

Oasis Dental Care Limited

Oasis Dental Care - Lincoln 2

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 October 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

Oasis Dental Care - Lincoln 2 is a mixed dental practice providing private and NHS dental care for both adults and

children. Where private treatment is provided some is provided under a fee per item basis and some under a dental insurance plan. The practice holds an NHS contract for the provision of orthodontic treatment on a referral basis only. The premises in which the practice is situated is a one storey purpose built facility with all services available on one level. At the time of our inspection there was no wheelchair access to the building.

The practice has eight dental treatment rooms, all on the ground floor. There is a separate decontamination room used for cleaning, sterilising and packing dental instruments, a patient recovery room and X-ray room. There is also a reception and waiting area and other rooms used by the practice for office facilities and storage. The practice is open from 8.00am to 7.00pm Monday, Tuesday and Thursday, from 8.00am to 8.00pm on Wednesdays, from 8.00am to 5.00pm on Friday and on alternate Saturdays from 09.00am to 1.00pm.

The practice has seven dentists who are able to provide services including the provision of dental implants (a dental implant is a metal post that is placed surgically into the jaw bone to support a tooth) and orthodontic treatment (where malpositioned teeth are repositioned to give a better appearance and improved function). They are supported by ten dental nurses, two dental hygienists, a practice manager and five receptionists.

The practice manager is the registered manager. A registered manager is a person who is registered with the

Summary of findings

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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We also spoke with patients on the day of our inspection. We received feedback from 32 patients. These provided an overwhelmingly positive view of the services the practice provides. Patients commented on the high quality of care, the kindness and care shown by staff, the cleanliness of the practice and the professionalism of staff.

Our key findings were:

- Patients commented that they were happy with their care, staff were helpful and professional and appointments were flexible.
- The practice had good facilities and was well equipped to treat patients and meet their needs. However the practice did not have access to a translation service for patients who did not speak English or have a hearing loop to support patients with a hearing aid.
- The practice appeared very clean and well maintained and infection control standards were in line with national guidance.
- The practice had carried out a Disability Discrimination Access audit and as a result planned to provide wheelchair access and provide disabled parking space.
- The practice had medicines and equipment for use in a medical emergency which were in accordance with national guidelines.
- There was not always an individual risk based approach to patient recalls or fluoride varnish applications for children in line with national guidance.
- On the whole staff had received training and support appropriate to their roles and were up to date with their continued professional development (CPD). However we found that one clinician was not up to date with radiation training and the dental hygienists were not always supported by a dental nurse.
- Staff reported incidents and these were investigated and learning implemented to improve safety.
- Governance arrangements were in place for the smooth running of the service. However some staff appraisals were overdue but had been scheduled.

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

- Review the practice's protocols and adopt an individual risk based approach to patient recalls giving due regard to National Institute for Health and Care Excellence (NICE) guidelines.
- Review the practice's protocols and procedures for promoting the maintenance of good oral health giving due regard to guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment, support and supervision of all staff, including staff appraisals.
- Review the current staffing arrangements to ensure all dental staff, including hygienists are suitably supported by a trained member of the dental team when treating patients in a dental setting.
- Review the availability of a hearing loop for patients with hearing difficulties.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had a system in place to identify, investigate and learn from significant events.

The practice had recruited new staff to ensure there were sufficient numbers of suitably qualified staff working there.

Staff had received safeguarding training and were aware of their responsibilities regarding the protection of children and vulnerable adults.

Use of X-rays on the premises was in line with relevant regulations. However evidence of up to date radiation training was not available for one member of staff.

Infection control procedures were in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health. Infection control procedures were audited to ensure they remained effective.

No action



Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The clinicians used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. However we found that consideration had not been given to carrying out recalls in line with patients' individual needs. There was no evidence of identifying children who would have benefitted from a fluoride varnish application.

The staff received on-going professional training and development appropriate to their roles and learning needs. However not all staff had received a recent appraisal of their performance and dental hygienists were not routinely supported by a dental nurse.

Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

The practice had a process in place to make and receive referrals to and from other dental professionals when appropriate to do so.

No action



Are services caring?

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

We received feedback from 32 patients and these provided a positive view of the service the practice provided. Comments reflected that patients were happy with the quality of care they received.

Patients commented on how caring and pleasant the staff were.

No action



Summary of findings

We saw that treatment options were explained to patients in order for them to make an informed decision.

We observed that patients were treated with dignity and respect.

The confidentiality of patients' private information was maintained.

