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Brunner Court Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 March 2016 to ask the practice the following key questions; are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Brunner Court Dental Practice is located in the centre of Northwich and comprises a reception and waiting room, two treatment rooms, an office and staff room and a decontamination room on the ground floor. Parking is available on nearby streets and in car parks. The practice is accessible to patients with disabilities, impaired mobility and to wheelchair users.

The practice provides general dental treatment to patients on an NHS or private basis, and is open Monday 8.30am to 5.00pm, Tuesday 9.00am to 5.00pm, Wednesday and Thursday 8.30am to 6.00pm, Friday 8.30am to 4.00pm and Saturday by appointment. The practice is staffed by a practice manager, three dentists, one dental therapist, one dental hygienist, one receptionist and three dental nurses, one of whom is a trainee.

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

Summary of findings

We spoke to three patients during the inspection about the services provided. Every comment was positive about the staff and the service. Patients commented that they found the staff helpful, kind and and caring. They said that they were always given explanations about dental treatment and choices.

Our key findings were:

- The practice had procedures in place to record and analyse significant events and incidents and acted on safety alerts.
- Staff had been trained to deal with medical emergencies and emergency medicines and equipment were available.
- Premises and equipment were clean, secure and well maintained.
- Infection control procedures were in place and the practice followed current guidance.
- Patients' needs were assessed and care and treatment were delivered in accordance with current legislation, standards and guidance.
- Patients received explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Staff were supported to deliver effective care, and opportunities for training and learning were available.
- We observed that patients were treated with kindness, dignity and respect and their confidentiality was maintained.
- The appointment system met the needs of patients, and emergency appointments were available.
- Services were planned and delivered to meet the needs of patients and reasonable adjustments were made to enable patients to receive their care and treatment.
- The practice gathered the views of patients and took into account patient feedback.
- Staff were supervised, felt involved and worked as a team.
- Governance arrangements were in place for the smooth running of the practice although some improvements to these could be made.
- Staff had received safeguarding training but not all to the level appropriate to their role and they were not fully familiar with the process to follow to raise concerns.
- There were sufficient numbers of suitably qualified and skilled staff to meet the needs of patients but the recruitment process was not in accordance with regulations.

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

- Review the practice's arrangements for responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the frequency of checks on emergency equipment having due regard to guidelines issued by the Resuscitation Council (UK) and the General Dental Council standards for the dental team.
- Review the practice's recruitment procedures to ensure they are in accordance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is retained.
- Review the practice's safeguarding policy and staff training ensuring it covers both children and vulnerable adults and all staff are trained to an appropriate level for their role and aware of their responsibilities.
- Review staff awareness of Gillick competency and the requirements of the Mental Capacity Act 2005 and ensure all staff are aware of their responsibilities.
- Review the practice's waste arrangements to ensure waste is securely stored in accordance with relevant regulations having due regard to guidance issued in the Department of Health Health Technical Memorandum 07-01 Safe management of healthcare waste.
- Review the practice's sharps risk assessment, policy and procedures having due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and meet the requirements of their professional regulator.

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 systems and processes in place to ensure that care and treatment were carried out safely, for example, there were systems in place to minimise the risk and spread of infection, for the management of medical emergencies, and for investigating and learning from incidents and complaints. Staff were aware of their responsibilities to report incidents. Safety alerts were received by the practice and acted on.

The practice had a system in place to keep patients safe from abuse but we did not see evidence that all staff had received training to an appropriate level in safeguarding adults and children. Staff knew how to recognise the signs of abuse; however they were not fully familiar with the procedure to report concerns.

The provider did not have all the prescribed information available in relation to pre-employment checks for the safe recruitment of staff. Staff were suitably trained and skilled, and there were sufficient numbers of staff. We saw evidence of inductions for new staff and ongoing assessments.

The practice had identified and assessed risks and staff were aware of how to minimise risks; however some risk assessments needed updating to reflect the requirements of regulations.

We found the equipment used in the practice, including medical emergency and radiography equipment, was well maintained and tested at regular intervals. The practice had the recommended emergency medicines and equipment available, including an automated external defibrillator and staff were trained in dealing with medical emergencies.

The premises and equipment were clean, secure and properly maintained. The practice was cleaned regularly and there was a cleaning schedule in place. Staff had received training in infection prevention and control. There was guidance for staff on effective decontamination of dental instruments which staff were following.

