Buckingham House Dental Surgery

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 1 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

Buckingham House has been a dental practice for 97 years. It is situated in a residential area of Malvern, Worcestershire and provides private dental treatment for all age groups. The practice has five dentists (two of whom are the partners who own the practice), nine dental nurses, two dental hygienists/therapists and one dental hygienist. The team also includes a trainee dental nurse and an apprentice dental nurse. The clinical team are supported by a practice manager (who is also a registered dental nurse), an accounts manager and a team of reception staff.

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

The practice has six dental treatment rooms and a separate decontamination room for the cleaning, sterilising and packing of dental instruments. There are steps into the building from the car park but the practice

Summary of findings

provides portable ramps to assist patients unable to walk up these. There is level access throughout the ground floor where four of the treatment rooms are located. There are waiting rooms on the ground and first floors; these are separate from the reception area which helps provide privacy when reception staff are dealing with patients. There is a wheelchair accessible patient toilet with grab rails and a call bell system.

The practice is open from 8.30am to 5pm Monday to Friday.

Before the inspection we sent Care Quality Commission comment cards to the practice so patients could give us their views about Buckingham House. We collected 48 completed cards and looked at the practice's November 2015 patient survey results based on 116 responses. All the information we gathered about patients views of the practice were positive. Most of the comment cards included detailed comments from patients and all were positive. Patients described the dentists and the other members of the practice team as professional, courteous and caring. Many commented that their dentist provided clear explanations about the treatment they needed. Most specifically mentioned the high standards of cleanliness and hygiene at the practice. Of the 116 patients who completed a practice survey form 98% said they would recommend the practice to family or friends.

Our key findings were:

- The practice was visibly clean and feedback patients provided confirmed this was their usual experience.
- The practice had suitable child safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- The practice had clear processes for dealing with medical emergencies and for maintaining the equipment used at the practice.
- Dental care records provided clear information about patients' care and treatment and the practice were actively developing their approach to this.
- Staff received training appropriate to their roles and supported to meet the continuous professional requirements of the General Dental Council.
- Patients were able to make routine and emergency appointments when needed.
- The practice used in-house patient surveys, a suggestions box, social media and staff surveys to enable patients and staff to give their views about the practice.
- Patients were positive about the service provided by the practice and spoke highly of the practice team and the service they received.
- The practice had comprehensive governance processes to help them manage the service and continued to review and develop these with the aim of ongoing improvement.

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

- Review the practice's recruitment arrangements so an effective process which reflects relevant legislation and guidance is in place for future staff appointments.
- Review the arrangements for grading X-rays so that this is a dentist led process.
- Review the stock control arrangements for antibiotics and other medicines at the practice (including recording the dates of checks).
- Review the recording arrangements for some aspects of practice management, specifically incoming safety alert information, staff induction, mandatory training and complaints.
- Review the Legionella action plan to confirm that all actions have been completed.

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 was committed to providing a safe service and had comprehensive systems for this which were established and monitored by an external health and safety consultancy company. There were policies and processes for important aspects of health and safety such as infection prevention and control, clinical waste management, dealing with medical emergencies, dental radiography (X-rays) and fire safety.

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

No action ✓

Are services effective?

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

The practice provided personalised dental care and treatment. The dental care records we looked at provided information about patients' care and treatment and the practice was in the process of developing this aspect of their practice. The information we gathered confirmed that the care and treatment provided reflected published guidance. The practice used their website and social media to provide oral health information for patients.

Clinical staff were registered with the General Dental Council and completed continuous professional development to meet the requirements of their professional registration. Staff understood the importance of obtaining informed consent. The practice were aware of the importance of taking the Mental Capacity Act 2005 into account when considering whether patients were able to make their own decisions.

No action ✓

Are services caring?

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

The patient feedback we reviewed confirmed that patients were pleased with the way the practice team treated them. Patients described the dentists and the other members of the practice team as professional, courteous and caring. The practice was aware of the importance of confidentiality and this was covered in staff training. Staff we spoke with were respectful about patients and during the inspection we saw them speaking with people in a polite and friendly way. Patient feedback confirmed that the dentists explained their treatment clearly and involved them in decisions about their dental care.