Are services responsive to people's needs?

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

The practice had carried out a Disability Discrimination Access audit and as a result planned to provide wheelchair access and disabled parking space.

The practice had access to telephone interpreter services should they be required but did not have a hearing loop available for use by patients with hearing impairments.

Patients said they were usually able to get an appointment. Patients who were in pain or in need of urgent treatment were seen on the same day.

There was information available to support patients to raise complaints. When complaints had been made they were responded to appropriately and in a timely way.

No action



Are services well-led?

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

There was a new practice manager in post who provided effective leadership with support from an area manager. Staff were clear about their role and responsibilities.

The practice had policies and protocols in place to assist in the smooth running of the practice.

Clinical audit was used as a tool to highlight areas where improvements could be made. The provider also undertook their own internal audits across all areas of the practice in order to identify areas for improvement. We saw that an action plan had been produced as a result of this which was in the process of being implemented.

There was an open culture within the practice and staff told us they were well supported and able to raise any concerns within or outside of the practice.

Feedback was obtained from patients and we saw evidence that this was discussed and acted upon to make changes to the service provided if appropriate.

No action



Oasis Dental Care - Lincoln 2

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

We carried out an announced, comprehensive inspection on 13 October 2016. The inspection was led by a CQC inspector who was supported by a specialist dental adviser and a second CQC inspector.

We reviewed information we held about the practice prior to our inspection.

During the inspection we spoke with dentists, the practice manager, dental hygienists, dental nurses and reception staff.

To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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 systems and processes to report, investigate and learn from significant events and near misses. There was a significant event policy which was dated May 2016. Events were recorded within the practice and then sent to the provider's head office where they were logged and analysed to identify any themes or trends. Events were reviewed and discussed at practice meetings if appropriate to share any learning. For example, we looked at the record of a significant event which related to a sharps' injury. We saw meeting minutes which reflected that the incident had been discussed. This resulted in staff undertaking further sharps training and the protocol being reviewed.

The practice manager demonstrated awareness of the duty of candour and this was encouraged through the significant event reporting and complaint handling process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

There was a system in operation for the practice to receive alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Relevant alerts were logged and included a record of actions taken in response to alerts. We saw evidence of four recent alerts which had been actioned.

We discussed with the practice manager their responsibility in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). They were aware of when a report should be made and accident forms were available which aided staff to consider when a report was necessary. They were also aware of incidents or events that should be reported to the Care Quality Commission.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding children and vulnerable adults which had been reviewed in May 2016. A flow chart detailing the actions a staff member may take if

concerned and contact numbers for raising a concern were available in the safeguarding folder. The practice manager was the safeguarding lead and we saw evidence that staff had received safeguarding training to the appropriate level for their roles. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. An example was given of a safeguarding concern that had been raised and dealt with appropriately.

Discussions with dentists identified they were using rubber dams when providing root canal treatment to patients. This was in line with guidance from the British Endodontic Society. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We saw that rubber dam kits were available and dental care records we reviewed documented when they had been used.

We spoke with staff about the procedures in place to reduce the risk of sharps' injury in the practice. The practice had a risk assessment in place relating to sharps and were moving to using 'safer sharps' throughout the practice in line with the requirements of the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation.

Medical emergencies

The practice had medicines and equipment to manage medical emergencies. These were stored together securely and staff we spoke with were aware how to access them and use them. Emergency medicines were available in line with the recommendations of the British National Formulary.

Equipment for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

Are services safe?

There was a system to ensure that all medicines and equipment were checked on a regular basis to confirm they were in date and serviceable should they be required. Records we saw showed that the emergency medicines, oxygen and the AED were checked on a weekly basis in line with national guidance from the Resuscitation Council UK. These checks ensured the oxygen cylinder was sufficiently full, the AED was fully charged and the emergency medicines were in date. The medicines we checked were in date.

Staff had completed practical training in emergency resuscitation and basic life support in July 2016.

Staff recruitment

The practice had a recruitment policy dated April 2014 which was due to be reviewed in December 2016. We reviewed five staff recruitment files which were well organised and saw evidence that appropriate recruitment checks were present, such as qualifications, photographic proof of identification and registration with the appropriate professional body. There was evidence of checks through the Disclosure and Barring Service (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Monitoring health & safety and responding to risks

The practice had systems in place to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had a health and safety policy and a health and safety poster was displayed in the staff room. Comprehensive health and safety risk assessments had been completed throughout the year and included risk assessments for clinical waste disposal, the autoclave, the washer disinfectant, environmental slips, trips and falls, and lone working.

