Dr. Perminder Chaggar

Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 20 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

Dr. Perminder Chaggar's Dental Practice is located in the London Borough of Richmond-upon-Thames. The premises are situated on the ground floor of converted residential building in a high-street location. There is one treatment room, a decontamination room, a reception and waiting area, a patient toilet, and a staff office.

The practice provides private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges. The practice also offers intravenous conscious sedation for some treatments.

The staff structure of the practice consists of a principal dentist, a dental nurse, a trainee dental nurse, and a receptionist.

The practice opening hours are Monday to Wednesday from 8.30am to 5.00pm.

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

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Summary of findings

Twelve people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection. However, some improvements to the infection control processes were identified on the day of the inspection; these were promptly resolved by the provider.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- There were effective arrangements in place for managing medical emergencies.
- Equipment, such as the autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced. However, the ultrasonic bath and air compressor had not been serviced at the time of the inspection. The provider sent evidence after the inspection to confirm that these items had been serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients. However, there were some areas where the need for additional staff training was identified during the course of the inspection. The provider subsequently confirmed that the relevant training courses had been booked.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services. However, there were some areas where governance arrangements could be strengthened through the use of additional risk assessments or audits. The provider assured us that these systems would now be implemented.

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

- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review it's responsibilities as regards to the Control of Substances Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification and records of qualifications are requested and recorded suitably.
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. We found the equipment used in the practice was well maintained and checked for effectiveness.

We identified some improvements that were required to the infection control protocols. The practice subsequently confirmed that action had been taken in this area.

No action ✓

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff told us they were well-supported and supervised by the principal dentist. Staff engaged in continuous professional development (CPD) and were working towards meeting all of the training requirements of the General Dental Council (GDC). However, one member of staff had not completed safeguarding training, at the time of the inspection, and also needed to renew their medical emergency training. The practice confirmed with us that the safeguarding training had been completed and the medical emergency training had been booked.

No action ✓

Are services caring?

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

We received positive feedback from patients through comment cards and by speaking with patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

No action ✓

Are services responsive to people's needs?

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

No action ✓

Summary of findings

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. The practice was wheelchair accessible with the treatment room situated on the ground floor.

There was a complaints policy in place and the practice actively sought feedback from staff and patients with a view to monitoring the quality of the care.

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 clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. However, further improvements were needed, for example, in terms of monitoring risk related to the Control of Substances Hazardous to Health (COSHH), as well as through the use of regular infection control audits. Some improvements in terms of staff record keeping were also identified. The principal dentist was responsive to our feedback and implemented changes immediately after the inspection.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist or practice manager. They were confident in the abilities of the principal dentist and practice manager to address any issues as they arose.

Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 20 September 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with three members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The trainee dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Twelve people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents and accidents. There was an incident reporting policy and an accidents reporting book. Staff understood the process for accident reporting, including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

The principal dentist told us they were committed to operating in an open and transparent manner; they would always inform patients if anything had gone wrong and offer an apology in relation to this. However, they were not specifically aware of the Duty of Candour, but confirmed with us that they would review this regulation and share their findings with the rest of the team. [Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

The practice had a well-designed safeguarding policy which referred to national guidance. The principal dentist was the named practice lead for child and adult safeguarding. Information about the local authority contacts for safeguarding concerns was displayed in the staff room.

Staff were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia. There was evidence in staff records showing that the principal dentist had been trained in safeguarding adults and children to an appropriate level. However, the receptionist had not had formal safeguarding training at the time of the inspection. The principal dentist sent us evidence two days after the inspection confirming that this training had now been completed.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. There was a written protocol for staff to follow in the event that they did experience a needle stick injury. The practice also followed a protocol to minimise needle stick injuries during the administration of local anaesthetics. The dentist used a 'safer sharps' system where a sliding, protective sheath covered the needle between use, and also during disposal of the syringe. The principal dentist told us they disposed of the syringes themselves, directly after use, in the sharps box located in the treatment room.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. Rubber dam should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in patients' dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction, in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

The clinical staff had all received annual training in using the emergency equipment. However, the receptionist had not completed such training in the past year. They receptionist confirmed that this training had been booked for October 2016.

Staff recruitment

Are services safe?