We saw evidence that the practice was following current legislation and guidance in relation to X-rays which demonstrated the practice was protecting patients and staff from unnecessary exposure to radiation.

Are services effective?

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

Current guidelines were followed in the delivery of dental care and treatment for patients.

Patients received an assessment of their dental needs which included assessing and recording their medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were fully explained and consented to. The practice kept detailed dental records and monitored any changes in the patients' oral health. The practice provided regular oral health advice and guidance to patients.

Patients were referred to other services where necessary, in a timely manner.

Patients were provided with a written treatment plan which detailed the treatments considered and agreed together with the fees involved.

Qualified staff were registered with their professional body, the General Dental Council. Staff received training and support; however the provider did not carry out checks to ensure dentists were meeting the requirements of their professional body.

Summary of findings

Are services caring?

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

Patients commented that staff were caring and helpful. They told us that they were treated with respect and that they were happy with the care and treatment given. Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. We saw patients being treated compassionately.

The practice had separate rooms available if patients wished to speak in private.

We found that treatment was clearly explained and patients were provided with information regarding their treatment and oral health. Patients were given time to decide before treatment was commenced.

Are services responsive to people's needs?

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

Patients had access to appointments and choice of dentists, to suit their preferences, and emergency appointments were available on the same day. Patients could request appointments by telephone or in person. The practice opening hours and out of hours appointment information was provided at the entrance to the practice, in the patient leaflet and on the practice's website.

The practice captured social and lifestyle information on the medical history forms completed by patients which helped the dentists to identify patients' specific needs and direct treatment to ensure the best outcome was achieved for the patient.

The practice had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. Staff had access to interpreter services where patients required these.

The practice had a complaints policy in place which was displayed in the waiting room and outlined in the practice leaflet.

Are services well-led?

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

The practice had a management structure in place and some staff had lead roles. Staff we spoke to were aware of their roles and responsibilities within the practice. Staff told us that the managers were approachable and helpful and took account of their views.

The provider had a number of systems and processes in place for monitoring and improving the services provided for patients. Most systems were operating effectively; however the recruitment process was not operating effectively. The recruitment policy did not reflect current regulations to ensure staff were recruited in line with requirements relating to workers' suitability for their role and the provider was not obtaining all the prescribed information before employing staff.

The provider had arrangements in place to ensure risks were identified, understood and managed, for example, the provider had carried out risk assessments and put in place reasonable measures in order to mitigate these risks. We saw that risk assessments and policies were regularly reviewed but some had not taken into account current regulations and guidance.

There was a range of policies and risk assessments in place at the practice. Protocols and procedures were in place to assist and guide staff in undertaking tasks. Policies, procedures and protocols were regularly reviewed and audited for their effectiveness.

Summary of findings

The practice monitored quality and safety at the practice by learning from complaints, carrying out audits and gathering patient feedback which helped the practice continually improve.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete, accurate and securely stored. Patient information was handled confidentially.

The practice held regular staff meetings and these were used to share information to inform and improve future practice and gave everybody an opportunity to openly share information and discuss any concerns or issues.

Brunner Court Dental Practice

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.

The inspection took place on 30 March 2016 was led by a CQC inspector who had access to remote advice from a specialist advisor.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included details of complaints they had received in the last 12 months, their latest statement of purpose, and details of their staff members including their qualifications and proof of registration with their professional body. We also reviewed information we held about the practice.

During the inspection we spoke to the Registered Manager, Practice Manager, dental care professionals and receptionists. We reviewed policies, procedures and other documents and observed procedures. We also spoke to patients.

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 procedures in place to report significant events and incidents, however the provider told us there had been no recent significant events. We discussed examples of what could constitute a significant event in a dental practice and were assured that if any did occur they would be reported and analysed in order to learn from them and improvements put in place to prevent re-occurrence.

Staff had an understanding of the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 and were aware of how and what to report. The practice had procedures in place to record and investigate accidents, and we saw examples of these in the accident book.

Staff had an understanding of their responsibilities under the Duty of Candour. Duty of Candour means relevant people are told when a notifiable safety incident occurs and in accordance with the statutory duty are given an apology and informed of any actions taken as a result. The provider knew when and how to notify CQC of incidents which could cause harm.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency and Department of Health. These alerts identify problems or concerns relating to a medicine or piece of medical or dental equipment, or detail protocols to follow, for example, in the event of an outbreak of pandemic influenza. The practice manager brought relevant alerts to the attention of the clinicians; however did not document action taken in response to alerts.