A fire risk assessment had been carried out in May 2016 and identified actions had been completed. We saw there was an automatic fire detection system and emergency lighting installed within the premises. Staff had received fire safety training and there were appointed fire marshals. Fire drills had last been undertaken in April and October 2016. Weekly checks of equipment such as the fire alarm, emergency lighting and fire extinguishers had been carried out.

There were arrangements to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a comprehensive file of information pertaining to the hazardous substances used in the practice with a risk assessment and safety data sheet for each product which detailed actions required to minimise risk to patients, staff and visitors. We saw that this was updated on an annual basis, having last been reviewed in August 2016.

There was a business continuity policy dated March 2016. This outlined the arrangements in case of a major incident such as power failure, loss of the computer system or incapacity of staff. This gave details of alternative premises to be used if necessary. The plan contained details of contractors who may be required in these instances and staff contact details in order to inform them in an emergency. Staff had signed the plan to indicate they were aware of the arrangements.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' 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 cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy in place which was dated May 2016. This gave guidance on areas which included the decontamination of instruments and equipment, hand hygiene and environmental cleaning of the premises.

The decontamination process was performed in a dedicated decontamination room and we discussed the process with the lead dental nurse who was also the infection control lead.

Instruments were cleaned using a washer disinfectant, a machine for cleaning dental instruments similar to a domestic dish washer. Instruments were then inspected under an illuminated magnifier before being sterilised in an autoclave. At the completion of the sterilising process, all instruments were stored in line with national guidance. We saw that the required personal protective equipment was available to be worn throughout the process.

Are services safe?

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

The practice had a policy for dealing with blood borne viruses. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps' containers, clinical waste bags and general waste were used and stored in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. We saw the relevant waste consignment notices. (When hazardous waste is moved it must be accompanied by correctly completed paperwork called a consignment note.)

Practice staff told us how the dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). They described the method they used which was in line with current HTM 01 05 guidelines. We saw a Legionella risk assessment which had been carried out at the practice by an external company in October 2016. Control measures had been implemented to reduce the risk of legionella in line with the risk assessment which included the monthly monitoring of water temperatures.

We saw that the dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms, the decontamination room and toilet. Hand washing protocols were also displayed appropriately in various areas of the practice.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The practice contracted an external cleaning company to carry out daily cleaning tasks in line with their cleaning schedule. The practice used the nationally recognised colour coding system for cleaning equipment.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in accordance with the Pressure Vessel Regulations 2000. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing had been carried out in October 2016.

The practice had contracts to ensure equipment was maintained, serviced and tested at the appropriate intervals.

Records we reviewed confirmed that batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records.

The practice kept a log of medicines dispensed which included all the appropriate information.

Radiography (X-rays)

There was a Radiation Protection file which contained the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice used intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth).

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS). The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, which were available for technical advice regarding the machinery. The Ionising

Are services safe?

Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and only by qualified staff.

Records showed the X-ray equipment had been inspected in line with the Ionising Radiation Regulations 1999 (IRR 99) which require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive that X-rays were being carried out on the premises. Documentary evidence confirmed this had been completed.

The practice used digital X-rays, which allowed the image to be viewed almost immediately. These also relied on lower doses of radiation and therefore reduced the risks to both the patient and staff.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

We saw evidence that clinical staff were up to date with radiation training as specified by the General Dental Council, with the exception of one staff member.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with both dentists who demonstrated their awareness of National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines in relation to lower wisdom tooth removal and recall intervals. However this was not reflected in a sample of dental care records we were shown which indicated that recall intervals were a standard six months. The NICE guidance in relation to dental recall intervals between oral health reviews recommends that intervals should be determined specifically based on risk for each patient.

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described and showed us records which confirmed how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire and we noted that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

Patients were presented with treatment options and we saw evidence of the advantages, disadvantages and costs being explained.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive. A justification, grade of quality and report of the X-ray taken was documented in the dental care record.

Health promotion & prevention

The practice had one waiting room for patients. A range of health promotion leaflets and information was available relating to good oral health and hygiene. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums such as toothbrushes and mouthwash; these were available in the reception area.

Dentists we spoke with showed a knowledge and understanding of the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. One of the recommendations of this guidance was that children seen at the practice should be offered fluoride varnish application or fluoride toothpaste if they were identified as being at risk. Dental care records we were shown did not demonstrate that this had been considered. Information in the waiting room explained the importance of fluoride and the benefits for patients' teeth.

