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Angel Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 November 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

Angel Dental Practice is owned and run by one dentist who works full time, a trainee dental nurse, a practice manager, administration manager and a receptionist. The practice's opening hours are 9am to 5pm on Monday to Friday with late night extended opening hours on a Tuesday until 8pm.

Angel Dental Practice provides private dental treatment for adults and children. The practice has one dental treatment room on the ground floor. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area.

Before the inspection we sent Care Quality Commission comments cards to the practice for patients to complete to tell us about their experience of the practice. During the inspection we spoke with two patients. Overall we received feedback from 15 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good and staff were professional, friendly and caring.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.

Summary of findings

- The principal dentist had not registered to received medicines and health regulatory agency patient safety alerts, although they were aware of recent updates via another source.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Staff had been trained to deal with medical emergencies.
- The principal dentist was unsure of the processes to follow to obtain best interests decisions where a patient lacked the mental capacity to make a decision.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The governance systems were effective.
- The practice was well-led and there were clearly defined leadership roles within the practice. Staff told us they felt supported, involved and they all worked as a team.

There were areas where the provider could make improvements and should

- Review the practice's systems in place for receiving patient safety alerts from the medicines and health regulatory authority.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

Systems were in place for recording significant events and accidents. Staff told us that they were confident about reporting incidents, accidents and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Emergency medical equipment and medicines were available on the premises in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. Staff had received training in responding to a medical emergency.

Staff were suitably qualified for their roles and the practice had undertaken relevant recruitment checks to ensure patient safety.

Decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use. Infection control audits were being undertaken on a six monthly basis. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

The practice used oral screening tools to identify oral disease. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. Patients' dental care records confirmed this and it was evident that staff were following recognised professional guidelines.

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?

No action

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

We observed the staff to be welcoming and caring towards the patients. Staff treated patients with kindness and respect and they were aware of the importance of confidentiality Patient's privacy and confidentiality was maintained on the day of the inspection. Feedback from patients was overwhelmingly positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful.

Summary of findings

Are services responsive to people's needs?

No action

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

Patients had good access to treatment and urgent care when required. The practice had ground floor treatment rooms. Ramped access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference.

Are services well-led?

No action

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

There were good governance arrangements and an effective management structure in place.

Systems were in place to share information with staff by means of monthly practice meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us that the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

Angel Dental

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.

This inspection took place on 9 November 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with four members of staff. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records.

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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Systems were in place to enable staff to report incidents and accidents. An accident book and significant event reporting forms were available and staff spoken with were aware of the location of accident and incident records. The accident record book demonstrated that there had been two staff or patient accidents since 2010 with the date of the last accident being 25 February 2015.

Reporting forms were comprehensive and included details of the accident, details of the cause of the injury, actions taken and follow up information. Staff spoken with confirmed that completed forms were to be forwarded to the principal dentist or practice manager.

We were told that accidents and incidents were discussed with all staff on an informal basis as and when they occurred.

The practice had no significant events to report. The practice had developed a significant events policy which had been reviewed on a regular basis with the date of last review as October 2016.

We saw that there was an accident reporting policy and Health and Safety Executive information to guide staff when and how to report an incident. Incident reporting forms were also available.

Information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) was also available for staff. We were told that there had been no events at the practice that required reporting under RIDDOR. Practice meeting minutes for 5 October 2016 demonstrated that RIDDOR and the policies in place for staff to refer to had been discussed.

There were no systems in place to ensure that all staff members were aware and responsive to national patient safety and medicines alerts. The practice manager confirmed that they would register with an appropriate organisation to receive updated alerts from the MHRA (Medicines and Healthcare Products Regulatory Agency). The principal dentist was aware of recent alerts via another source.

The practice had information regarding Duty of Candour. This provided guidance for staff regarding Duty of Candour and explained that patients would be told when things went wrong, when there was an incident or accident and would be given an apology.

Reliable safety systems and processes (including safeguarding)

The practice had a well organised safeguarding file which contained various pieces of information and guidance for staff. A child protection and safeguarding vulnerable adults policy was in place which had been reviewed in June 2016. Various other pieces of information such as a child protection and the dental team flowchart and child protection and vulnerable adults guidance for staff. Training presentations such as basic awareness safeguarding were available on this file for staff to review as required. Details of how to report suspected abuse to the local organisations responsible for investigation were available.

