Care Quality Commission

Tradex Services Limited

Orpington Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 01 October 2015 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

Orpington Dental Care practice is located in the London Borough of Bromley. The premises are laid out over the ground floor with a shop front on a high street location. There are four treatment rooms, a dedicated decontamination room, waiting room with reception area, staff room, and toilet.

The practice provides private dental services for adults and NHS and private services for children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), three associate dentists, two hygienists, five dental nurses, and two receptionists. There was also an anaesthetist who was contracted to provide sedation services, when required.

The practice opening hours are from 8.00 am to 5.00pm on Monday, 8.00am to 7.00pm on Tuesday and Wednesday, 8.30am to 4.00pm on Thursday and 8.00am to 3.00pm on Friday.

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

Summary of findings

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

Sixteen 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.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- 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.
- The principal dentist 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.

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

- Review and update the complaints policy to reflect changes in personnel and regulations, and put in place a system for identifying trends in complaints over time.
- Review and undertake additional risk assessments, and implement associated risk reduction protocols, in relation to the location of the air compressor and X-ray equipment (OPG), as well as for the safe use of sharp dental instruments.
- Review staff training to ensure that dental nursing staff who are assisting in conscious sedation have the appropriate training and skills to carry out the role giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care' (2015).
- Review recruitment procedures to ensure that references for new members of staff are sought prior to the commencement of the employment contract.

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. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control and medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

We found the equipment used in the practice was well maintained and checked for effectiveness. The location and use of some items of equipment presented some additional risk to staff or patients. This should have been considered and minimised through risk assessment processes.

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.

Conscious sedation was undertaken by a qualified, visiting anaesthetist. The dental nurses demonstrated a good understanding of their role in conscious sedation. They were well-supervised by the anaesthetist. However, they had not had the formal training to carry out this role.

Staff had engaged in continuous professional development (CPD) and were meeting all of the other training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

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 checking the results of the practice's own patient satisfaction survey. 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.

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 access to telephone interpreting services to support people who did not have English as their first language. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment rooms on the ground floor. Patients were invited to provide feedback via a satisfaction survey.

Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

Summary of findings

There was a complaints policy in place and we saw that complaints received in the past year had been acted on in line with this policy. However, the policy had not been updated to reflect the new arrangements as regards which member of staff had responsibility for investigating complaints. The practice could also make improvements by monitoring complaints to identify trends over time and use staff meetings effectively to share learning about the outcomes of different complaints.

Are services well-led?

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. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose. However, improvements could be made to strengthen the governance structures and protocols.

Care Quality Commission

Orpington Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 01 October 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit we reviewed policy documents and spoke with six members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We asked one of the dental nurses to demonstrate how they carried out decontamination procedures of dental instruments.

Sixteen 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. Two incidents had been recorded in the past year. There was a policy for staff to follow for the reporting of these events and the staff we spoke with were aware of the reporting procedures. The records kept relating to the incidents noted actions taken at the time as well as areas for improvement which could be shared with staff. For example, changes to the premises, equipment and staffing structures were discussed at staff meetings.

There was also a Duty of Candour policy which directed staff to operate in an open and transparent manner in the event that something went wrong. This included offering patients an apology if they identified that something had gone wrong.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was a book for the recording of any accidents.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. The safeguarding lead was 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.

The practice had a well-designed safeguarding policy which referred to national guidance, held evidence of staff training and local authority telephone numbers for escalating concerns that might need to be investigated. This information was displayed in the staff room so that staff could act promptly in response to any concerns.

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, there was a risk assessment and associated protocol in relation to fire safety. Staff received training in fire safety and there was a named fire marshal. Emergency exit routes were shown on the back of each surgery door and an appropriate assembly point outside had been established.

The practice did not have a formal, written risk assessment, and associated risk-reduction protocol, for the safe handling of sharps (e.g. needles used for injections). However, our discussions with staff demonstrated that all staff were following the same sharps protocol, for example, the re-sheathing and disposal of needles was the responsibility of the dentist. There was also a written protocol for what to do in the event of a sharps injury or accident.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance supplied by 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.]