We saw examples in patients' dental care records that the dentist had provided advice on the harmful effects of smoking and diet and their effect on oral health. Patients were signposted to smoking cessation services. The dental care records we reviewed recorded risk assessments for oral cancer, caries (tooth decay) and periodontal disease (gum disease).

Staffing

The practice was staffed by seven dentists and was able to provide services including the provision of dental implants (a dental implant is a metal post that is placed surgically into the jaw bone to support a tooth) and orthodontic treatment (where malpositioned teeth are repositioned to give a better appearance and improved function). They were supported by two dental hygienists, ten dental nurses, a practice manager and five receptionists. Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). On the day of our inspection we also saw evidence of current professional indemnity cover for all relevant staff.

The practice manager had taken up post in April 2016. They told us there had been difficulty recruiting dentists prior to this but we saw that effective recruitment had taken place and new dentists were due to start which would mean the practice would be fully staffed. We found that staff had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dental

Are services effective?

(for example, treatment is effective)

professionals. The training needs of staff were monitored by the practice manager as they had reviewed training needs and introduced a training matrix. We saw there was a comprehensive new staff induction agenda and process.

We were told the dental hygienists normally worked without chairside support but support was available when requested. This was not in line with the General Dental Council's Standard (6.2.2) for the Dental Team which recommends dental staff being supported by an appropriately trained member of the dental team when treating patients in a dental setting. However the practice had a lone working risk assessment and told us they planned to provide this support going forward.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding.

Working with other services

The practice manager explained how they worked with other services when required. Dentists referred patients to a range of specialists in primary and secondary services if the treatment required was not available in the practice. There were not a large number of referrals due to the skill mix of dentists within the practice and the services they were able to provide such as orthodontics, implants and periodontal treatment. This meant the practice received incoming referrals and had an effective system in place for accepting referrals from general dental practitioners.

The practice also had a system to track and follow up urgent referrals to ensure patients were seen in a timely manner.

Consent to care and treatment

The Mental Capacity Act 2005 (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. Dentists we spoke with demonstrated their understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment. They also demonstrated their understanding regarding Gillick competence which relates to children under the age of 16 being able to consent to treatment if they are deemed competent.

There was a consent policy dated September 2016. We found that the dentists had a clear understanding of consent issues and that they explained different treatment options and gave the patient the opportunity to ask questions before gaining consent. The dentists we spoke with were able to describe clearly the process they used to obtain valid and informed consent. This included discussing the options for treatment, as well as any alternatives, and the advantages and disadvantages of any particular option. Information was also available relating to certain treatments which patients could take away and make decisions in their own time if necessary.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before our inspection, Care Quality Commission (CQC) comment cards were left at the practice to enable patients to tell us about their experience of the practice. We also spoke with patients on the day of our inspection. We received feedback from 32 patients which provided a positive view of the service the practice provided. Patients expressed satisfaction with the quality of care they had received and told us that they were treated with dignity and respect. Staff were described as pleasant, helpful and caring. During the course of our inspection we observed staff interacting with patients and noted that they were friendly and professional.

The confidentiality of patients' private information was maintained as computer screens were not visible at reception which ensured patients' confidential information could not be seen.

Involvement in decisions about care and treatment

Our discussions with dentists, reviews of dental care records and feedback from patients made it clear that patients were given treatment plans which contained details of treatment options and the associated cost.

There was information displayed in the waiting room on the prices of private and NHS treatments available and included details of the various monthly payment plans available at the practice. This information was also available on the practice's website.

Patients commented that they were listened to by all staff enough time was allocated to explain and discuss treatment options and implications with them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we toured the premises and found that the practice had good facilities and was well equipped to treat patients and meet their needs.

We looked at the variety of information available to patients. We saw that the practice waiting area displayed a wide range of information. This included a patient information folder and leaflets about the services offered by the practice and information available covered complaints information, the cost of treatments, opening hours and arrangements for both when the practice was open and when it was closed. The practice's website also contained comprehensive information for patients about different types of treatments available at the practice.

We reviewed the appointment system and saw that sufficient time was given for each type of appointment to allow for adequate assessment and discussion of patients' needs. This was also reflected in patient feedback.

The practice manager told us that when they took up post they were aware of some patient dissatisfaction with the cancellation of appointments and availability of appointments due to staffing issues. We saw that this had been addressed by effective recruitment as new dentists had been employed. Some comments we received reflected that patients had had appointments cancelled and preferred to have permanent dentists rather than locums. Other patients commented that they had always been able to get appointments easily and did not usually have to wait to be seen beyond their appointment time.