The staff structure of the practice consists of a principal dentist, a dental nurse, a trainee dental nurse, and a receptionist.

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

We checked the staff recruitment records, including those for two members of staff who had been recruited within the past two years. We saw that the majority of documents related to the recruitment process had been kept, but that some elements were not routinely placed in the records.

We queried the completeness of the files with the principal dentist. They told us that the dental nurse had been recruited through an agency and that it had been the agency's responsibility to source all relevant documentation, including CV, qualifications and references. There was a formal agreement in place between the practice and the agency to this effect. In the case of the recruitment of the trainee dental nurse, the principal dentist had worked with the trainee at another practice over the course of a year, thus precluding the need to seek references. Further improvements could be made to the staff records by ensuring consistency in the recording of identification, employment histories, and qualifications.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check prior to employment. (The 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

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were monitored by the receptionist via email. These were disseminated at staff meetings, where appropriate.

There was a business continuity plan in place. There was an arrangement in place to use one of the provider's other practice locations for emergency appointments in the event that the practice's own premises became unfit for use.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. However, this file had not been updated for some time and the information contained in the file was limited. The principal dentist assured us that a thorough review of the contents of the file would be implemented.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste.

The practice had not carried out any practice-wide infection control audits in line with the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. HTM 01-05 guidance. The principal dentist told us that an infection control audit would now be carried out by the end of the month (September 2016).

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in the treatment room. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment room, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the trainee dental nurse to demonstrate the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the

treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept indicating water temperature checks had been regularly carried out, but a record of the actual temperatures reached had not been maintained. The receptionist, who carried out these tests, assured us that such a record would now be kept.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The trainee dental nurse demonstrated the cleaning and sterilisation process to us. Instruments were manually cleaned prior to being placed in an ultrasonic bath. Items were then inspected under a light magnification device prior to being placed in an autoclave (steriliser). We noted that items were cleaned above the water, which increased the risk of aerosol exposure.

When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the ultrasonic bath and autoclave were working effectively. These included, for example, the automatic control test and steam penetration test for the autoclave and the 'foil' test for the ultrasonic bath. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

We found that the ultrasonic bath had not been serviced within the past year. We discussed our concerns with the principal dentist who assured us that a manual cleaning protocol would now be followed until the ultrasonic bath had been properly serviced.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme. There was a cleaning schedule for staff to follow which described daily, weekly and monthly tasks.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.) However, in one case, the practice had only kept a record indicating that the immunisation process had commenced, but not the outcome of a subsequent blood test to confirm immunity. We discussed this with the principal dentist and relevant member of staff. They told us that such a blood test would now be sought.

Equipment and medicines

We found that the majority of the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that fire equipment,

Are services safe?

autoclave and X-ray equipment had all been inspected and serviced. The principal dentist told us that their engineer had inspected the air compressor on the day after the inspection.

We found that the ultrasonic bath had not been serviced within the past year. The principal dentist sent us evidence after the inspection confirming that the bath had been sent for a service; a manual cleaning protocol had been implemented in the interim.

Portable appliance testing (PAT) had been completed in accordance with good practice guidance in May 2016. PAT is the name of a process during which electrical appliances are routinely checked for safety.

A small number of medicines, such as amoxicillin, were dispensed by the practice. These were correctly labelled and a log book was kept in relation to any items that were dispensed. The principal dentist demonstrated that they correctly wrote out private prescriptions.

The principal dentist also carried out conscious sedation on site. (Conscious sedation is a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The practice kept small stocks of the medicines used in intravenous conscious sedation, (e.g. Midazolam and the reversal agent Flumazenil). We found that these were stored appropriately and were in date. The batch number and expiry dates of Midazolam along with the amounts used were recorded during each episode of conscious sedation in each patient's dental care record.

We found that the practice was meeting the standards set out in the guidelines published by the Standing Dental Advisory Committee: "Conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry" (Department of Health 2003). The principal dentist was aware of the updated guidance issued in 2015 and was working towards achieving the standard outlined in the 2015 guidance.

The expiry dates of medicines, oxygen and equipment were monitored using weekly and monthly check sheets which enabled the staff to replace out-of-date drugs and equipment promptly.

Radiography (X-rays)

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules.

We saw evidence in the staff records which showed they had completed radiography and radiation protection training.