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. 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. An automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction, were available 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 emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the locations of the emergency equipment.

Staff recruitment

The practice staffing consisted of a principal dentist, three associate dentists, two hygienists, five dental nurses, and two receptionists. There was also an anaesthetist who was contracted to provide sedation services, when required.

There was a recruitment policy in place and we reviewed the recruitment files for four staff members. We saw that relevant checks to ensure that the person being recruited was suitable and competent for the role had been carried out. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We noted that

it was the practice's policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff and details related to these checks were kept. However, in one instance we found that a newly recruited member of staff had references requested, but these had not been received prior to the staff member starting work.

Some patients required conscious sedation as part of their treatment. The practice used a visiting medical anaesthetist to provide this service. The practice did not have a written agreement in place to provide assurance that the visiting professional was providing services in accordance with current guidelines. However, we met with the anaesthetist on the day of the inspection who assured us that this agreement had been discussed and would now be signed by both parties. The documentation supplied by the anaesthetist also covered their suitability for the role, including relevant background checks and provision of evidence regarding current qualifications.

There were also documents available which described the responsibilities and accountability of the visiting professional which were shared with patients prior to any procedure. It included information about the systems, processes and the equipment and medicines in relation to conscious sedation service that the professional provided.

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.

There were effective 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. This file was in the process of being updated at the time of the inspection. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

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 received by the principal dentist and disseminated where appropriate to the staff.

There was a business continuity plan in place. There was an arrangement in place to use another practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts in the local area were displayed in the staff room for prompt access in the event that a maintenance problem occurred at the premises.

Infection control

There were systems in place to reduce the risk and spread of infection. 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 head dental nurse was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were 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.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms and the toilets.

The practice had followed 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)'. 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.

We examined the facilities for cleaning and decontaminating dental instruments. There was one decontamination room. It was well organised with a clear flow from 'dirty' to 'clean'. One of the dental nurses demonstrated how they used the room. They showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. The practice used a system of ultra-sonic cleaning bath and manual scrubbing (utilising the double sink method) as part of the initial cleaning process. Following inspection of cleaned items,

they were placed in an autoclave (steriliser). When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines.

The dental nurse showed us that systems were in place to ensure that the autoclaves and ultra-sonic bath were working effectively. These included the automatic control test and steam penetration tests for the autoclave and foil tests for the ultrasonic cleaning bath. It was observed that the data sheets used to record the essential daily validation were complete and up to date.

The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread. The treatment rooms were generally well-maintained, although we noted that one chair had an arm removed and the remaining joint was not covered. This may have posed an environmental risk as adequate disinfection between patients could not be completed. We were told a new chair had been ordered and the principal dentist agreed to cover this area in the meantime.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. For example, we observed that sharps containers, clinical waste bags and municipal waste were properly maintained and stored. The practice used a contractor to collect dental waste from the practice. Waste consignment notices were available for inspection.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an appropriate contractor in August 2015. The contractor had been engaged to carry out continuous and regular monitoring of the water systems.

The practice had carried out practice-wide infection control audits every six months, with the most recent one having been completed in May 2015. Issues that were identified during the audit were discussed at staff meetings and acted on. For example, we noted that instrument trays for one of the sterilisers had been replaced following an audit.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced in 2015. We observed that the air compressor was behind a cupboard door in the decontamination room. This may have posed a fire risk as there was not adequate ventilation around the equipment, although this had not been identified in the practice's own fire risk assessment. We discussed this with the principal dentist who agreed that a ventilation hole in the cupboard was needed and would be put in place.

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

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

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

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection file, in line with these regulations, was present. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive. The maintenance log was within the current recommended interval of three years with the next service due in 2018. We saw evidence that staff had completed radiation training.

The practice had not carried out a radiological audit to check the quality of X-rays carried out at the practice. There was a list of audits due to be carried out in the next year, which included an audit of X-ray quality. We also checked a random sample of dental care records and noted that X-rays were justified, reported on and quality assured every time.

