Cotswold Dental Limited

Broadway Dental Care - Cotswold Dental Limited

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 September 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

Broadway Dental Care is situated in the Cotswold village of Broadway, Worcestershire and provides private dental treatment for all age groups. It has been operated by the same dentist since 1998, initially as a sole trader and then from 2007 as Cotswold Dental Limited, a limited company. The company secretary is the practice manager and a dental nurse. They are also 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. The practice has one dentist (the Company Director) and three other dental nurses. The registered manager and clinical team are supported by a receptionist.

The practice has one dental treatment room and a separate decontamination room for the cleaning, sterilising and packing of dental instruments. The waiting room is separate from the reception area which helps provide privacy when staff are dealing with patients at the reception desk or on the telephone.

Summary of findings

The practice is on the first floor of the building and there is no lift. The practice had carried out an assessment as required under the Disability Discrimination Act. Through this they identified that apart from fitting robust handrails there are no other changes they can make to the structure of the building to improve access for patients unable to climb stairs. They have explored the possibility of moving to different premises but none suitable are available in the village. The practice assists patients unable to use stairs to find or move to practices with suitable access.

The practice is open from 9am to 5pm Monday to Friday except Wednesdays when the practice opens by special arrangement. The practice is closed for lunch from 1pm to 2pm.

Before the inspection we sent Care Quality Commission comment cards to the practice so patients could give us their views about Broadway Dental Care. We collected 48 completed cards and spoke with two patients at the practice. The information provided showed that the practice was highly regarded by patients who were very complimentary about the dentist and the other members of the practice team. They described receiving gentle, thorough care and being treated with kindness and respect by staff. A large proportion commented on how well the dentist explains treatment to help them make decisions about their care. More than a third of patients specifically mentioned that cleanliness and hygiene at the practice was very good with several saying this was exemplary.

Our key findings were:

- The practice was visibly clean and feedback from patients confirmed this was always the case. National guidance for cleaning, sterilising and storing dental instruments was followed.
- The practice had suitable safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- The practice had clear processes for dealing with medical emergencies and for maintaining the equipment used at the practice.
- Dental care records provided clear information about patients' care and treatment and patients received written treatment plans.
- Staff received training appropriate to their roles and were supported to meet the continuous professional requirements of the General Dental Council.
- Patients were able to make routine and emergency appointments when needed.
- The practice used in-house patient surveys, to enable patients to give their views about the practice. Staff had opportunities to contribute their views through daily discussions, regular staff meetings and annual appraisals.
- Patients' comments showed they held the practice in high regard; they were complimentary about the practice team and all aspects of the care and treatment they received.
- The practice had comprehensive governance processes to help them manage the service and continued to review and develop these with the aim of ongoing improvement.

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

- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and ensure all staff are aware of their responsibilities under the Act as it relates to their role.
- Review the availability of an interpreting service for patients who do not speak English as their first language or who use British Sign Language.
- Review progress in obtaining a hearing loop to assist those who use hearing aids.
- Review the practice's recruitment procedures so they provide more specific guidance regarding information required for staff being recruited.
- Review the options available for the registered manager to receive annual appraisals.

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.

The practice was committed to providing a safe service and had well organised systems to ensure care and treatment was carried out safely. This included processes to discuss and make improvements when things went wrong.

There were policies, risk assessments and well organised arrangements for important aspects of health and safety. These included infection prevention and control, clinical waste management, dealing with medical emergencies, dental radiography (X-rays) and fire safety. Maintenance of equipment was well organised. The staff recruitment policy needed to provide additional about the information needed for new staff.

Staff were aware of their responsibilities for safeguarding adults and children. The practice had safeguarding policies and procedures and contact information for local safeguarding professionals was readily available for staff to refer to if needed.

Are services effective?

No action

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

The practice assessed patients' and care and treatment in a personalised way taking into account current legislation, standards and evidence based guidance. They provided patients with written treatment plans and patient feedback confirmed that their care was discussed with them clearly and thoroughly. Referrals to other dental or NHS services were made in line with relevant guidance when this was necessary and the practice worked in partnership with other health professionals.

Clinical staff were registered with the General Dental Council and completed continuous professional development to meet the requirements of their professional registration

Staff understood the importance of obtaining informed consent and used written consent forms. The practice team were aware of the importance of taking the Mental Capacity Act 2005 into account when considering whether patients were able to make their own decisions but needed to develop this further.

