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THE dentist @ KT3

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 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

THE Dentist @ KT3 is located in New Malden, in the London Borough of Kingston. The premises are in a residential property, with the practice located on the ground floor only. The practice consists of four treatment rooms, a waiting area and reception and a staff kitchen. There are also toilet facilities for both staff and patients.

The practice provides NHS and private dental services and treats both adults and children. The majority of services are provided under an NHS contract. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns, bridges, dentures and oral hygiene.

The staff structure of the practice is comprised of the principal dentist; four associate dentists; a locum dentist; three dental nurses; two trainee dental nurses; a practice manager and a receptionist.

The practice is open from 8.30am-12.45pm on Monday to Thursday. It is open 2pm-5.45pm Monday, Wednesday and Thursday and 2pm-6.15pm on Tuesday. The practice is open from 8.30am-13.15pm on Friday and is closed on Friday afternoon and weekends.

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

Summary of findings

We spoke with three patients on the day of our inspection and received 35 completed CQC comment cards. Patients we spoke with, and those who completed CQC comment cards, were very positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- The practice had good decontamination procedures for dental equipment and thorough checks of the decontamination equipment were carried out.
- 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).
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients were very positive about their care; they felt listened to, involved in their care and found practice staff helpful and friendly.
- From reviewing comments cards and speaking to patients, all patients felt they received an excellent and efficient service.
- The practice provided a responsive service; patients were able to access emergency appointments on the day they needed them.
- The practice had a stable leadership structure and staff told us they were well supported by the management team.
- The practice routinely completed a range of risk assessments to identify health and safety risks and provided regular servicing for most equipment.
- We found that the governance arrangements including management of risks, policies and procedures and learning and improving from incidents and accidents were in place.

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

- Review the security of prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review recruitment procedures to ensure appropriate records of references are maintained for all staff.
- Review audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had a number of policies and risk assessments in place for health and safety, which were regularly updated. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

The practice had comprehensive systems in place for the servicing of equipment, infection control and decontamination of equipment, management of medical emergencies and dental radiography. There was evidence that systems for reporting and learning from incidents, safety alerts were in place, although improvements could be made to record actions.

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) and The Department of Health (DH). 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.

There were systems in place for recording written consent for treatments, with detailed, tailored proposed treatment plans provided to patients. The practice worked well with specialist colleagues and timely referrals were made. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

However, the practice did not always maintain detailed dental care records and improvements were required.

Are services caring?

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

We received highly positive feedback from speaking to patients, from NHS Friends and Family Test results and through comment cards that they were treated with dignity and respect. Patients reported a positive and caring attitude amongst the clinical and administrative staff.

Dental care records were stored securely in the practice and patient confidentiality was 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. Staff were able to provide a very flexible service to meet the needs of patients. The needs of people with disabilities had been considered in terms of accessing the service.

There was a clear complaints procedure and complaints received in the last 12 months had been efficiently and effectively handled by the practice.

Are services well-led?

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

Summary of findings

Comprehensive governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings. We found that the outcomes of risk assessments, the infection control audits and complaints had been reviewed and acted on in a timely manner. Staff received appraisals and there was evidence that communications with staff were well-managed. Patient feedback was gathered and displayed in the practice.

However there was evidence that some audits were not always being used effectively drive improvements.

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Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 30 September 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. This included the practice's statement of purpose and complaints received over the previous 12 months.

During our inspection visit, we reviewed policy documents, staff records and dental care records. We spoke with six members of staff, which included the principal dentist, one associate dentist, one dental nurse, one trainee dental nurse, the practice manager and the receptionist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We reviewed the practice's decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Thirty eight people provided feedback about the service. Patients we spoke with and those who completed CQC comment cards were very positive about the care they received from the practice. They were highly complementary 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

The practice had a system in place to report and record incidents and accidents in the practice. The records we reviewed showed appropriately recorded accidents relating to staff injuries, for example a needle stick injury. The staff were aware of the need to report incidents as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR) and we saw a policy in place, although they had never needed to use this. We were told that if an incident occurred they would be discussed in the monthly staff meeting.