Tackling inequity and promoting equality

Practice staff told us that they always treated patients equally but at the same time were aware of the need to accommodate their individual needs.

The practice had made some adjustments to enable patients to access their services. The practice had access to an interpreting service to support patients whose first language was not English. The practice did not have a hearing loop to assist hearing aid users.

The practice had carried out a Disability Discrimination Access Audit in April 2016. This highlighted that while the premises were purpose built with all facilities on one level,

they were not wheelchair accessible as access to the building was by means of a set of steps. The practice manager told us they were progressing with making the practice accessible as they had plans to install ramped access and a disabled parking space. In the meantime they were able to refer patients to their sister practice nearby. The NHS choices website stated that the practice was not wheelchair accessible.

Access to the service

The practice was open from 8.00am to 7.00pm Monday, Tuesday and Thursday, from 8.00am to 8.00pm on Wednesdays, from 8.00am to 5.00pm on Friday, and on alternate Saturdays from 9.00am to 1.00pm. The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised through the telephone answering service when the practice was closed.

The practice told us they would arrange to see a patient on the same day if they were in pain or it was considered urgent. Patients commented that they had been seen quickly when their need was more urgent.

Concerns & complaints

The practice had an effective system for handling complaints and concerns.

There was a complaints policy and procedures dated March 2016. These were in line with recognised guidance and contractual obligations for dentists in England. The practice manager was the designated person responsible for handling all complaints in the practice.

We saw that information was available to help patients understand the complaints system. This was available in the reception area in the patient information folder. There was also comprehensive information available on the practice's website.

We looked at the eight complaints which had been received in the last 12 months and found these had been satisfactorily handled in a timely way. Lessons were learnt from individual concerns and complaints. Action was taken as a result to improve the quality of care where appropriate. We saw evidence that complaints were discussed at practice meetings in order to share any learning with staff.

Are services well-led?

Our findings

Governance arrangements

There was a governance framework which provided a staffing structure whereby staff were clear about their own roles and responsibilities.

Practice specific policies were available to all staff which had been regularly updated. We reviewed policies which included those relating to infection control, health and safety, complaints and safeguarding children and vulnerable adults.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

The team within the practice was led by the practice manager. There was also support available from an area manager. Staff told us they felt able to raise concerns and were listened to and supported if they did so. They also told us they worked well together as a team.

The practice was aware of the duty of candour and this was demonstrated in the records we reviewed relating to incidents and complaints.

We saw evidence of monthly staff meetings which staff were encouraged to participate in fully. The meetings had a set agenda, were minuted and were displayed in the staff room for staff unable to attend. The practice manager also circulated a memorandum on a weekly basis to keep staff up to date with any relevant information.

Learning and improvement

In the last year, the practice had undertaken audits in order to monitor quality and to make improvements. There were action plans documented as a result of the audits. We saw that infection control audits had been completed regularly, the last ones being in March and September 2016 and that the areas identified in the corresponding action plan had been completed.

We saw that an X-ray audit had been completed in September 2016 and an audit of clinical record keeping had also been undertaken in March 2016.

The practice ensured that all staff underwent regular training in cardio pulmonary resuscitation (CPR), infection control, safeguarding of children and vulnerable adults and dental radiography (X-rays). Staff development was by means of online training, staff meetings and attendance on external courses. Staff was supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that clinical staff were up to date with the recommended CPD requirements of the GDC with the exception of one staff member for whom evidence of up to date radiation training was not available.

We saw evidence of appraisal in some staff recruitment files and saw that any which were not up to date were scheduled to take place.

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

The practice received on-going feedback from patients by means of making feedback forms available in the waiting room and reception staff asking patients to complete them. They also monitored the feedback on the NHS choices website and responded to comments made on this forum.

The practice aimed for a return of at least 40 feedback forms a month in order to get a representative view from patients. We saw evidence in the minutes of practice meetings which reflected that patient feedback was regularly discussed as a team and where possible changes implemented. The results of the feedback were displayed in the waiting room and updated on a monthly basis. A theme identified from the feedback was issues with continuity of staffing and cancellation of appointments. The practice manager was aware of this and told us this was the result of staffing and recruitment changes which were being resolved as new staff had been recruited.

The minutes of practice meetings demonstrated that staff were able to raise issues for discussion and staff told us these were acted upon.