Are services caring?

No action

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

The patient feedback we reviewed was unanimously positive and showed that the practice was highly regarded by patients.

Summary of findings

Patients described the dentist and the other members of the practice team as professional, skillful, courteous and caring. The practice was aware of the importance of confidentiality and this was covered in staff training. Staff spoke about patients respectfully and during the inspection we saw they were welcoming and helpful. Patient feedback confirmed that the dentist explained their treatment clearly and involved them in decisions about their dental care.

Are services responsive to people's needs?

No action

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

The patient feedback we reviewed showed high levels of satisfaction with the practice and confirmed that patients received a personalised service that met their needs.

The practice was on the first floor of the building and there was no lift so was not suitable for patients unable to climb stairs. The practice had carried out an assessment as required under the Disability Discrimination Act. This identified that apart from fitting robust handrails on the staircase there were no other changes they could make to the structure of the building to improve access for patients unable to climb stairs. They had explored the possibility of moving to different premises but nowhere suitable was available in the village. The practice assisted patients unable to use stairs to find or move to practices with suitable access. The practice did not have a hearing loop to assist patients who used hearing aids or details of interpreter services.

The practice had out of hours arrangements so patients could obtain urgent as well as routine treatment when they needed.

The practice had a complaints procedure and responded to complaints promptly and constructively. Information about this and a wide range of other topics was available in the practice information pack and on their website.

Are services well-led?

No action

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

The practice had established governance arrangements to help them ensure that that the practice was well organised and effectively managed. The practice team worked together well. Staff told us they were well supported by the dentist and registered manager. The practice had structured arrangements for managing and monitoring the quality of the service including audits of clinical and non-clinical aspects of the service. There were relevant policies and processes available to all staff.

Dental nurses and reception staff received annual appraisal and were supported and encouraged to take up training opportunities. The dentist was committed to developing their own knowledge and expertise. They were undertaking a master's degree and were actively involved in dental education as a lecturer.

The practice took the views of patients seriously and used patient surveys to give them feedback. A variety of informal communication and structured staff meetings took place for the practice team to meet and discuss the management of the practice and the care and treatment provided.

Broadway Dental Care - Cotswold Dental Limited

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 was carried out on 26 September 2016 by a CQC inspector and a dental specialist adviser. We reviewed information we held about the provider and information that we asked them to send us in advance of the inspection.

During the inspection we spoke with the dentist, registered manager, dental nurses and receptionist. We looked around the premises including the treatment rooms. We viewed a range of policies and procedures and other documents and read the comments made by 48 patients in comment cards provided by CQC before the inspection. We spoke with two patients while we were at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a significant event policy and recording forms for staff to use. Staff we discussed significant events with were aware of the process to follow if they were aware of an event which needed to be reported. We reviewed the three significant event forms completed since 2014. We saw that the practice had acted on these and made changes where necessary. The events were discussed at staff meetings showing that the practice recognised the need for openness, learning and improvement. The practice was aware of the requirement under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and had guidance for staff to refer to. Suitable accident record forms were used. The practice had recorded three incidents in the last year. These were also discussed at staff meetings.

The registered manager explained that they used a commercial dental service to keep up to date about national alerts of safety issues relating to medicines, equipment and medical devices. They confirmed they checked which were relevant to them and took action when needed. The registered manager was aware of recent safety alerts relevant to dentistry and confirmed they had acted on these at the practice. They did not have a structured system to record they had done this. They devised and sent us a form for this within a few hours of the inspection. The practice also signed up to receive direct safety alerts from the government website on the day of the inspection to supplement their existing system.

The practice had a policy regarding the legal requirement, the Duty of Candour and guidance about this from the General Dental Council (GDC) was available for staff to refer to. The legislation requires health and care professionals to tell patients the truth when an adverse incident directly affects them. The registered manager had linked other procedures such as those for significant events and complaints to the Duty of Candour requirement and kept information about these together. We saw evidence that the subject had been discussed at a staff meeting.