The practice had an incident reporting policy in place; and significant event forms were available for staff to use. The needle stick injury that had occurred two years previously had been recorded in the accident book but not been treated as a significant event. However, although actions and learning had not been recorded, the practice had implemented safer sharps systems as a result of this incident. There had been two reported clinical significant events in the last year which were complaints that had been treated as a significant event, with clearly recorded learning points and actions taken.

We were told that if incidents arose where people who use services were affected, the practice would inform them where something had gone wrong, give an apology and inform patients of any actions taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults, which had been updated yearly. These included contact details for the local authority safeguarding team. This information was easily accessible to staff in a central folder.

The principal dentist was the safeguarding lead for the protection of vulnerable children and adults. All staff had completed safeguarding training for adults and children to level two. Staff were able to describe potential signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been one previous safeguarding issue reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing 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. A whistleblowing policy for the practice was available.

Most dental care records were electronic and held securely, and x-rays were stored securely.

During procedures such as root canal surgery and fillings, the practice often used rubber dams, though file holders were also used routinely as an alternative measure. (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.) To prevent wrong-site surgery, the practice had systems in place where the dental nurse double-checked the notes and x-ray with the dentist.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. The practice had comprehensive policies and procedures for the safe handling of sharps and guidance for the management of a sharps injury and a sharps risk assessment had been undertaken as part of the practice's health and safety risk assessment. We noted that the practice were currently trialling a safer sharps system with a view to use this system indefinitely.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received annual training in emergency resuscitation and basic life support. Staff were aware of the practice protocols for responding to an emergency and we saw the updated medical emergencies policy which was available for staff to refer to and the emergency procedure protocol was displayed in the reception area.

The practice had a full range of emergency equipment in accordance with guidance issued by the Resuscitation Council UK. The practice stocked a full range of relevant emergency medicines in line with guidelines issued by the British National Formulary. Two oxygen cylinders and an automated external defibrillator (AED) were available in the practice. (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). The oxygen and defibrillator were checked

daily and we saw records of this. The emergency medicines were checked monthly and these checks were also recorded. The practice agreed to commence the checks for emergency medicines on a weekly basis.

Staff recruitment

The practice staffing consisted of a principal dentist who was the director, four associate dentists, a locum dentist, three dental nurses, two trainee dental nurses, a practice manager and a receptionist. All staff who were employed by the practice had a range of information in their personnel files including updated criminal records checks, evidence of professional registration and identification.

The practice had a thorough, updated recruitment policy in place and a supporting Disclosure and Barring Services (DBS) check policy. All staff had criminal records checks in their files. The practice had recruited two new permanent trainee dental nurses and the reception staff member in 2015. We found that they had completed identity checks, disclosure and barring service (DBS) checks and had evidence of employment history, Hepatitis B status for clinical staff and a signed contract and confidentiality agreement. However two written references were not always obtained and where they were verbal references, these were not documented. There was an induction programme and checklist for new staff.

Monitoring health & safety and responding to risks

The practice had a range of health and safety risk assessments and policies in place that were updated annually by the principal dentist, and there was a track record to demonstrate this. The practice had recently started utilising an online resource to assist with monitoring and updating practice policies and we were shown how policy was updated using the new system. Policies included a general health and safety policy, a fire policy, a range of infection control policies and procedures, mercury handling and waste management. A health and safety risk assessment was carried out by the principal dentist every year, the most recent being in October 2014. Actions resulting from this risk assessment had been implemented or were in the process of being implemented.

The principal dentist and the practice manager were nominated fire marshals for the practice. They completed a fire risk assessment annually and had completed fire safety training. Other staff had not received training in fire safety, although the practice's fire procedure was discussed and minuted in a recent staff meeting. The practice had booked fire safety training for November 2015 for all staff and we were shown evidence of this. The practice reported they had six-monthly fire drills, to go over the practice procedure, but these were not recorded. The practice had a track record showing that fire alarms, fire safety signs, emergency exits and fire extinguishers were checked annually.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a comprehensive COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. This folder was updated annually or more frequently if new substances were introduced.