The principal dentist and the practice manager had been identified as safeguarding lead and all staff spoken with were aware that they should speak to one of these people for advice or to report suspicions of abuse. Posters regarding reporting abuse were on display in the reception. We were told that there had been no safeguarding issues to report.

We saw evidence that all staff had completed the appropriate level of safeguarding training. On-line training was available to all staff. Safeguarding vulnerable adults and child protection had been discussed at a practice meeting on 2 November 2016. Further discussions would be held as necessary in the event of any suspected abuse being reported by the practice.

The practice had conducted a needle stick injury assessment; this was an internal audit on the potential causes for needle stick injuries. Any issues identified had been recorded, addressed and ways for prevention were highlighted.

Needle stick policies were on display in each treatment room. Contact details for the local occupational health department were recorded on these policies. Sharps bins were stored in appropriate locations which were out of the reach of children. We were told that there had been one sharps injury at the practice.

No action

Are services safe?

The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist.

We asked about the instruments which were used during root canal treatment. The principal dentist explained that these instruments were single use only. We were told 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).

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support on 19 October 2016.

Equipment for use in medical emergency including oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available in line with the recommendations of the Resuscitation Council UK.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored in a clearly marked cupboard. Records confirmed that emergency medical equipment and medicines were checked weekly by staff.

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. For example plasters, dressings and bandages. Records were available to demonstrate that equipment in the first aid box was also checked on a weekly basis to ensure it was available and within its expiry date.

Staff recruitment

The practice had a recruitment policy that described the process to follow when employing new staff. The policy was implemented in 2013 but there was no date of review recorded.

We discussed the recruitment of staff, we were told that one member of staff had been employed in August 2016 and another in September 2016. We looked at the recruitment files of the two newly employed staff members in order to check that recruitment procedures had been followed. We saw that these files contained pre-employment information such as proof of identity, written references details of qualifications and registration with the professional body. Staff had also completed a pre-employment medical questionnaire.

Recruitment files contained other information such as contracts of employment, job descriptions and a list of policies that had been given to staff such as accident reporting, complaints and health and safety.

We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. An on-line check had been requested for the newest member of staff employed. 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.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that the practice manager would be able to provide dental nurse cover during times of annual leave or unexpected sick leave. A dental nurse agency would also be contacted to provide cover as needed. The dentist always worked with a dental nurse during patient treatment.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that the practice had developed a health and safety checklist which was used to ensure that health and safety systems in place were robust. For example the checklist required staff to ensure that employer's liability insurance was in place, health and safety policies were available which had been reviewed and legionella risk assessment completed.

The principal dentist and the practice manager were the named leads regarding health and safety. All staff spoken with said that they could speak with either of these people

for health and safety advice if required. A health and safety poster was on display in the staff kitchen. Health and safety including a review of policies was discussed at the practice meeting of 29 July 2016.

Numerous risk assessments had been completed such as a practice risk assessment, radiation, sharps, lone worker and a fire risk assessment. Risk assessments were reviewed on an annual basis. The date of last review for the practice risk assessment was 4 October 2016.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire risk assessment was completed on 3 June 2016 by the practice manager and the principal dentist. We saw that this had a review date of June 2019. We saw that a low risk had been identified throughout the practice and no issues for action had been identified.

Records seen confirmed that fire extinguishers were subject to routine maintenance by external professionals on 29 February 2016. An engineer's report dated 29 February 2016 demonstrated that emergency lighting and the fire alarm system were also checked and serviced on that date. We saw records to demonstrate that a weekly visual fire safety check was completed.

Fire safety training including fire drills had taken place on a six monthly basis with the dates for 2016 being 6 April and 24 October 2016.

A well organised COSHH file was available. Details of all substances used at the practice which may pose a risk to health were recorded in a COSHH file. An itemised list was available which had been reviewed and updated when new products were used at the practice.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment room, waiting area, reception and toilet were visibly clean, tidy and uncluttered. Patient feedback also reported that the practice was always clean and tidy. The practice's dental nurse was responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area. A cleaning plan and schedule had been produced and records were being completed by the staff member who completed the cleaning.

Infection prevention and control policies and procedures had been developed to keep patients safe. These were kept in an infection control folder; all of the contents of this folder were reviewed on an annual basis with the last review taking place on 6 April 2016. This folder contained various infection prevention and control related policies, for example decontamination processes, infection prevention and control and a sharps and blood spillage policy. We saw that infection prevention and control was discussed at the practice meeting of 2 November 2016.