Reliable safety systems and processes (including safeguarding)

The practice team were aware of their responsibilities regarding potential concerns about the safety and well-being of children, young people and adults living in circumstances which might make them vulnerable. The practice had up to date child and adult safeguarding policies and procedures based on local and national safeguarding guidelines. The contact details for the relevant safeguarding professionals in Worcestershire were readily available for staff to refer to. Information for the other neighbouring counties of Warwickshire and Gloucestershire was also available. The registered manager told us they had not yet needed to make any safeguarding referrals.

Staff had completed on-line safeguarding training at a level suitable for their roles. The registered manager was the practice's lead for safeguarding and in addition to on-line training had attended a training course provided by Worcestershire NHS Trust.

We saw a variety of evidence to confirm that the dentist used a rubber dam during root canal treatment in accordance with guidelines issued by the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. The dentist also used a rubber dam during some other dental procedures.

The practice was working in accordance with the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the EU Directive on the safer use of sharps which came into force in 2013. We confirmed that the practice used single use 'safer sharps' syringes to minimise the risk of injury to dentists and dental nurses.

Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. There was 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. We saw evidence that staff had recently completed training relevant to their role including management of medical emergencies, basic life support training and training in how to use the defibrillator. All staff at the practice completed First Aid at Work training every three years.

Are services safe?

The practice had the emergency medicines as set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. Staff carried out checks of the emergency medicines and equipment to monitor that they were available, in date, and in working order. We saw that the practice had records to monitor that this was being done. These included the batch numbers of each item of medicine and their expiry dates. A poster about resuscitation procedures and the correct information to provide when making a 999 call were displayed in reception.

Staff recruitment

There was a recruitment policy but this was not sufficiently detailed to ensure the practice obtained all of the information required. The registered manager confirmed that they would review this policy with reference to relevant legislation and guidance.

We looked at the recruitment records for the two most recently appointed staff. These showed that the practice had obtained the majority of the required information for these staff including satisfactory evidence of employment in a healthcare related setting where this was relevant. The practice policy was to obtain Disclosure and Barring Service (DBS) checks for all staff at the practice and we saw evidence that they did this in practice. The DBS carries out checks to 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 had evidence that the clinical staff were registered with the General Dental Council (GDC) and that their professional indemnity cover was up to date. The registered manager checked this as part of staff appraisals each year.

Monitoring health & safety and responding to risks

The practice had a variety of health and safety related policies and risk assessments. These covered both general workplace and specific dentistry related topics. The practice reviewed these each year and added new topics when needed. For example, following advice from an infection prevention and control trainer they had introduced a risk assessment about treating patients with cold sores. The policy and risk assessment files were well organised with comprehensive contents lists to help staff refer to them when needed. Between them the registered manager and other staff completed daily, weekly and monthly safety checks and a full premises safety review twice a year.

The practice had comprehensive information about the control of substances hazardous to health (COSHH). This included risk assessments and individual information sheets for relevant dental products and materials. The registered manager had developed their own format for these using the information provided in the manufacturers' data sheets. They did this so that all the COSHH information was available in the same format making it easier for staff to refer to. We saw that they reviewed and updated these forms annually. There were separate risk assessments for household products such as cleaning materials. These did not include the same level as detail and the registered manager said they would in future use the same detailed format that they used for dental products.

The practice used latex free disposable gloves, rubber dams and other products to remove the risk to patients or staff who may be allergic to latex.

The practice had a fire risk assessment completed by an external fire safety consultant and this had been updated in February 2016. This identified a number of improvements that were needed. We saw records confirming that the majority of these had been addressed. This included the fitting of new smoke detectors with lights and the provision of torches because the practice did not have emergency lighting system. The practice was in the process of arranging for internal doors to be upgraded to fire doors; this was outstanding from the risk assessment.

A specialist contractor checked and maintained the fire extinguishers in the practice annually. We saw the records of the routine daily, weekly and monthly checks the staff made in respect of fire safety precautions at the practice. We learned that all members of the practice team had completed fire marshall training to ensure there were always staff on the premises who had been trained to take charge in the event of a fire.

The practice had a business continuity plan describing how the practice would deal with a wide range of events which could disrupt the normal running of the practice. The registered manager had access to this off site and following discussion at the inspection confirmed that they would

provide another member of staff with a copy as well. They told us that in the event of a catastrophic incident which would prevent the building being used their insurance provided the possibility of a mobile dental unit being supplied for them to continue to treat patients.