The practice had a comprehensive business continuity plan in place, which was updated annually. The plan contained details of actions in response to staff absence, and a variety of catastrophes. A buddying system was evident with a local dental practice in the event of any incident affecting the business.

The practice had good measures in place in response to Medicines and Healthcare products Regulatory Agency (MHRA) alerts and an updated policy was in place. If there were any medicines alerts we were told these were sent through to the principal dentist. Alerts were shared with staff in staff meetings when required.

The practice completed risk assessments for trainee dental nurses so that mitigating actions were put in place, for example, relating to exposure to x-rays and infection control. The practice had a member of staff who had recently started maternity leave. The practice had not carried out an expectant mother's risk assessment to ensure any risks were mitigated, although the practice had a policy in place which stated that these were required.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy that had been recently updated, with detailed infection control procedures which included the decontamination of dental instruments, hand hygiene, use of personal protective equipment, the segregation and disposal of clinical waste,

Are services safe?

sharps safety and dealing with spillages. The head dental nurse was the infection control lead. Staff had completed regular infection control training internally, and we saw evidence of this.

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 surgeries and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. Decontamination was carried out for all four surgeries in the decontamination room, which had a dedicated dental nurse each day. The decontamination room had a clear flow from 'dirty' to 'clean'. Each surgery had clearly marked 'dirty' and 'clean' areas. Each surgery had dedicated sinks for cleaning used dental instruments and for hand washing, and a removable bowl for rinsing of instruments. Dental nurses wore appropriate personal protective equipment, such as heavy duty gloves and eye protection which were changed weekly.

Decontamination protocols were displayed on the wall in the decontamination room. Following manual cleaning in the decontamination room, equipment was checked with an illuminated magnifier for any debris during the cleaning stages. If any debris was noted, the items would be re-cleaned. The items were then packaged and placed in the vacuum autoclave. After sterilisation in the autoclave the items were date stamped. The date stamps indicated an expiry date, identifying how long they could be stored for before the sterilisation became ineffective. All sterilised dental instruments we checked were in date. The practice had a robust system of daily, weekly and quarterly logs used by the dental nurses, for the checking of the autoclave. There were also testing strips attached to the log books.

Clinical areas and decontamination rooms were clean and free of clutter. The practice had sealed floors and work surfaces. Cleaning was carried out by an external company Monday to Thursday and on Sundays, but no cleaning occurred after surgery was finished on a Friday afternoon. The practice advised they would change the cleaning rota to Friday instead of Sunday, to reduce risk of aerosol contamination. A clear schedule was in place for areas to be cleaned daily and monthly. The practice took into account national guidance on colour coding equipment, to prevent the risk of cross-infection. We were told that cleaning spot checks were undertaken monthly by the lead nurse and we were shown records of these.

We saw adequate hand washing facilities including hand soap and paper towels by all hand washing sinks. Sufficient stocks of personal protective equipment (PPE) including gloves and eye protection were available for staff.

The practice completed six-monthly infection control audits, the most recent being in September 2015 and a hand hygiene audit in July 2015. There was evidence of action plans following the audit with some actions implemented, including the use of safer sharps systems and the practice told us they were to commence use of the installed washer-disinfector that had not been working for some time, so that the practice were conforming to best practice guidance.

The practice had an on-going contract with a clinical waste company. We saw a record of waste consignment notices for the last two years. This included the collection of clinical waste including amalgam, x-ray developer, extracted teeth and safe disposal of sharps. We were shown a secure, locked area outside of the practice where waste was stored. We saw that all clinical staff had Hepatitis B immunisation records in their files. All clinical staff are required to show that they have been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Practice staff followed recommended guidelines to assure dental water line safety and had a dedicated water folder. An annual water-safe review was carried out; the last being September 2015, and a Legionella risk assessment and certificate were available. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings.) The practice, undertook monthly water temperature tests and there was a track record of these being recorded.

Equipment and medicines

We found that most of the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor and autoclave had all been serviced. We saw the recent

Are services safe?

pressure vessel certificate dated June 2015. Portable appliance testing (PAT) was completed in July 2015 in accordance with good practice guidance. (PAT is the name of a process during which electrical appliances are routinely checked for safety.) The four dental chairs had never been serviced; however shortly after the inspection the practice provided us with evidence that servicing had been arranged.