Audits on X-ray quality were undertaken at regular intervals.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The principal dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. They described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed 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 were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies.

The principal dentist was aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting).

They told us they held discussions with their patients, where appropriate, around effective tooth brushing, smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting areas. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff records to confirm that this was the case. We noted that staff training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and radiography and radiation protection training. Staff involved in providing conscious sedation had regularly renewed their training on this topic.

However, we identified some gaps in staff training at the time of the inspection. Two members of staff needed to complete safeguarding training and one member of staff was also overdue for renewing their training in responding to medical emergencies. The principal dentist sent us evidence two days after the inspection demonstrating that the safeguarding training had been completed and a date set for the medical emergencies training.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they were engaged in an appraisal process on a yearly basis. This reviewed their performance and identified their training and development needs. We checked some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

Working with other services

Are services effective?

(for example, treatment is effective)

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The principal dentist and receptionist explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for implants or more complicated extractions.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the principal dentist about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

The principal dentist was aware of the Mental Capacity Act 2005. (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). They could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received, and the patients we spoke with, all made positive remarks about the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. We saw that the treatment room door was closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in an electronic format. Records stored on the computer were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the private dental charges or fees.

Staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. The dentist decided on the length of time needed for their patient's consultation and treatment. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

The receptionist told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting room displayed a variety of information including opening hours and practice policy documents. The practice had a website which reinforced this information.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. There was an equality and diversity policy which staff were following.

Staff spoke a range of different languages, which supported some patients to access the service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired. The practice was wheelchair accessible with access to the treatment rooms on the ground floor and a disabled toilet.

Access to the service

The practice opening hours are Monday to Wednesday from 8.30am to 5.00pm.

The reception staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentists in the event of needing emergency treatment.

We asked the reception staff about access to the service in an emergency or outside of normal opening hours. Calls from patients were redirected to a member of staff's mobile phone so that they could assess the urgency of need. The principal dentist then contacted the patient directly to discuss their concerns. The dentist saw the patient on the same day, if necessary, or gave further information on how to access out-of-hours emergency treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the waiting room. The staff we spoke with were aware of the contents of the complaints policy. No complaints had been received in the past year.

The practice periodically assessed patient satisfaction through the use of a survey. The most recent of these had been carried out in the past year and sought to identify any concerns around waiting times. The results of this audit had been discussed at a staff meeting.

Patients were also invited to give feedback through the use of a suggestions box situated on the reception desk.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

Staff told us there were regular staff meetings to discuss ongoing concerns and key governance issues such as infection control. We reviewed minutes from these meetings and saw that they covered a range of topics including safeguarding, infection control and staffing levels.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. These were regularly reviewed and staff were following protocols to mitigate risk. There was one area where a risk assessment was required in relation to the Control of Substances Hazardous to Health (COSHH).

We also found that infection control procedures were generally robust, but that further improvements were required to cleaning protocols and equipment monitoring

Records related to patient care and treatments were kept accurately. Staff records were generally well maintained, although improvements could be made, for example, in relation to the recording of references during any recruitment process.

The principal dentist was responsive to our feedback in these areas. They sent us evidence after the inspection confirming that the issues had been addressed.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring and committed to their work and overall there was a sense that staff worked together as a team.

There was a system of yearly staff appraisals to support staff in carrying out their roles to a high standard. Notes from these appraisals also demonstrated that they identified staff's training and career goals.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits of clinical record keeping, waiting times, and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made.

The auditing system demonstrated a generally high standard of work with only small improvements required. We saw notes from meetings which showed that results of audits were discussed in order to share achievements or action plans for improving performance.

However, the system of audits had not included a six-monthly review of infection control practices. We identified some need for improvement in this area. The principal dentist confirmed that regular infection control audits would now be carried out.

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC). There were some training gaps that we identified during the course of the inspection. The practice sent us evidence after the inspection to demonstrate that these were being addressed.

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

The practice gathered feedback from patients through the use of a comments box in the reception area and through the use of patient surveys. The most recent of these had been carried out in the past year and sought to identify any concerns around waiting times. The results of this audit had been discussed at a staff meeting.

Staff told us that the principal dentist was open to feedback regarding the quality of the care. They had also been engaged in a staff survey during the past year. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.