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

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

The ground floor of the practice premises was accessible for patients with physical disabilities. Portable ramps were provided for patients unable to use the steps to the front entrance. There was level access throughout the ground floor and a patient toilet with grab rails, an alarm call system and sufficient space for patients who used wheelchairs. The practice had a hearing loop to assist patients who used hearing aids and provided large print information and a magnifying glass for patients who had sight problems. The practice provided a wheelchair so patients did not necessarily need to bring their own.

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

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

Are services well-led?

No action

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

The practice team worked together well. Staff told us the practice was a happy place to work and that they were well supported by the dentists and practice manager. A variety of structured and informal opportunities were provided for staff to meet and discuss the management of the practice and the care and treatment provided.

The practice had structured arrangements for managing and monitoring the quality of the service including internal and external scrutiny and audit. There were relevant policies and processes available to all staff.

Dental nurses and receptions staff received annual appraisal and were supported and encouraged to take up training opportunities.

The practice took patients' views seriously and used patient surveys and social media to enable patients to give them feedback.

Buckingham House Dental Surgery

Detailed findings

Background to this inspection

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

The inspection was carried out on 1 September 2016 by a CQC inspector and a dental specialist adviser. We reviewed information we held about the provider and information that we asked them to send us in advance of the inspection.

During the inspection we spoke with dentists, dental nurses, the practice manager, the administrator and two of the reception team. We looked around the premises including the treatment rooms. We viewed a range of policies and procedures and other documents and read the comments made by 48 patients in comment cards provided by CQC before the inspection. We also looked at the results of the practice's patient survey in November 2015 which had 116 responses.

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.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.

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Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a significant event policy and recording forms for staff to use. The policy included the stages to follow to analyse significant events and identify any action and learning needed. It also emphasised the importance of sharing information with staff. Staff we discussed significant events with were aware of the process they should follow if they became aware of an event which needed to be reported. We reviewed six of the most recent significant event forms and saw that these covered a variety of topics. This demonstrated that the practice were aware that they should review any incident where there was potential for learning and improvement.

We saw evidence that the practice received and reviewed national alerts about safety issues relating to medicines and medical devices. They confirmed they checked which were relevant to them and took action when needed. We also saw that they reviewed and kept copies of articles in professional journals identifying any concerns about equipment. The practice did not have a structured system to help them monitor their process for these checks. The practice manager said they would establish a system to show they had checked which applied to them and, if necessary what action they had taken.

The practice had a policy regarding the legal requirement, the Duty of Candour and guidance about this from the General Dental Council (GDC) was displayed for staff. The legislation requires health and care professionals to tell patients the truth when an adverse incident directly affects them.

Reliable safety systems and processes (including safeguarding)

The practice team were aware of their responsibilities regarding potential concerns about the safety and well-being of children and young people. The practice had up to date child and adult safeguarding policies and procedures based on local and national safeguarding guidelines. The contact details for the relevant safeguarding professionals in Worcestershire were readily available for staff to refer to. Staff, including the external dental specialist who provided treatment at the practice, had completed safeguarding training at a level suitable for their roles. Staff we spoke with told us they received updates during an annual essential topics training day and also covered it during their individual continuous professional development (CPD). The partners, the practice manager and head receptionist shared the responsibility for dealing with safeguarding to ensure that at least one person was always available to respond to a concern. Discreet information regarding safeguarding and domestic violence support was available for patients.

We confirmed that the dentists used a rubber dam during root canal treatment in accordance with guidelines issued by the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment.

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

Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. There was an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. We saw evidence that staff had recently completed training relevant to their role including management of medical emergencies, basic life support and training in how to use the defibrillator. The practice manager also held a current full first aid at work certificate.