The practice was well stocked with single use equipment, with a clear system for the re-ordering and monitoring of stock and dental materials kept in the refrigerator. There were no checks carried out for the monitoring of the refrigerator temperature, but shortly following the inspection the practice provided us with evidence that they had ordered a thermometer and temperature log record book for this.

All prescriptions were handwritten. Prescription pads were stored securely; however the practice did not have a system to track and monitor the use of prescription pads. We saw the practice had an updated prescribing policy available.

Batch numbers for local anaesthetics were recorded in the clinical notes from records we saw. 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 each treatment room that housed an x-ray machine as well as in the file. An external radiation protection advisor (RPA) gave support to the practice and the principal dentist was the radiation protection supervisor (RPS). The folder contained an inventory of equipment with evidence of a track record of maintenance logs for the four machines, critical examination packs and the Health and Safety Executive (HSE) notification certificate. We saw certificates confirming that annual x-ray safety checks had been carried out over the previous few years.

All clinical staff had completed radiation training with evidence of certificates in the radiation protection file and staff certificate files. We saw radiography audits had been undertaken, but no actions following the audit had been documented.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection we checked dental care records to confirm the findings and discussed patient care with two dentists and one dental nurse. We found that the dentists regularly assessed patients' gum health, and soft tissues (including lips, tongue and palate) were regularly examined. Dentists took x-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The justification and findings of X-ray images were recorded in dental records.

The dentists were aware of and complied with National Institute for Health and Care Excellence (NICE) guidance in relation to deciding appropriate intervals for recalling patients and antibiotic prophylaxis.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool in both adults and children over the age of seven. (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.) If scores were indicative of advanced gum disease, dentists carried out a full charting; however some dental care records we checked indicated no charting had been completed.

Records we viewed showed that dental care records, though well maintained, on the whole could be improved. We noted that although treatment options and documented price discussions were recorded suitably, medical history updates and X-ray grading was not consistently recorded.

Health promotion & prevention

The practice promoted maintenance of good oral health. Staff were aware of the Department of Health Delivering Better oral Health Toolkit and guidance was mostly being following, with the exception of fissure sealants. (Delivering Better oral Health is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.) Staff told us they discussed oral health with their patients, for example, effective tooth brushing; oral hygiene; prevention of gum disease and dietary advice, especially for children. Dentists and dental nurses identified patients' smoking status and discussed smoking cessation; we were told that the practice could refer to a smoking cessation clinic.

Dentists also carried out examinations to check for the early signs of oral cancer. Prescription of high fluoride toothpastes were evident in dental care records and the practice provided all children under 16 years of age with fluoride varnish applications every six months. We were shown data from the Dental Assurance Framework (DAF) for 2014 which showed that the practice fluoride varnish rate was double that of the England average.

We observed that the practice provided targeted health promotion materials, by issuing these and discussing them directly with patients during consultations. There were some health promotion materials displayed in the waiting area.

Staffing

The practice benefited from employing a range of experienced staff who had worked at the practice for a number of years. Each dentist had a dental nurse that normally worked with them, to ensure continuity of care; however where needed dental nurses would assist other dentists. The practice had an agreement with a local dental surgery to provide dental cover in times of short staffing. Opportunistic advice could be sought from peers where needed.

Staff told us they received appropriate continuing professional development (CPD) and training from the practice and were given time to attend courses. We reviewed some staff files and saw some evidence of training certificates. The training covered the mandatory requirements for registration issued by the General Dental Council (GDC). The practice ensured they had up to date details of registration with the GDC for all dental staff but did not have a record of all CPD activities undertaken by practice staff.

Working with other services

Most referrals were to other specialist colleagues for orthodontic and periodontal treatment that could not be done in-house and for procedures where sedation was required. Referrals were made to secondary care for complex cases requiring oral surgery.

Are services effective?

(for example, treatment is effective)

All referral letters we viewed were comprehensive to ensure enough information was provided. Patients were given a copy of their referral letter when requested.