A general infection prevention and control policy statement was on display in the decontamination room. This recorded the practice manager as the infection control lead. The practice manager confirmed that they were responsible for ensuring infection prevention and control measures were followed.

Infection prevention and control audits were completed on a six monthly basis. The last audit was undertaken on 31 October 2016 and we saw evidence of previous audits completed on a six monthly basis.

Records demonstrated that all staff had undertaken in-house training regarding infection control during the practice meeting of 2 November 2016. Training certificates were available to demonstrate that the principal dentist had undertaken infection prevention and control training as part of their CPD. The trainee dental nurse was undertaking all training at college, this included infection prevention and control training.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

We looked at the procedures in place for the decontamination of used dental instruments. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05).

No action

Are services safe?

Decontamination of used dental instruments took place in a dedicated decontamination room which had clearly identified zones in operation to reduce the risk of cross contamination.

The dental nurse showed us the procedures involved in manual cleaning, rinsing, inspecting and decontaminating dirty instruments. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty zone to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. We saw that heavy duty gloves used during the decontamination process were replaced on a weekly basis. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. Packaged instruments were appropriately stored in cupboards and rotated to ensure appropriate usage.

Equipment used in the decontamination process had been regularly serviced and maintained. A log sheet was available to demonstrate tests completed to ensure that the equipment was functioning correctly.

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)

they described the method they used which was in line with current HTM 01 05 guidelines.

A risk assessment regarding Legionella had been carried out by an external agency in 2010. As there had been no changes at the practice and a low risk was identified during the initial risk assessment, staff at the practice had completed annual risk assessments thereafter. We saw records to confirm that routine temperature monitoring checks were being completed.

We discussed clinical waste and looked at waste transfer notices. We saw that the practice had a contract in place regarding the disposal of clinical and municipal waste. Evidence seen demonstrated that clinical waste was collected every few weeks. Clinical waste was securely stored in an area where members of the public could not access it. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

The practice had maintenance contracts for essential equipment and records seen demonstrated the dates on which the equipment had recently been serviced. For example fire safety systems were serviced on 29 February 2016. We saw a certificate that demonstrated that the compressors had been serviced in 2015, although the certificate provided by the external company who completed the work did not record a date of servicing. We were shown evidence to demonstrate that the compressors were booked in for their annual service on 11 November 2016.

All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions; records demonstrated that the autoclave was serviced on 31 March 2016.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) on15 June 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine could be stored at room temperature with a shortened expiry date. However, the practice's preference was to store this medicine in the fridge. Records were kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients.

Radiography (X-rays)

The principal dentist was the Radiation Protection Supervisor (RPS) and a Radiation Protection Advisor (RPA) had been appointed to ensure equipment was operated safely and by qualified staff only. We saw evidence that the dentist was up to date with the required continuing professional development on radiation safety.

Local rules were available in each of the treatment rooms were X-ray machines were located for all staff to reference if needed. Clear signage was available identifying that X-ray machinery was located in the room.

No action

Are services safe?

We saw that the practice had notified the Health and Safety Executive on the 12 September 2013 that they were planning to carry out work with ionising radiation.

The practice used digital X-rays which do not require chemical processing. In addition they are available to view almost instantly, and use a lower effective dose of radiation than traditional films.

The practice had an intra-oral X-ray machine that can take an X-ray of one or a few teeth at a time

and in addition an orthopantomogram (OPG) machine which can take a panoramic X-ray of the jaws. Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the current recommended interval of three years. For example the intra-oral X-ray machine was serviced on 27 March 2015 and the OPG machine on 29 June 2016.

Dental care records where X-rays had been taken showed that dental X-rays were justified and reported on every time. The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines.

We saw a recent X-ray audit completed in July 2016. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Wediscussed patient care with the dentist and checked dental care records to confirm the findings. The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment.

Patient dental care records that we were shown demonstrated that the dentist was following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping. The practice used a proforma on their computer to record details of their assessment of soft tissues. Records were comprehensive and included details of the condition of the teeth, soft tissues lining the mouth and the gums using the basic periodontal examination (BPE) scores. (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).

Risk factors such as diet, oral cancer, tooth wear, dental decay, gum disease and patient motivation to maintain oral health were taken into consideration to determine the likelihood of patients experiencing dental disease. Patient care records demonstrated that risk factors had been documented and discussed with patients.

The Dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient.

