients who used the service were able to provide feedback about the service and feedback forms were available to patients. We were given examples of how staff had used patient feedback to make improvements to the service, such as providing hand rails to help patients to use the stairs. The practice used the friends and family test to gain information about the service and there was a suggestions box in the waiting room.