Consent to care and treatment

The practice ensured signed, 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 dental care records and a copy of the signed consent form was kept by both the patient and the dental practice. Patients told us they were given a copy of their treatment plans and costs.

We saw evidence that dental staff had an understanding of the requirements of the Mental Capacity Act 2005 (MCA), although staff had not received any MCA training. Staff 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 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

We received 35 CQC comments cards and found that 100% of feedback was highly positive about the practice. Patients felt that the service provided exceptional care, staff were patient friendly and highly professional. The patients we spoke with all commented positively on their experience at the practice with both the clinicians and reception staff and felt it was a very efficient service. The majority of patients who provided feedback had been with the dental practice for a number of years and some patients travelled some distance to continue receiving dental care at the practice after moving away.

Patients who reported some anxiety about visiting the dentist commented that the dental staff were good about providing them with reassurance by clearly explaining procedures. The practice had alerts on the computer system to indicate if patients were anxious so they could provide the appropriate support. Parents reported they were pleased with the level of care their children received, especially those with anxiety and they felt children were treated as individuals. Positive comments about how the practice dealt with patients with learning difficulties and dementia were also provided. We saw that the practice had received 20 compliment letters over the past two years.

NHS Friends and Family Test data for the previous five months showed that on average 95% of respondents would recommend the practice. The Dental Assurance Framework (DAF) report for the practice for 2014 showed that 100% of patients reported that they were satisfied with the dental services received.

We observed that clinical and administrative staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking to patients on the telephone.

Patients indicated they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke with and feedback from comments cards indicated no concerns about confidentiality and we noted there had been no complaints or incidents related to confidentiality. Dental care records were stored securely.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the dental fees for the range of procedures that the practice offered. CQC comments cards and patients we spoke with indicated that all patients felt involved in their care and felt they were always given adequate information about their treatment and fees.

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 proposed treatment plans.

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. Staff told us they had enough time to treat patients and that patients could always book to see the dentist of their choice. The practice were able to book longer appointments for patients who needed them, such as those with a learning disability. We found that the service was very flexible and was able to adapt to needs of the patients, to accommodate emergency appointments. The practice allocated emergency appointments to each dentist each day.

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 to receive treatment. Patients we spoke with reported they had been able to access emergency appointments the same day.

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 practice had policies in place for equal opportunities and equality and diversity. The practice was wheelchair accessible and dental chairs were height adjustable. Toilet facilities were large enough for a wheelchair and had had been adapted for those with mobility difficulties. The practice had a lowered section of the reception desk to allow accessibility for wheelchair users. The waiting room was large enough for wheelchairs and pushchairs.

Access to the service

The practice was open from 8.30am-12.45pm on Monday to Thursday. It was open from 2pm-5.45pm Monday, Wednesday and Thursday and 2pm-6.15pm on Tuesday. The practice was open from 8.30am-13.15pm on Friday and was closed on Friday afternoon and weekends. The practice displayed its opening hours on their premises. Patients were also given a practice information leaflet which included the practice contact details and opening hours.

We asked dental and reception staff about access to the service in an emergency or outside of normal opening hours. The practice directed patients to the out-of-hours provider contracted by NHS England. The out-of-hours provider operated between 5pm and 10pm on weekdays and 9am-10pm at weekends and bank holidays. The practice answer phone message, information leaflet and signs in the practice gave details on how to access out-of-hours emergency treatment.

All patients we spoke with and all CQC comments cards reviewed were positive about their experience of getting an appointment, including emergency appointments. The Dental Assurance Framework (DAF) report for 2014 showed that 100% of patients reported that they were satisfied with the wait for appointments.

Concerns & complaints

Information about how to make a complaint was displayed on a notice board outside the front door of the practice and on the practice information leaflet. The practice reported that they had received three complaints over the last 12 months. There was a recently updated complaints policy in place which was sent with each acknowledgement letter. We reviewed the complaints folder, which was stored securely and contained detailed correspondence related to each complaint. The practice had evidence of the original complaint and accompanying acknowledgement and response letters. We could see that all complaints had been very well-handled, in a timely way. We could see that the practice would inform patients where something had gone wrong, give an apology and inform patients of any actions taken as a result.