Following the clinical assessment patients were made aware of the condition of their oral health; the diagnosis was then discussed and treatment options explained in detail.

Health promotion & prevention

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Medical history forms completed by patients included questions about smoking and alcohol consumption. Staff told us that patients were asked to review and update their medical history forms at each six monthly routine appointment. Where patients attended the practice more frequently they were verbally asked by the dentist if there had been any changes to their medical history. Patient care records shown to us demonstrated this and patients we spoke with told us that they were asked regularly to update their medical history.

Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice. Information regarding oral cancer and health promotion leaflets and posters were on display in the waiting room to support patients to look after their teeth. Details of discussions regarding improving oral health were recorded in patient dental care records.

The dentist gave oral health advice and explained tooth brushing and interdental cleaning techniques. The dental nurse told us that a model of the mouth could be used to demonstrate cleaning techniques so that patients had a visual reference which helped to provide information in a way that patients understood.

Free samples of toothpaste were available in the reception area for patients.

Staffing

Practice staff included a principal dentist, a part time practice manager, part time administration manager, a dental nurse and a receptionist. The dental nurse and receptionist had recently been employed. Records seen demonstrated that these staff had completed a period of induction to familiarise themselves with the systems and policies at the practice. This included ongoing training and a three month probationary review meeting. Staff told us that the induction was comprehensive and provided them with all of the information needed including familiarisation with the emergency procedures including fire and emergency medicines and equipment, safeguarding and confidentiality.

Appraisal systems were in place. We saw that personal development plans were available for staff. We were told that discussions were held with staff about continuing professional development (CPD) and training during appraisal meetings. CPD is a compulsory requirement of registration as a general dental professional. Staff confirmed that they were encouraged to attend training courses.

No action

Are services effective?

(for example, treatment is effective)

Records demonstrated that the dentist was up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding training. The dental nurse was undertaking training provided by a local college.

Records seen confirmed that professional registration with the GDC was up to date for all relevant staff and monitoring systems were in place to ensure staff maintained this registration.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required dental implants, sedation and orthodontics.

Systems were in place to ensure referrals were received in a timely manner. Copies of referrals would be scanned onto patient notes. A referral log was set up for each patient; a copy of the referral letter was kept. The referral log remained 'open' until the dentist had confirmed that the referral had been received and treatment completed.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. These records were comprehensive. The dentist followed Federation of General Dental Practice (FGDP) guidelines when making notes for these referrals.

Consent to care and treatment

A consent policy had been implemented and reference was made to the Mental Capacity Act 2005 (MCA) in this policy. 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.

Discussions were held with the dentist who was unsure of information regarding power of attorney or best interest decisions. However we were told that support would be obtained when patients were unable to give consent. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. We saw that consent was reviewed as part of a recent record card audit in August 2016.

We were told that patients were given verbal and written information to support them to make decisions about treatment. Information leaflets were available to assist with the decision making process. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment.

Staff confirmed individual treatment options were discussed with each patient and during the course of our inspection we were shown entries in dental care records where treatment options were discussed to confirm this. Any risks involved in treatment were also recorded. There was evidence in records that consent was obtained.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. The treatment room was situated off the waiting area. We saw that the treatment room door was closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment room which protected patient's privacy.

There was a television in the waiting area or music could be played in the reception, waiting area and treatment rooms, this helped to distract anxious patients and also aided confidentiality as people in the waiting room would be less likely to hear conversations held at the reception desk.

Patients' clinical records were stored electronically. Computers were password protected and backed up on a daily basis to secure storage. The computer screen at the reception desk was not overlooked which helped to maintain confidential information at reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. Patients provided overwhelmingly positive feedback about the practice on comment cards which were completed prior to our inspection. Patients we spoke with during the inspection said that they were always treated with respect; we were told that staff were efficient, professional, caring, helpful and respectful.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Staff told us that they took their time to fully explain treatment, options, risks and fees. Patients confirmed they felt involved in their treatment and it was fully explained to them. Feedback from patients reported that they were always given options and there was no problem when a patient changed their mind about the option chosen. We saw that clear treatment plans were given to patients which detailed possible treatment and costs.