Are services safe?

We observed that the Orthopantomogram (OPG) – (a panoramic scanning dental X-ray of the upper and lower jaw) machine was located in a lead-lined corner, off the main corridor, and was not fully enclosed. The direction of the X-ray was towards the back wall. We asked the principal dentist about arrangements regarding patients or staff walking in the vicinity during an X-ray. They told us that the protocol was to check that the toilet and corridor was clear prior to taking the X-ray. However, there was no written risk assessment or protocol for sharing with staff to ensure that risks were minimised.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with two dentists about how they carried out patient assessments and checked a random sample of their records to confirm their descriptions. All patients had their medical history reviewed prior to an examination of the condition of the patient's teeth, gums and soft tissues. Patients were all made aware of the condition of their oral health and any changes since the last appointment were discussed. Treatment options were explained and the dental care record updated with details of these discussions. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Our check of dental care records showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw notes containing details about the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). These were carried out at each dental health assessment. Details of the treatments carried out were also documented; local anaesthetic details including type, site of administration, batch number and expiry date were recorded.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist 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 area; including information aimed at engaging children in good dental hygiene practices. 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 reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and X-ray 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 had been engaged in yearly appraisals which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had a development plan in place.

However, we noted that some of the dental nurses were providing assistance during sedation procedures, but did not have any formal training in this area. Guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care' (2015) state that all members of the care team must undertake appropriate, formal training. We discussed the arrangements for carrying out sedation with the nurses and visiting anaesthetist. The dental nurses were well-supervised by the anaesthetist and demonstrated a good awareness of their role during the procedures. All of the nurses had relevant training in responding to medical emergencies. The principal dentist also assured us that they would enrol the dental nurses on a relevant training course at the earliest possible date.

Working with other services

The principal dentist and one of the associate dentists explained how they worked with other services, when required. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. 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

Are services effective?

(for example, treatment is effective)

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, though was not routinely supplied.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the dental care records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments, such as tooth extraction.

Staff were aware of the Mental Capacity Act 2005. They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from 16 patients. They described a positive view of the service. Patients commented that the team were courteous, friendly and kind. Patients were happy with the quality of treatment provided. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically. Any paper correspondence was scanned and added to the electronic record. Electronic records were password protected and regularly backed up; paper records were stored securely and were locked up. Staff understood the importance of data protection and confidentiality and had received training in information governance. Reception staff told us that people could request to have confidential discussions in an empty treatment room, if necessary

The practice had recently started to obtain feedback from patients via a satisfaction survey and through the use of the 'Friends and Family Test'. The practice had engaged an external company to analyse results received through these surveys and to monitor the NHS choices website for feedback. They had received 45 responses either through the satisfaction survey or the NHS choices website in the past two months. The feedback indicated that people were largely satisfied with the care they received. The principal dentist had acted on feedback to improve the service. For example, the feedback had indicated some problems with the automated appointment reminder system which they had aimed to address through the installation of new computer software.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the NHS and private dental charges and fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We checked a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments. However, we also noted that some of the complaints received in the past year related to explanations about fees, indicating that more work could be done to improve communication in this area.

We spoke with the principal dentist, one of the associate dentists, one of the dental nurses, and both members of the reception team on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. The patient feedback we received via comments cards, together with the data gathered by the practice's own survey, confirmed that the majority of 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' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The dentists we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

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. The practice had access to a telephone translation service, although they had not had to use this so far. There was written information for people who were hard of hearing as well as a hearing loop in the reception area. Large print documents for patients with some visual impairment were also available. The three of the four treatment rooms were wheelchair accessible. There was also a disabled toilet accessible via a portable ramp.

Access to the service

The practice opening hours were from 8.00 am to 5.00pm on Monday, 8.00am to 7.00pm on Tuesday and Wednesday, 8.30am to 4.00pm on Thursday and 8.00am to 3.00pm on Friday.