Each complaint had an attached significant events form with details of learning and actions taken as a result. Complaints were shared at practice meetings, and we saw minutes of meetings to confirm this.

Are services well-led?

Our findings

Governance arrangements

The practice had a management structure in place. The principal dentist was the clinical lead and worked closely with the practice manager. The principal dentist was in day to day charge. When the principal dentist was not working, an associate dentist led in all clinical areas.

There were relevant policies and procedures in place, including a range of health and safety polices. The principal dentist and practice manager reviewed all policies and procedures annually and these were clearly dated. All policies we saw contained comprehensive information to enable staff to carry out their roles, and all policies had been reviewed. Staff were aware of these policies and procedures and they were easily accessible to all staff in the reception area. We were told that during practice meetings staff were made aware of any changes to policies and procedures. We saw that some policies were signed by staff indicating they had read these and it was evident from minutes of staff meetings that changes were communicated to staff.

Governance and monitoring of equipment and procedures were well-managed, with the exception of monitoring refrigerator temperatures, weekly emergency medicines checks and annual servicing of dental chairs. The practice provided evidence they had brought a thermometer and log book and had arranged servicing for dental chairs shortly following the inspection.

The practice had completed a range of up to date risk assessments in relation to health and safety, infection control, fire safety, control of substances hazardous to health (COSHH) and legionella. We noted that there had been one sharps injury in 2013 and although this was not recorded as a significant event, following an infection control audit and sharps risk assessment, the practice had implemented a safer sharps system as a result. The practice were routinely utilising safety information to monitor risks through the use of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and business risks were clearly identified with mitigating actions in the practice's business continuity plan.

The practice also assessed risk through other scheduled audits including record keeping and radiography. During the inspection we found that improvements could be made to record keeping.

Staff were being supported to meet their continuing professional development (CPD) standards set by the General Dental Council, and staff records contained information to confirm that dental staff had carried out mandatory CPD. All staff records contained a range of recruitment information and mandatory training certificates to provide assurances that staff could perform competently in their role. Most recruitment checks were being carried out in line with guidance. Records, including those related to patient care and treatment, as well as staff employment, were kept securely.

Leadership, openness and transparency

Staff told us that the practice encouraged a team approach and they described a transparent culture which encouraged candour, openness and honesty where any issues were discussed and amended quickly and we saw evidence that this had occurred. Staff said that they felt very comfortable about raising concerns with the principal dentist and practice manager. Staff told us they really enjoyed their work and were well supported.

Staff knew who to report to depending on the issue raised, for example, the principal dentist was in day to day charge for safeguarding concerns, complaints and the head nurse was the infection control lead.

The principal dentist outlined the practice's mission statement for providing good care for patients. They shared with us their Statement of Purpose. We saw that the practice had put in place a duty of candour policy and had a whistleblowing policy as well as a range of other updated human resources policies to support staff.

The principal dentist engaged with staff on a monthly basis via regular staff meetings and we saw that comprehensive minutes of these were kept and staff signed to say they had read these. We saw that changes to practice procedures, complaints and areas for improvement were discussed.

Learning and improvement

We were told that clinical staff were up to date with their continuing professional development (CPD). All staff were supported to pursue development opportunities. We saw

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evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice completed annual appraisals for all dental nurses and non-clinical staff. We saw evidence of appraisals completed after four months of commencing employment for the trainee dental nurses.

The principal dentist was a member of the local dental association and organised CPD training days. The practice's safeguarding procedures had been amended with new posters for the practice, following shared learning through this association.

Appropriate audits were carried out in relation to dental records and radiography; however improvements could be made to ensure that the action plans were implemented and to ensure that these audits were driving improvements.

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

The practice had gathered feedback from patients previously via the monthly NHS Friends and Family Test. The practice had bought a tablet device which was set up in the waiting area to encourage patients to provide feedback. Results from the last five months were very positive. The practice displayed the monthly result in the patient waiting area. The practice also had a comments box and we were told that changes had been made as a result of patient comments, such as providing the option to make electronic card transactions.

Staff feedback was gained where the need arose as staff were happy to raise concerns opportunistically or during practice meetings.