Reliable safety systems and processes (including safeguarding)

The practice had a whistleblowing policy in place and staff were encouraged to bring safety issues and concerns to the attention of the managers.

One of the principal dentists and the practice manager had lead roles for safeguarding and oversaw safeguarding procedures within the practice. The practice had a copy of the local authority's policy for safeguarding children and vulnerable adults but this did not reflect specific practice policy. Local safeguarding authority's contact details for reporting concerns and suspected abuse for children and vulnerable adults were displayed. Records we reviewed and further evidence provided to us following the inspection demonstrated that staff were not all trained to the appropriate level in safeguarding for their roles. Staff were aware of how to identify abuse but not fully clear on how to follow up concerns. There had been no safeguarding concerns raised by the practice in the last three years.

We observed that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records were stored securely. Records contained a medical history which was completed or updated by the patient and reviewed by the clinician prior to the commencement of dental treatment and at regular intervals of care. The clinical records we saw were well structured and contained sufficient detail to demonstrate what treatment had been prescribed and completed, what was due to be carried out next and details of alternatives.

We saw evidence of how the practice followed recognised guidance and current practice to keep patients safe. For example, we checked whether dentists used dental dam routinely to protect the patient's airway during root canal treatment, and we established the practice's policy and protocols for the use of endodontic equipment, and for the placement of dental implants.

Medical emergencies

The provider had procedures in place for staff to follow in the event of a medical emergency. All staff had received basic life support training as a team and this was updated annually. One member of staff was additionally trained to provide first aid.

The practice had emergency medicines and equipment available in accordance with the Resuscitation Council UK and British National Formulary guidelines. Staff had access to an automated external defibrillator (AED) on the premises, in accordance with Resuscitation Council UK guidance and the General Dental Council standards for the dental team. [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]. We saw records to show that the medicines and equipment were checked monthly. Oxygen was checked quarterly. All medicines were within their expiry date.

The practice stored emergency medicines and equipment centrally in the practice and staff were able to tell us where they were located.

Staff recruitment

There were sufficient numbers of suitably qualified and skilled staff working at the practice. The practice manager was additionally a qualified dental nurse and able to provide cover for unexpected absences.

The provider used the skill mix of staff in a variety of clinical roles, for example, dentists, a dental therapist, a dental hygienist, and dental nurses to deliver care in the best possible way for patients. Responsibilities were shared between staff, for example there were lead roles for waste, infection control and risk assessments. Staff we spoke to were aware of their own competencies and skills.

We saw evidence to demonstrate that the dentists had undertaken postgraduate training.

The practice had a recruitment policy in place which did not reflect current regulations to ensure staff were recruited in line with requirements relating to workers' suitability for their role. We reviewed eight staff employment records, one of which was the employment record for the most recently recruited member of staff, (2015), and found they did not all contain the prescribed information, for example, some were missing photographic identification and qualifications. We did not see saw indemnity insurance for one member of staff. Staff employment information was stored collectively in one file.

The practice had an induction programme in place. We observed that the training policy stipulated all new staff should receive an induction. We saw records to demonstrate that the newest member of staff had received an induction. We saw the induction programme was comprehensive. The practice had produced a manual which contained a wide range of policies, procedures and information, for example, on handling complaints, first aid and decontamination and was a reference source for all staff.

Monitoring health and safety and responding to risks

The provider had systems in place to assess, monitor and mitigate risks, with a view to keeping staff and patients safe.

The practice had an overarching health and safety policy in place, underpinned by several specific policies and risk specific assessments. A range of other policies, procedures, protocols and risk assessments were in place to inform and guide staff in the performance of their duties and to manage risks at the practice. Policies, procedures and risk assessments were regularly and consistently reviewed.

We saw evidence of a control of substances hazardous to health risk assessment and associated procedures. Staff maintained a file containing details of products used at the practice, for example, chemicals for dental treatment and details to inform staff what action to take in the event of a chemical spillage, accidental swallowing or contact with the skin. Measures were identified to reduce risks, for example, the use of personal protective equipment for staff and patients and secure storage of chemicals.