The practice displayed its opening hours at their premises and on their website. New patients were also given a practice information leaflet which included the practice contact details and opening hours.

The reception staff we spoke with told us that the dentists planned some gaps in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the electronic appointments system and saw that this was the case.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. Reception staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could generally get an appointment when they needed one and that they had adequate time scheduled with the dentist.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area and on the practice website. The practice also had a feedback box displayed in the waiting area.

There was a complaints policy which described how the practice handled formal and informal complaints from patients. We noted that this policy had not been updated since a recent change in personnel to reflect the new member of staff responsible for investigating complaints. The principal dentist told us that a member of the reception team was responsible for handling complaints, with clinical input from themselves. However, this member of the team stated that the principal dentist was the lead for managing complaints.

There had been eleven complaints recorded in the past year. These complaints had been responded to in line with the practice policy. A record was kept of what had occurred, actions taken at the time, as well as wider changes that were implemented to policies and protocols to prevent problems from recurring. We noted that the discussion of complaints was a set agenda item at each staff meeting. However, we reviewed meeting notes and could not find evidence that any specific complaints had been discussed with a view to sharing information and learning points. The complaints had also not been monitored to identify trends over time. For example, four out of the eleven complaints related to misunderstandings about fees for treatments

Patients had received a written or verbal response following the investigation of any complaint. However, the practice policy did not explicitly state that an apology would be given. We noted some examples where the records showed that an apology had been offered.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements with a management structure. The principal dentist was in the process of changing the management structure. The new structure would require the principal dentist to lead on governance issues with the support of a head nurse and head receptionist.

The majority of records, including those related to patient care and treatment, as well as staff employment, were kept accurately. However, there was one instance where a member of staff had started work without references having been obtained.

There were relevant policies and procedures in place. Staff were aware of these policies and procedures and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were areas where the further risk assessments could be used to review risk and formalise arrangements for the reductions of risk. This included assessing the location of the air compressor, the OPG equipment and the handling of sharp dental instruments.

The principal dentist had organised staff meetings, where necessary, to discuss key governance issues. For example, we saw minutes of meetings held throughout the year where discussions about maintenance, confidentiality, NICE guidelines, and infection control had been held.

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. Staff told us they enjoyed their work and were well supported by the management team. Staff appraisals were used effectively to discuss their own performance, experience of working at the practice, and career goals.

We spoke with the principal dentist who outlined the practice's ethos for providing good care for patients. They had a clear vision about the future of the practice which included making improvements to the premises and implementing changes to the management structure with a view to improving governance arrangements. Staff were aware of these plans and shared the overall ethos.

Learning and improvement

The practice had a rolling programme of clinical audit and risk assessments in place. There were audits for infection control and clinical record keeping. There was a clear plan for a range of other audits to be carried out in the coming months. This included an audit of X-ray quality.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). 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 GDC. However, the principal dentist had not identified the need to provide additional training for dental nurses who were assisting in conscious sedation procedures.

We also found that practice meetings were scheduled to take place regularly with a set agenda to discuss a range of governance issues, including complaints and incidents. However, the minutes from these meetings indicated that this agenda was not being followed. This meant that opportunities to share learning following adverse events were missed. For example, an incident had occurred with a patient relating to a spill of some liquid during a procedure in February 2015. This had led to a complaint by the patient. The next staff meeting (held in May 2015) had complaints as a topic on the agenda, but the notes from the meeting indicated that no complaints had been discussed. The dentist involved in the incident had taken action at the time to prevent a recurrence by changing the type of protective equipment used during the procedure. However, there was no evidence that this prevention strategy had been shared with the staff.

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

The practice had started to gather feedback from patients through the use of a patient satisfaction survey. The survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The majority of responses indicated a high level of

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satisfaction. We noted that the practice acted on feedback from patients where they could. For example, the principal dentist had investigated problems with the automated appointment reminder system.

Staff commented that the principal dentist was open to feedback regarding the quality of the care. The staff meetings also provided an appropriate forum in which to give their feedback.