Infection control

The practice was visibly clean and tidy and the 35% of patients who specifically mentioned cleanliness in CQC comment cards were very positive about this. Staff had specific cleaning checklists for the treatment and decontamination rooms and a general daily cleaning list to monitor that the various cleaning tasks were done at the expected frequency. Cleaning equipment was available and stored appropriately.

The practice had an infection prevention and control (IPC) policy and one of the dental nurses was the IPC lead for the practice. They held a City and Guilds level 3 certificate in dental decontamination. They carried out six monthly IPC audits and in June 2016 had achieved a score of 99%. The practice also had an annual IPC statement as set out by the Department of Health in the Code of Practice on the prevention and control of infections and related guidance.

The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We found that they met the HTM01-05 essential requirements for decontamination in dental practices.

Decontamination of dental instruments was carried out in the separate decontamination room which was staffed by a dental nurse each day. The dental nurses took it in turns to do this so they were all familiar with it. The separation of clean and dirty areas in the decontamination rooms and treatment room was clear. We discussed the processes and equipment for transporting, cleaning, checking, sterilising and storing instruments with a dental nurse. They were knowledgeable about these and able to explain them clearly.

The practice kept records of the expected decontamination processes and checks. These included those which confirmed that equipment was working correctly. We saw that instruments were packaged, dated and stored appropriately. The practice confirmed that they used single use instruments whenever possible in line with HTM01-05 guidance and did not re-use items designated as single use only.

The dentist carried out dental implants, a surgical procedure which requires specific hygiene and decontamination standards. We discussed this with the IPC lead. They confirmed that separate instruments, including dental handpieces were kept for these processes. Instruments used for these procedures were cleaned, sterilised and packed after use and were then sterilised again the day before they were next needed.

The practice had personal protective equipment (PPE) such as heavy duty and disposable gloves, aprons and eye protection available for staff and patient use. We saw that staff working in the decontamination room used full face visors to protect them from splashes. The treatment rooms and decontamination room had designated hand wash basins for hand hygiene and liquid soap and paper towels. Staff completed regular infection control and handwashing training to maintain their awareness.

Suitable spillage kits were available to enable staff to deal with any loss of bodily fluids safely. A mercury spillage kit was also available although the practice no longer provided new amalgam fillings.

The practice had a Legionella management policy and an up to date Legionella risk assessment carried out by a specialist company every two years. Legionella is a bacterium which can contaminate water systems in buildings. The most assessment was completed in August 2015 and no outstanding issues were identified. We saw that staff carried out routine water temperature checks and kept records of these. The practice had annual water quality testing carried out annually by the same specialist company. The practice used an appropriate chemical to prevent a build-up of potentially harmful biofilm, such as Legionella, in the dental waterlines. Staff confirmed they carried out regular flushing of the water lines in accordance with current guidelines and the chemical manufacturer's instructions. They used a testing regime certified by the manufacturer of the chemical used.

The practice's arrangements for segregating and storing dental waste reflected current guidelines from the Department of Health. The practice used an appropriate

contractor to remove dental waste from the practice. We saw the necessary waste consignment and duty of care documents and that the practice stored waste securely before it was collected.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. This was available for staff to refer to and they were aware of what to do. The practice had documented information about the immunisation status of each member of staff. Appropriate secure boxes for the disposal of sharp items were used.

Equipment and medicines

The practice had maintenance arrangements for equipment to be maintained in accordance with the manufacturers' instructions using appropriate specialist engineers. This included equipment used to sterilise instruments, the compressor, X-ray equipment and portable electric appliances. Appropriate pressure vessel insurance was in place for the equipment used to sterilise instruments.

The practice kept a stock of various antibiotics, fluoride toothpaste and one type of pain relief to prescribe for patients. These medicines were securely stored. Staff kept records of the prescriptions provided which included the name of the patient, the amount and name of the antibiotic prescribed and the batch number. The registered manager had a stock control system to monitor the amounts of medicines at the practice and that these were in date. The practice provided patients with copies of the manufacturers' patient information leaflets and a practice's own guidance leaflet with their prescribed medicine. The practice was taking part in the Public Health England initiative to be an 'Antibiotic Guardian'. This campaign urges members of the public and healthcare professionals to take action in helping to slow antibiotic resistance and ensure our antibiotics work now and in the future.