The practice had the emergency medicines as set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. Staff carried out checks of the emergency medicines and equipment to monitor that they were available, in date, and in working order. We saw that the practice had records to monitor that this was being done. These included the batch numbers of each item of medicine and their expiry dates. This record was not dated which meant staff could not check or

confirm when the last check had been done. Staff knew where the emergency medicines and equipment were stored. Three first aid kits were available in various locations throughout the building.

Staff recruitment

The practice had a structured recruitment process but this did not include a system to ensure it obtained all of the information required. The practice manager confirmed that they would review this policy with reference to relevant legislation and guidance.

We looked at the recruitment records for two staff. These showed that the practice had obtained the majority of the required information for these staff including satisfactory evidence of employment in a healthcare related setting where this was relevant. This included Disclosure and Barring Service (DBS) checks. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice policy was to obtain DBS checks for all staff and this was supported by a written risk assessment setting out which level of check they obtained according to the role applied for. An external dentist visited the practice regularly to provide specialist treatments and the practice also held the necessary information for them, including a DBS check.

The practice had evidence that the clinical staff were registered with the General Dental Council (GDC) and that their professional indemnity cover was up to date.

Monitoring health & safety and responding to risks

The practice had a variety of health and safety related policies and risk assessments covering a variety of general workplace and specific dentistry related health and safety topics. These were part of a strong governance procedure for the management of health and safety which was provided and monitored by an external health and safety consultancy company. This company provided interactive computer software with relevant policies and procedures and practice specific risk assessments. Ongoing health and safety assessments and reviews were scheduled, carried out and monitored by the company to ensure ongoing compliance with health and safety matters. In addition the practice manager completed monthly site safety audits. The system included comprehensive information about the control of substances hazardous to health (COSHH).

The practice had a business continuity plan describing how the practice would deal with a wide range of events which could disrupt the normal running of the practice. All the dentists, the practice manager and head receptionist had copies of this off site so they always had access to a copy. The plan included a clear flow chart showing the practice's agreed communication process. This described which members of the team were responsible for informing and liaising with the wider staff group, patients and external organisations including the emergency services in the event of a major incident.

The practice had a fire risk assessment completed by an external fire safety consultant and this had been updated in January 2016. This had identified some remedial work including repairs to plaster in the cellar and moving a fire detector to a more suitable location. Both were booked to be done in September 2016. A new fire door had already been fitted. We saw the records of the routine weekly and monthly checks the staff made in respect of fire safety precautions at the practice. The fire equipment in the practice was checked by a specialist contractor twice a year; most recently in June 2016. We learned that the practice manager and eleven other members of staff had completed fire marshall training to ensure there were always staff on the premises who had been trained to take charge in the event of a fire.

Infection control

The practice was visibly clean and tidy and patients who mentioned cleanliness in CQC comment cards were positive about this. The practice employed a cleaner who had previously worked at the practice in another role and was therefore fully aware of expectations regarding cleanliness in a clinical setting. They kept written records to enable the practice to monitor that the various cleaning tasks were done at the expected frequency.

The practice had an infection prevention and control (IPC) policy and the practice manager was the IPC lead for the practice. The practice carried out six monthly IPC audits and at the last audit in March 2016 had achieved a score of 99%.

The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's

processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We found that they met the HTM01- 05 essential requirements for decontamination in dental practices.

Decontamination of dental instruments was carried out in the separate decontamination room which was staffed by a dental nurse each day. There was a rota for this. The separation of clean and dirty areas in here and in the treatment rooms was clear and the decontamination processes followed by staff were thorough. We discussed the process with a dental nurse who understood and clearly explained the process for cleaning, checking, sterilising and storing instruments.

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

The specialist who came to the practice to do dental implant work brought their own instruments.

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

Suitable spillage kits were available to enable staff to deal with mercury spillages or any loss of bodily fluids safely.

The practice had a Legionella management policy and an up to date Legionella risk assessment carried out and reviewed every two years by a specialist company. Legionella is a bacterium which can contaminate water systems in buildings. The risk assessment action plan had four action points which the practice had completed. Staff were unclear whether another action related to the water supply in the cellar had been completed and the practice manager said they would review this. We saw that staff carried out routine water temperature checks and kept records of these.