We saw evidence that the practice had carried out a sharps risk assessment and some measures had been implemented to mitigate the risks associated with the use of sharps, for example, the provider had implemented a sharps policy identifying responsibility for the dismantling and disposal of sharps. The practice's procedures were not in accordance with the practice's policy in a number of aspects, for example, the policy was to use safer sharps wherever possible; however the provider had not implemented a safer sharps system to dispose of used needles but had risk assessed the existing system. The provider had documented procedures to follow in the event of a sharps injury. These procedures were displayed in the treatment rooms for quick reference. Staff were familiar with the procedures and able to describe the action they would take should they sustain an injury. We saw recorded evidence of several sharps injuries to staff. Action taken was in line with the policy and recognised guidance.

We saw evidence in a sample of eight staff employment records we reviewed demonstrating that most clinical staff had received a vaccination to protect them against the Hepatitis B virus and evidence of it's effectiveness for most of these staff. People who are likely to come into contact with blood products and are at increased risk of injuries from sharp instruments should receive this vaccination to minimise the risks of acquiring blood borne infections.

Are services safe?

However we did not see evidence of the vaccination or it's effectiveness for two clinical staff. One member of staff who undertook clinical duties was part way through the vaccination treatment course and the provider had not assessed the risk to this person from working in a clinical environment without adequate protection. No risk assessments were in place for staff who undertook clinical duties in whom the vaccination was ineffective.

We observed that sharps bins were suitably located in most clinical areas except one treatment room. We were assured a sharps bin would be put in place to allow the user to dispose of used sharps at the point of use.

We saw that a fire risk assessment had been carried out and this was reviewed and updated annually. The provider had arrangements in place to manage and mitigate the risks associated with fire, for example, one of the staff undertook a lead role for fire safety, safety signage was displayed, fire-fighting equipment was available, fire drills were carried out regularly and an evacuation plan was identified.

We saw evidence to demonstrate that the provider had implemented a business continuity plan which detailed arrangements to be able to respond to and manage, disruptions and developments.

Infection control

The practice had an overarching infection control policy in place underpinned by clear, comprehensive procedures and protocols which detailed decontamination and cleaning tasks. Procedures were displayed in appropriate areas such as the decontamination room and treatment rooms for staff to refer to.

One member of staff had a lead role for infection prevention and control.

The practice undertook infection control audits six monthly and we saw evidence of these. We saw actions clearly identified and carried out.

We observed that there were adequate hand washing facilities available in the treatment rooms, the decontamination room, and in the toilet facilities. Hand washing protocols were displayed appropriately near hand washing sinks.

We observed the decontamination process and found it to be in accordance with the Department of Health's guidance, Health Technical Memorandum 01- 05 Decontamination in primary care dental practices, (HTM 01-05). The practice had a dedicated decontamination room which was accessible to staff only. The decontamination room and treatment rooms had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff used sealed boxes to transfer used instruments from the treatment rooms to the decontamination room. Staff followed a process of cleaning, inspecting, sterilising, packaging and storing of instruments to minimise the risk of infection. Packaged instruments were dated with an expiry date in accordance with HTM 01-05 guidance. Staff wore appropriate personal protective equipment during the decontamination process.

We observed that instruments were stored in drawers in the treatment rooms. We looked at the packaged instruments in the treatment rooms and found that packages were sealed and marked with an expiry date which was within the recommendations of the Department of Health.

Staff showed us the systems in place to ensure the decontamination process was tested and decontamination equipment was checked, tested and maintained in accordance with the manufacturer's instructions and HTM 01-05, and we saw records of these checks and tests.

Staff changing facilities were available and staff wore their uniforms inside the practice only.

The practice had had a Legionella risk assessment carried out in 2010 to determine if there were any risks associated with the premises. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). No further assessments or reviews had been carried out since then. Actions were identified in the assessment and these had been carried out, for example, we saw records of checks and testing on water outlet temperatures, which assists in monitoring the risk from Legionella, however dates of these checks had not been recorded. The provider intended to address this. The dental water lines and suction unit were cleaned and disinfected daily, in accordance with guidance to prevent the growth and spread of Legionella bacteria.

The treatment rooms had sufficient supplies of personal protective equipment for staff and patient use.