The dentist recorded the type of local anaesthetic used, the batch number and expiry date in patients' dental care records.

Temperature sensitive medicines and dental materials were stored in a suitable refrigerator. Staff monitored and recorded the refrigerator temperature.

Radiography (X-rays)

We looked at records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). These were well maintained and included expected information such as the local rules, the names of the Radiation Protection Adviser and the Radiation Protection Supervisor and notification to the Health and Safety Executive that radiography equipment was used at the premises. The records showed that the practice had arrangements for maintaining the X-ray equipment and that relevant annual checks were up to date.

We confirmed that the dentist's IRMER training for their continuous professional development (CPD) was up to date.

The practice used a particular type of equipment on its X-ray machines known as a rectangular collimator which reduces the dose of X-rays patients receive. They used beam aiming devices to reduce the need for repeat exposures. The X-ray equipment was digital which eliminated the need for staff to handle chemicals used to develop traditional X-rays.

We saw evidence that the practice justified, graded and reported on the X-rays they took. They were recording the percentage of X-rays achieving a diagnostic quality grading of one, two or three and completing audits regarding this. The most recent audit was completed in January and had been discussed at a staff meeting.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist placed high importance on maintaining their knowledge through continued learning and development and providing evidence based treatment. They were therefore aware of and took into account published guidelines such as those from the Faculty of General Dental Practice (FGDP) and other professional and academic bodies. Although as a fully private dental practice they did not have a contractual obligation to follow National Institute for Health and Care Excellence (NICE) guidance they took this into account as part of their overall evidence based approach. The dentist provided information on their website about this.

The practice kept detailed records about patients' dental care and treatment. The dentist completed detailed and structured risk assessments for every patient using a format they had devised. These included a range of relevant information from their assessments of all aspects of a patent's oral health and used a scoring system to evaluate and establish potential failure rates for proposed treatments in an objective way. They then used this as the foundation for a patient's treatment plan. The dentist carried out all treatments using a dental surgical telescope to improve their quality of vision. We noted that the dentist wrote notes by hand which were then typed into patients' electronic records by a member of staff. They told us they found this enabled them to make more detailed records whilst being able to have face to face discussions with patients.

In addition to assessing their teeth and gums the dentist also completed assessments of patients' general oral health including monitoring for possible signs of oral cancer. The practice occasionally took their own biopsies which reduced the need for referrals to other NHS services for initial testing and therefore the time this might take. They used the local GP practice to send the samples for laboratory testing.

The practice asked all patients to fill in a medical history form and checked and updated this information at each appointment.

Health promotion & prevention

The practice was aware of the Delivering Better Oral Health Tool Kit from the Department of Health and took this into account as part of their individualised and risk based approach to patients' treatment. The practice was in an area with fluoridated water. The practice had fluoride toothpaste available and prescribed this if a patient's risk of tooth decay indicated this would be beneficial. Similarly, the dentist told us they used fluoride varnish for children only where this was indicated by their risk assessment of a child's dental health.

There was a file in the waiting room containing 46 different information leaflets for patients about all aspects of oral health, general and specialist dental treatments, dietary advice and alcohol and smoking. The practice's medical history forms included questions about smoking and alcohol consumption both of which have an impact on oral health. The practice website also provided a wide range of information about the treatments provided at the practice.

One of the dental nurses was planning to complete an oral health education course to enable to extend their knowledge and expertise in this subject.

A range of dental care products were available for patients to buy.

Staffing

The practice completed annual appraisals for staff which included identifying personal development plans (PDPs). Of the current team of dental nurses two had been at the practice less than a year. They had not yet had their first annual appraisal but we saw written evidence that the practice manager had monitored their induction period and carried out a formal review at the end of this. The registered manager was also a dental nurse. We identified that they had not received annual appraisals since qualifying as a dental nurse in 2012. The practice provided the team with access to online training courses. The dental nurses also had the opportunity to complete enhanced training to enable them to fulfill extended duties if they wished. For example one had identified that they wanted to do an oral health education course and was looking into funding for this.

We confirmed that clinical staff undertook the continuous professional development (CPD) required for their registration with the General Dental Council (GDC). The practice had evidence that clinical staff held current GDC registration. The practice held copies of staff training

Are services effective?