We saw evidence in the records that we were shown that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided private treatment and details regarding treatment costs were clearly displayed in the waiting area. Information about private fees was available on the practice's website.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. Patients we spoke with told us that the reception made every effort to secure an appointment at a time and date that was convenient. We were told that the dentist took their time to explain treatments to them and they were always able to ask questions and never felt rushed. There were vacant appointment slots to accommodate urgent appointment and patients were always able to get an appointment within 24 hours if they were in dental pain. Routine appointments were usually available within a few days of the patient's contact with the practice and the receptionist told us that they were able to accommodate patient's needs regarding appointment times. Feedback confirmed that patients were not kept waiting beyond their appointment time. Patients told us that whilst they were waiting to see the dentist they were offered a drink and that staff engaged in friendly conversation which made them feel at ease.

Tackling inequity and promoting equality

The practice did not have a hearing induction loop for use by people who were hard of hearing. Staff told us of the alternative methods used to accommodate patients with hearing impairments. For example we were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

We asked about communication with patients for whom English was not a first language. We were told that the majority of patients were able to communicate using English language. However staff told us that a translation service could be used if required and confirmed that they had the contact details for this service which they were able to use as necessary.

This practice was suitable for wheelchair users, having ground floor treatment rooms with level access to the front of the building and a ground floor disabled access toilet.

Access to the service

The practice was open from 9am to 5pm on Monday to Friday with late night extended opening hours on a Tuesday until 8pm. The opening hours were displayed in the entrance to the practice and on the practice's website. A telephone answering machine gave contact details for patients with dental pain when the practice was closed including during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone or in person. The website also had a contact us form which patients were able to complete and send queries or requests for appointments via email. Emergency appointments were set aside for the dentist every day that the practice was open; this ensured that patients in pain could be seen in a timely manner. Patients commented that they were able to see a dentist easily in an emergency.

Patients could access care and treatment in a timely way and the appointment system met their needs.

Concerns & complaints

The practice had a complaints policy which provided guidance about how to handle a complaint and the timeframes for responding to complaints. The policy indicated that all complaints would be acknowledged in writing and investigated by the practice. Complainants would be offered a meeting with the principal dentist or practice manager. If the patient was not satisfied with the response from the practice the policy also detailed who they could escalate their complaint to. For example: the General Dental Council, the dental complaints service or the Parliamentary and Health Service Ombudsman.

Details of how patients could make a complaint were on display in the waiting area. Patients were also able to complain through the practice website using the contact us form if they preferred. Staff spoken with were knowledgeable about how to handle a complaint. Staff told us that any complaints received would be sent to the practice manager and principal dentist. We were told that no complaints had been received at the practice.

No action

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information regarding 'Duty of Candour' was available on file for staff to review. This recorded that patients would be informed of any incident that affected them; they would be given feedback and an apology.

Practice meeting minutes for 18 May 2016 demonstrated that staff had received update training regarding complaints.

No action

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service and a part time practice manager and administration manager were also available to provide support and guidance for staff. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice such as complaints management, safeguarding and infection control.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints,

safeguarding, and infection control policies. Systems were in place to review these policies on at least an annual basis and these were discussed with staff during practice meetings. Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, sharps, infection prevention and control, radiography and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. These included six monthly infection prevention and control audits, audits regarding clinical record keeping and radiography. We saw evidence to demonstrate that all audits and risk assessments were reported on and action plans completed.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. We were also told that staff worked well as a team, provided support for each other and were praised by the management team for a job well done. Staff said that they felt supported and involved at the practice.

All staff were aware of whom to raise any issue with and told us that they would speak with the principal dentist or the practice manager. We were told that the principal dentist was approachable, would listen to their concerns and act appropriately

We saw that practice meetings took place on a regular basis; during 2016 there had been five formal practice meetings which included staff update training. We were told that informal meetings were held on a more regular basis and daily discussions were held regarding the day ahead and any issues or concerns.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a six monthly basis. Other audits included radiography, record card and waste audit. Action plans were recorded as required.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Staff said that support was provided to enable them to complete training required. Annual appraisal meetings were held and personal development plans available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. Patients were able to contact the practice via their website to leave comments or ask questions. Fifty satisfaction surveys were given to patients; 25 were posted to patients chosen at random and 25 given to patients who attended the practice, the results were reviewed and correlated. We were shown the results of the survey conducted in August 2016. We saw that 32 responses had been received and all provided positive feedback.

A suggestions box was available in the waiting area and feedback was reviewed on a regular basis. The principal dentist told us that as they were a small team ongoing feedback was given to staff regarding the results of satisfaction surveys. A member of staff discussed some action taken as a result of a suggestion made by a patient.