The practice had an environmental cleaning policy and procedures in place. Cleaning was the responsibility of a

cleaner but the dental nurses were responsible for the cleaning of the clinical areas. The practice had a cleaning schedule in place. We observed that the practice was clean and treatment rooms and the decontamination room were clean and uncluttered. We observed cleaning equipment was not stored suitably.

We saw that the segregation and disposal of dental waste was in accordance with current guidelines laid down by the Department of Health in the Health Technical Memorandum 07-01 Safe management of healthcare waste. Spillage kits were available for contaminated spillages. The practice had arrangements for all types of dental waste to be removed from the premises by a contractor. We observed that clinical waste awaiting collection was stored securely in the appropriate containers but the containers were stored unsecured in a yard to which the public had access.

Equipment and medicines

We saw evidence that the provider had systems, processes and practices in place to protect people from the unsafe use of materials, medicines and equipment used in the practice.

The provider dispensed antibiotics to patients where required. Staff responsible for stock control showed us the recording system for the prescribing, storage, stock control and recording of medicines.

Staff showed us contracts for the maintenance of equipment, and recent test certificates for thedecontamination equipment, the air compressor and X-ray machines. The practice carried out regular current portable appliance testing, (PAT). PAT is the name of a process under which electrical appliances are routinely checked for safety.

We saw records to demonstrate that fire detection and fire-fighting equipment, for example, fire extinguishers were regularly tested.

We saw that the practice was storing NHS prescription pads securely and in accordance with current guidance and operated a system for checking deliveries of blank NHS prescription pads. The practice maintained records of all prescriptions issued including void ones. Private prescriptions were printed out when required following assessment of the patient.

Radiography (X-rays)

The practice maintained a radiation protection file which contained the required information.

The provider had appointed a Radiation Protection Advisor and a Radiation Protection Supervisor.

We saw a critical examination pack for the X-ray machines. Routine testing and servicing of the X-ray machines had been carried out in accordance with the current recommended maximum interval of three years.

We observed that local rules were displayed in areas where X-rays were carried out. These included specific working instructions for staff using the X-ray equipment.

We saw evidence of regular auditing of the quality of the X-ray images which demonstrated the practice was acting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and patients and staff were protected from unnecessary exposure to radiation.

Dental care records confirmed that X-rays were justified, reported on and quality assured in accordance with IR(ME)R, current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with current National Institute for Health and Care Excellence guidelines, Faculty of General Dental Practice, (FGDP), guidelines, the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' and General Dental Council guidelines. The dentists described to us how examinations and assessments were carried out. Patients completed a medical history form which included detailing health conditions, medicines being taken and allergies, as well as details of their dental and social history. The dentists then carried out a detailed examination. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the examination the diagnosis was discussed with the patient and treatment options and costs explained. Follow-up appointments were scheduled to individual requirements.

Details of the treatments carried out were documented and details of medicines used in the dental treatments were recorded. This would enable a specific batch of a medicine to be traced to the patient in the event of a safety recall or alert in relation to a medicine.

We checked dental care records to confirm what was described to us and found that the records were complete, clear and contained sufficient detail about each patient's dental treatment. The dental care records adhered to current guidance. We saw patients' signed treatment plans containing details of treatment and associated costs.

We saw evidence that the clinicians used current National Institute for Health and Care Excellence Dental checks: intervals between oral health reviews, guidelines to assess each patient's risks and needs and to determine how frequently to recall them.

Health promotion and prevention

Staff had some awareness of guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is used by dental teams for the prevention of dental disease in primary and secondary care settings.

Tailored preventive dental advice and information was given to the patients in order to improve health outcomes for them. This included dietary advice and advice on general dental hygiene procedures. Where appropriate fluoride treatments were prescribed. Adults and children attending the practice were advised during their consultation of steps to take to maintain good oral health. Tooth brushing techniques were explained to them in a way they understood. The sample of dental care records we observed confirmed this.

Staffing

We observed that staff had the skills, knowledge and experience to deliver effective care and treatment.

The practice had a training policy and a training plan in place which outlined details of training for staff and included the mandatory General Dental Council topics, health and safety and a variety of generic and role specific topics.

The practice used a variety of training methods to deliver training to staff, for example, staff meetings, courses and online learning.

New staff and trainees undertook a programme of training and supervision before being allowed to carry out any duties at the practice unsupervised.