(for example, treatment is effective)

certificates and we saw evidence that staff maintained their individual CPD folders. The registered manager checked staff progress with CPD requirements at each appraisal to ensure this was being completed.

In addition to training in respect of clinical matters staff also completed training in safety related topics. These included safeguarding, health and safety, management of medical emergencies, basic life support and defibrillator training, fire safety and infection control. The practice manager had a chart detailing the dates of all staff training to monitor that each member of the team was up to date. The online training system used by the practice also provided a log of training that staff completed.

The practice had a structured induction process for new staff and the practice manager made notes of progress with this. These records needed to be more structured to provide robust information to show staff were competent in the areas covered. We discussed this with the registered manager who said they would develop their processes before any new staff started.

The practice had two dental nurses on duty each day. One working with the dentist and the other in the decontamination room. This also ensured that cover was available for absences such as annual leave or sickness. The registered manager was a dental nurse and provided cover if necessary. These staffing levels ensured that two staff were available to assist with complex treatment such as dental implant procedures.

Working with other services

When necessary the practice referred patients, including children, to NHS dental hospitals and access clinics or to other private dental practices. This was usually because a patient needed specific specialist treatment that Broadway Dental Care did not provide. The dentist told us this was rare due to their own experience and ability in providing complex treatments. They told us they aimed to provide the majority of patients' treatments at the practice.

The practice referred patients for investigations in respect of suspected oral cancer in line with NHS guidelines. This included making referrals under the national two week wait arrangements. The practice took biopsies themselves in some cases and sent these through the local GP practice for laboratory testing.

The dentist told us they gave patients a copy of their referral letter if they wished to have one. Because of the low numbers of external referrals they made the practice had not previously used a structured tracking process for these. They asked patients to inform them if they did not hear promptly from the services they were referred to. The registered manager agreed a system would be helpful and said they would establish one straight away.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. Written consent was obtained for any treatment provided at the practice. Information we reviewed from patients confirmed that were given the time and information they needed to make informed decisions about their treatment. We saw that patients received written treatment plans which explained the costs, risks and benefits of any suggested treatment options.

The practice had a written consent policy and guidance for staff which included information about the requirements of the Mental Capacity Act (MCA) 2005. 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. All staff had completed MCA training and were aware of the relevance of this legislation to the dental team. We saw an example where the practice had acted in a patient's best interest in making a referral. However, they had not recorded how they established whether or not the patient had capacity to consent to specific decisions for their general dental care and the payments for this.

The practice consent policy referred to decision making where young people under the age of 16 may be able to make their own decisions about care and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We gathered patients' views from 48 completed cards and spoke with two patients. Patients described the dentists and the other members of the practice team as professional, courteous and caring and confirmed they were treated respectfully. Without exception patients were positive and appreciative about the quality of their care and treatment and the attitude and manner of the practice team.

The waiting room and reception area were separate which helped provide privacy when reception staff were dealing with patients. Staff told us that if a patient needed or wanted more privacy to discuss something they would take them into another room. We saw that the angle of the reception computer screen meant it could potentially be visible to patients. As soon as we mentioned this the practice moved the screen to avoid this. No personal information was left where another patient might see it.

The practice had a confidentiality policy and this topic was covered during induction and ongoing training staff. Reception staff understood their responsibility to take care when dealing with patients' information in person or over the telephone.

We spoke with staff about how they supported anxious patients. Staff told us that they offered patients a glass of water or sat and chatted with them to take their mind off their treatment while they waited to be seen. During the inspection we saw that all the staff greeted patients in a welcoming way and knew each of them by name.

Although the practice did not have a large number of patients who were children one comment card specifically mentioned that the dentist was extremely good with children and made them feel at ease.

Involvement in decisions about care and treatment

We saw evidence that the practice recorded information about patient's treatment options, and that they discussed the risks and benefits of these with them. All patients were given a written treatment plan. The dentist also used diagrams to help them explain treatments to patients.