The practice used an appropriate chemical to prevent a build-up of potentially harmful biofilm in the dental waterlines. Staff confirmed they carried out regular flushing of the water lines in accordance with current guidelines and the chemical manufacturer's instructions.

The practice's arrangements for segregating and storing dental waste reflected current guidelines from the Department of Health. The practice used an appropriate contractor to remove dental waste from the practice. We saw the necessary waste consignment and duty of care documents and that the practice stored waste securely before it was collected.

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

The practice did not routinely visit patients at home. However, we learned that in a very few cases the dentists did do this together with a dental nurse. Staff told us any such visits were for examinations only and that any treatment would take place at the practice. They told us they used labelled clean and dirty boxes to transport instruments and that they took with them the same PPE they would use for appointments in the practice.

Equipment and medicines

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

The practice kept a stock of various antibiotics to prescribe for patients. They provided these free of charge and so patients, many of whom were older people, did not have to go to a chemist to obtain them. The antibiotics were securely stored. Staff kept records of the prescriptions provided. These included the name of the patient, the amount and name of the antibiotic prescribed and the batch number. We saw electronic stock control records for these. These showed that over the previous three months the actual stock had not always reconciled with the expected stock. The practice had identified that this was

due to staff not always filling in the sheets when the medicines were prescribed. They produced an action plan during the inspection highlighting to staff the importance of accurate medicines records. The action plan confirmed that all future discrepancies would be analysed to establish the reason for this. The practice provided patients with copies of the antibiotic specific patient information leaflet with their prescribed medicine.

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

One treatment room had recently been refurbished. This included fitting new cupboards leaving a gap between the new cupboards and the flooring. New flooring was due to be fitted during September.

The practice carried out audits of dental devices used at the practice and at the most recent had achieved a score of 94% with no specific issues requiring attention.

Radiography (X-rays)

We looked at records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). These were well maintained and included expected information such as the local rules and the names of the Radiation Protection Adviser and the Radiation Protection Supervisor. The records showed that the practice had arrangements for maintaining the X-ray equipment and that relevant annual checks were up to date. The practice was part of a national dental payment plan organisation which also provided different levels of quality assurance scrutiny for member practices. This organisation reviewed the X-ray arrangements at the practice in October 2015. The practice had achieved a score of 100%.

We looked at the training certificates for three of the five dentists to confirm that their IRMER training for their continuous professional development (CPD) was up to date. The practice subsequently confirmed the IRMER training dates for the other two dentists who were also up to date.

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

We saw evidence that the practice justified, graded and reported on the X-rays they took. They were recording the percentage of X-rays achieving a diagnostic quality grading of one, two or three and completing audits regarding this. We identified that the dental nurses were checking and recording the grading and advised that this needed to be a dentist led process.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We discussed the assessment of patients' care and treatment needs with the dentists. The practice used practice meetings to share and discuss published guidelines such as those from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice (FGDP). These included guidance on a needs assessment approach to recall intervals, the prescribing of antibiotics and lower wisdom tooth removal. We confirmed in our discussions with dentists that they took these into account in their practice. One of the dentists explained that they used the minimal intervention approach to dentistry.

The practice kept suitably detailed records about patients' dental care and treatment. Our discussions with the dentists and information from dental care records confirmed that they completed assessments of patients' oral health including their gum health and checks of soft tissue to monitor for mouth cancer. They obtained details of new patients' medical history and checked and updated this information at each appointment.

One of the dentists used a specialised piece of equipment to assist in the examination of patients' mouths to identify possible early signs of disease, including oral cancers. They used it at each check-up appointment and the practice did not make an additional charge for this. The equipment was available for the other dentists at the practice to use if they judged it would be beneficial.

Health promotion & prevention

The practice worked in line with the Delivering Better Oral Health Tool Kit from the Department of Health and treated and advised patients accordingly.