The practice carried out staff appraisals annually but dentists were not appraised. We noted the appraisals were a two way process with actions identified. Staff confirmed appraisals were used to identify training needs. Staff we spoke to were aware of their own abilities and competencies and confirmed all their colleagues were supportive.

All qualified dental care professionals are required to be registered with the General Dental Council, (GDC), in order to practice dentistry. To be included on the register dental care professionals must be appropriately qualified and meet the GDC requirements relating to continuing professional development, (CPD). We saw evidence that the qualified dental care professionals were registered with the GDC.

The GDC highly recommends certain core subjects for CPD, such as cardio pulmonary resuscitation, (CPR), safeguarding, infection control and radiology. Checks to ensure dental care professionals were up to date with their CPD were carried out by the practice; however checks to

Are services effective?

(for example, treatment is effective)

ensure dentists were up to date with their CPD were not carried out. The provider told us the dentists maintained their own CPD records. We reviewed CPD records for the dental nurses and found these contained a variety of CPD, including the core GDC subjects, and a wide range of other subjects demonstrating that they were meeting the requirements of their professional registration.

Working with other services

The practice had effective arrangements in place for referrals. Clinicians were aware of their own competencies and knew when to refer patients requiring treatment outwith these. Clinicians referred patients to a variety of secondary care and specialist options where required. Information was shared appropriately when patients were referred to other health care providers. Urgent referrals were made in line with current guidelines.

We saw examples of internal referrals for example to the hygienist and these followed recognised guidelines.

Consent to care and treatment

The provider had a consent policy in place.

The clinicians described how they obtained valid informed consent from patients by explaining their findings to them and keeping records of the discussions. Patients were given a treatment plan after consultations and assessments, and prior to commencing dental treatment. The patient's dental care records were updated with the proposed treatment once this was finalised and agreed with the patient. The signed treatment plan and consent form were retained in the patients' dental care records. The plan and discussions with the clinicians made it clear that a patient could withdraw consent at any time and that they had received an explanation of the type of treatment, including the alternative options, risks, benefits and costs.

The clinicians described to us how they obtained verbal consent at each subsequent treatment appointment. We saw this confirmed this in the dental care records.

Treatment costs were displayed in the reception area. Private fees and NHS fees were displayed in the practice leaflet, and private fees displayed on the practice website. The provider was currently producing information leaflets on dental treatments leaflets to assist patients with treatment choices.

The dentists explained that they would not normally provide treatment to patients on their examination appointment unless they were in pain or their presenting condition dictated otherwise. The dentists told us they allowed patients time to think about treatment options presented to them.

The clinicians told us they would generally only see children under 16 who were accompanied by a parent or guardian to ensure consent was obtained before treatment was undertaken. Clinicians demonstrated a basic understanding of Gillick competency. (Gillick competency is a term used inmedical law to decide whether a child of 16 years or under is able to consent to their own treatment).

The Mental Capacity Act 2005, (MCA), provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Information on the MCA was contained in the practice manual. Staff we spoke to had a basic awareness and understanding of the MCA but were not clear about its application in relation to consent.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had a separate room available should patients wish to speak in private. Treatment rooms were situated away from the main waiting area and we saw that the doors were closed at all times when patients were with the clinicians. Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. We observed staff treating patients with kindness and respect.

Involvement in decisions about care and treatment

The dentists discussed treatment options with patients and allowed time for patients to decide before treatment was commenced. We saw this documented in the dental care records. Patients we spoke to told us treatments were always explained in a language patients could understand. Patients commented that they were listened to and that treatment options, risks and benefits were discussed with them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw evidence that services were planned and delivered to meet the needs of people. The practice premises provided a comfortable environment and the provider had a programme of maintenance and improvement in place.

We saw that the practice tailored appointment lengths to patients' individual needs and patients could choose from morning, afternoon, and early evening appointments. Patients had a choice as to which dentist they attended.

The practice captured social and lifestyle information on the medical history forms completed by patients. This enabled clinicians to identify any specific needs of patients and direct treatment to ensure the best outcome was achieved for the patient.

The provider had a system in place to gather the views of patients. Regular patient surveys were conducted on behalf of the provider. Staff told us that patients were always able to provide verbal feedback and we saw evidence of improvements in response to patients' verbal feedback.

Tackling inequity and promoting equality

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users and had carried out a Disability Discrimination Act audit which they reviewed annually. The provider told us they had a high number of disabled patients.