Many of the patients who completed CQC comment cards commented on how their dentist provided clear and thorough explanations about the treatment they needed. Many also said that the dentist always listened to them, answered their questions and took their concerns and opinions into account.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

National data shows that the local population has a lower proportion of people under 50 than the national average and a much higher percentage of people over 65. Broadway Dental Care was the only dental practice in the village and had the current dentist had been there for 18 years. This meant they knew their patients well and were aware of their needs. They confirmed that they did not have very many patients who were children, partly because parents tended to take children to NHS practices. The practice were aware that they would need to respond to the changing needs of some of their older patients in the future.

We gathered patients' views from 48 completed CQC comment cards and spoke with two patients during the inspection. All the information we reviewed confirmed that the practice treated patients as individuals and provided personalised care and treatment which met their needs. Several patients commented that they appreciated that staff knew them by name.

We discussed the appointment booking system with reception staff. They explained that check-ups and hygiene appointments were booked for 15 minutes and combined appointments were 20 minutes. Treatment appointments were booked according to the treatment needed; the dentist either came to reception with patients to discuss how long an appointment needed to be or used the instant messaging on the computer system. Staff told us they booked longer appointments if needed based on their knowledge of each patient's needs, including anxiety about dental treatment. They explained these were often booked at the end of the day so there was no pressure on the time available

The practice provided all patients with an information pack. This contained a practice leaflet with information about the dentist's background, training and experience and details of the range of treatments they offered. The leaflet also set out a range of other information including the practice opening times, emergency appointments, and information about the lack of access for patients with disabilities. The pack also contained a welcome letter, patient health and dental needs questionnaires, a price list, details about payment method available to patients and details about the British Dental Association Good Practice Scheme which the practice was signed up to. This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to standards of good practice in respect of professional and legal responsibilities.

The practice had additional leaflets for patients on its computer system which could be printed when needed. The practice provided a wide range of information on its website including a blog written by the dentist describing their approaches to treatment and ongoing professional development in respect of various aspects of oral health. A practice manual was available in the waiting room. This contained copies of the General Dental Council's Standards for the Dental Team, a copy of their CQC registration certificate, the practice statement of purpose and practice leaflet and other helpful information.

Tackling inequity and promoting equality

The practice had an equality and diversity policy available for staff and staff told us they had done training using an on-line training package.

Staff told us that they did not have any patients who unable to converse in English although one brought a family member with them to help during appointments. They did not have details for an interpreting service should they need one and agreed to look into this and the provision of information in Braille in case either were needed in the future.

The practice did not yet have an induction hearing loop to assist patients who used hearing aids although we saw that the registered manager had this noted as something they needed to provide. Information for patients could be provided in large print if needed.

Although the practice provided private dental care, staff told us they would see emergency patients with lower incomes at minimal cost if they were in pain and unable to obtain an appointment elsewhere.

The practice was on the first floor of the building and there was no lift. In 2009 the practice had carried out an assessment as required under the Disability Discrimination Act and reviewed it in May 2016. They had identified that apart from fitting robust handrails there were no other changes to the structure building they were able to make to improve access for patients unable to climb stairs. They had explored the possibility of moving to different

Are services responsive to people's needs?

(for example, to feedback?)

premises. This had gone as far as having planning applications approved for alternative premises on three separate occasions only for the owners to withdraw from the sales at an advanced stage. The registered manager told us no other suitable premises were available in the village and so they had decided they had no option but to stay in their current premises if they were to continue to provide a dental service to the village and surrounding area. The practice assisted patients unable to use stairs to find or move to practices with suitable access.

Access to the service

The practice was open from 9am to 5pm Monday to Friday. Information from patients confirmed they were able to make appointments easily, including at short notice. The reception staff described how they tried to meet patients' needs when booking appointments. For example, they arranged routine children's appointments outside school hours or in the holidays. The practice telephoned to remind every patient two days before their appointments.

The practice took part in an on-call rota with other local private dental practices in the evenings and at the weekends. Information about this was provided in the practice information pack. Staff told us patients with pain or other urgent dental needs would be seen the same day. The practice gave an out of hours telephone number to patients who had had complex treatment so they could speak with the dentist if they had a problem when the practice was closed. Staff told us the dentist made follow up telephone calls to patients following surgical dental procedures to make sure they were alright. This was confirmed by a patient in a comment card who had valued the aftercare they received.

Concerns & complaints

The practice had a complaints policy and procedure which they told us they provided in large print if needed. The procedure explained who patients should contact about concerns and how the practice would deal with their complaint. It contained contact details for the General Dental Council and the Dental Complaints Service, national organisations which patients may go to regarding concerns.

We looked at the three complaints the practice had received in the previous 12 months. These were the first they had received since 2013. The records showed that the practice had responded promptly and constructively to the concerns raised. External professional and legal guidance was sought appropriately. We saw that the practice aimed to act correctly and transparently and took patients wishes into consideration when deciding how to resolve complaints. We noted that all three complaints had been discussed at staff meetings to actively involve staff in learning from these. The practice kept some records for each complaint in the complaints folder and others remained in individual patient notes. We discussed the benefits of a system to help make information easier to collate if needed. The practice manager said they would implement a system for this.

Are services well-led?

Our findings

Governance arrangements

The dentist held the responsibility for clinical leadership and the registered manager was responsible for the day to day management of the service.

The practice was a member of the British Dental Association Good Practice scheme. This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to standards of good practice in respect of professional and legal responsibilities.

The practice had policies, procedures and risk assessments to support the management of the service. These reflected national guidance from organisations such as the General Dental Council (GDC) and the British Dental Association (BDA). We saw that the practice manager reviewed these annually so they were kept up to date and signed and dated them to show this had been done. They had a comprehensive checklist to help them ensure that all policy reviews, health and safety checks and other important management tasks were completed on time.

Although as a small team staff were able to communicate easily every day they recognised the importance of more structured communication to ensure information was available when needed. For example, because the receptionist had reduced their hours to four days a week they had introduced a handover sheet so there was a reliable system for passing information on.

In addition to informal discussions during each working day the practice held whole practice meetings. They told us these took place every six to eight weeks. Notes of the meetings were made for future reference and so staff who were not present could update themselves although staff told us they were usually booked on days when everyone could attend. We looked at the minutes for the last four meetings. These confirmed that they were used to discuss and share learning from practice audits, complaints, significant events and the introduction or updating of policies and procedures.

Leadership, openness and transparency

During the inspection we observed that the practice team worked closely and communicated in a relaxed and supportive way. Staff we asked told us the dentist and registered manager were supportive and approachable.

The practice had a policy regarding the Duty of Candour and information was available for staff to refer to. Staff told us they would have no hesitation in raising concerns or making suggestions for improvements. The practice had a bullying and harassment policy and a whistleblowing procedure for staff to use if they identified concerns at the practice. This included information about external contacts if they felt unable to report these internally.

Management lead through learning and improvement

In addition to their clinical work the dentist was involved in dental education as a lecturer and as an assessor for the Royal College of Surgeons. They were a member of a range of general and specialist dental societies and associations. They used their external roles to share knowledge and to develop their own expertise. They were studying for a Master's degree in Evidence-Based Healthcare at Oxford Universities Centre for Evidence-Based Medicine. The registered manager had been in post as practice manager since 1998. Subsequently they trained as a dental nurse to provide them with greater insight into all aspects of the practice's work. They sat on the General Dental Council's Fitness to Practise Panel and told us that they valued the additional knowledge and experience this brought to their role at the practice.

Dental nurses and reception staff received annual appraisals and had personal development plans identifying learning needs.

The practice used a variety of audits to monitor the quality of treatment and the overall service provided. These included audits regarding the grading of X-rays, infection prevention and control, hand hygiene, clinical record keeping and patient waiting times. We saw that where needed the audits had action plans and that the outcomes of audits were discussed at staff meetings.

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

The practice used patient surveys to ask patients for their views about the practice. The practice had not carried out a

Are services well-led?

survey during 2015 due to a low response to the one in 2014. They had halted their 2016 survey due to our CQC comment cards arriving and had given these priority. They planned to continue their own survey following the inspection. The practice manager told us that they had received very few suggestions from patients about improvements other than about the practice being upstairs. They had explored all available options to resolve this including moving to new premises but had been unsuccessful in securing suitable premises within the village. The registered manager was considering ways to encourage a higher response rate to their current and future patient survey.

Members of the practice team had opportunities to discuss issues and contribute their ideas in a variety of ways. Because the team was so small staff told us that they talked amongst themselves every day so that any problems or ideas were considered promptly. The practice also used annual appraisals and staff meetings to provide staff with opportunities to contribute.