The practice was located in a town centre property. Parking was available on nearby streets and car parks. The front entrance was flush with ground level and the practice was accessible to people with disabilities, impaired mobility, wheelchair users and people with prams.

Toilet facilities were situated on the ground floor and were accessible to people with disabilities and impaired mobility.

Staff told us they offered interpretation services to patients whose first language was not English and to patients with impaired hearing.

The practice made provision for patients to arrange appointments by email, telephone or in person. Where patients failed to attend their dental appointments staff contacted them to re-arrange appointments where possible and to establish if the practice could assist by providing adjustments to enable patients to receive their treatment.

Access to the service

We saw evidence that patients could access treatment and care in a timely way. The practice opening hours and out of hours appointment information were displayed at the entrance to the practice and provided in the practice leaflet, and on the practice website and answerphone. Emergency appointments were available daily.

Concerns and complaints

The practice had a complaints policy and procedure which was available in the waiting room for complaints about NHS and private treatment and included details as to further steps people could take should they be dis-satisfied with the practice's response to their complaint. The complaints procedure was outlined in the practice leaflet but details of further steps were not included. The complaints procedure was not provided on the practice's website.

We saw evidence that the practice had investigated complaints thoroughly and responded appropriately. We saw evidence of openness and transparency in the practice's responses to complaints. Details of verbal complaints were not captured by the provider but were responded to immediately if they arose.

Are services well-led?

Our findings

Governance arrangements

The practice had a management structure in place. The practice manager had access to suitable supervision and support in order to undertake the role effectively, and there was clarity in relation to management roles and responsibilities. Lead roles and responsibilities were shared among staff and roles were clearly identified in the practice manual. Staff reported that the practice managers were approachable and helpful.

The provider had a number of systems and processes in place for monitoring and improving the services provided for patients. Most systems were operating effectively; however the recruitment process was not operating effectively. The recruitment policy did not reflect current regulations to ensure staff were recruited in line with requirements relating to workers' suitability for their role and the provider was not obtaining all the prescribed information before employing staff.

The provider had arrangements in place to ensure risks were identified, understood and managed, for example, the provider had carried out risk assessments and put in place reasonable measures in order to mitigate these risks. We saw that risk assessments and policies were regularly reviewed but some had not taken into account or been updated with current regulations and guidance, for example the recruitment policy.

The provider had some arrangements in place to ensure that quality and performance were monitored, for example, through learning from complaints and auditing. The practice undertook a number of audits, for example, infection control, waste, X-rays and dental implants.

The provider had a training plan in place which supported staff in meeting some of the requirements of their professional registration; however the provider did not monitor the dentists continuing professional development to ensure they were meeting these requirements.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete and accurate. They were maintained electronically and on paper and securely stored. All computers were password protected and the computer was backed up daily.

Leadership, openness and transparency

We saw systems in place to support communication about the quality and safety of the service, for example staff meetings.

The practice held monthly staff meetings which were scheduled in advance to maximise staff attendance. We saw recorded minutes of these and observed that items discussed included, for example, clinical and non clinical issues, policies and training. Meetings were well structured and contained regular agenda items and staff told us they were able to bring suggestions to meetings.

Managers told us they operated an open door policy and staff told us they could speak to managers if they had any concerns.

Learning and improvement

The provider used quality assurance measures to encourage continuous improvement for example, auditing. The practice carried out some audits on quality and safety beyond the mandatory audits for infection control and radiography. We saw evidence that actions were identified on some audits, for example, radiography and infection control, and these actions were carried out. We saw evidence of improvement over audit cycles in the radiography audits. The managers assured us actions would be identified and carried out for all audits.

The provider told us information on the quality of care was gathered from patient feedback and used to evaluate and improve the service. We saw feedback from surveys of the practice's private patients but no feedback was gathered from NHS patients. We were told patients could always provide verbal feedback.

Staff confirmed that learning from complaints, incidents, audits and feedback were discussed at staff meetings to share learning to inform and improve future practice. We observed that items discussed in staff meetings included action taken and learning identified as a result of concerns and complaints.

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

We saw evidence that the provider had acted on verbal feedback from patients.

Are services well-led?

We were told staff could provide feedback to the practice managers at any time. Staff told us that suggestions for improvements to the service were listened to and acted on.

Staff told us they felt valued and involved.