The practice's medical history records included sections about smoking and alcohol consumption. The dentists reviewed this information with patients at each check-up appointment. A range of guidance information about these and other relevant topics were available on the practice's computer system and the dental nurses printed these for patients as necessary. There was an information book in the waiting rooms explaining various dental treatments.

A range of dental care products were available for patients to buy. The practice website included information about oral cancer and a link to a British Dental Association interactive oral health education tool. The practice used their social media page to provide information about the practice and oral health related topics. For example in the last three months they had posted information about the role saliva plays in preventing tooth decay, caring for children's teeth, dental flossing and a 'sugar free September' initiative.

The practice was in an area with fluoridated water and the dentists told us that patients (including children) generally had low levels of tooth decay. The need for prescribed fluoride toothpaste and topical fluoride applications was therefore low.

Staffing

The practice had a staff group of 25 and had a broad skill mix within the team of dentists, dental therapists, hygienists, dental nurses and reception staff. Dental nurses and reception staff confirmed that they had personal development plans and annual appraisals which included identifying personal development plans (PDPs).

Reception staff told us they were enrolled on an NVQ level three Business and Administration course funded by the practice. The dental nurses told us the practice funded comprehensive continuous professional development (CPD) materials and attendance at some external training events for them. Whilst none of the dental nurses had completed enhanced training to enable them to fulfil extended duties some told us this was covered in their PDPs. For example two staff said they hoped to start radiography training during the next year.

We confirmed that clinical staff undertook the CPD required for their registration with the General Dental Council (GDC). The practice had evidence that clinical staff (including the visiting dental implant specialist) held current GDC registration. The practice held copies of staff training certificates. These were kept in individual staff CPD folders.

In addition to clinically focused training, staff also completed training in safety related topics including health and safety, management of medical emergencies, basic life support and defibrillator training, fire safety and infection control.

The practice had a structured induction process for new staff. They did not record the dates they confirmed new staff were competent in the areas covered. We discussed

Are services effective?

(for example, treatment is effective)

this with the practice manager who said they would develop their processes before any new staff started. They subsequently told us they had already started this work and were excited that this would result in an improved process. A trainee dental nurse and an apprentice dental nurse were positive about their experience of joining the practice, the quality of their induction and the standard of teaching they received from the dentists and dental nurses.

Although we established that staff were completing training the practice did not have a structured recording system to help them monitor this. The practice manager agreed that in view of the size of the practice team this would be a helpful tool which would contribute to discussions during annual appraisals.

The practice workforce included additional dental nurse hours to provide cover for planned absences such as annual leave and did not use agency staff. The practice manager was also a dental nurse so was also able to provide cover if necessary. When the dental implant specialist was there to treat patients the practice ensured that two staff were available to assist with these procedures.

Working with other services

When necessary the practice referred patients, including children, to NHS dental hospitals and access clinics or to other private dental practices. This was usually because a patient needed specific specialist treatment that Buckingham House did not provide although they explained that they aimed to provide the majority of patients' treatments at the practice.

The practice referred some patients to a specialist in restorative dentistry and dental implants who saw and treated patients at Buckingham House. The practice found that patients appreciated the familiar surroundings and continuity of dental nurses and reception staff that this arrangement provided.

The practice referred patients for investigations in respect of suspected oral cancer in line with NHS guidelines.

In our discussions with dentists, dental nurses and the practice manager we established that they understood the importance of obtaining and recording patients' consent to treatment. We confirmed that they gave patients the information and time they needed to make informed decisions about their treatment. The practice told us that they had identified a need to develop the content and consistency of treatment plans and that this was an area the practice team were working on.

The practice had a written consent policy and guidance for staff. The practice manager had updated it to correctly reflect the requirements of the Mental Capacity Act (MCA) 2005.The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Some staff had completed MCA training and were aware of the relevance of this legislation to the dental team. The practice manager was unsure whether all staff had completed training in this subject and planned to review this. The practice consent policy referred to decision making where young people under the age of 16 may be able to make their own decisions about care and treatment. A dental nurse gave us an example of a dentist communicating effectively and sensitively with a young person to enable them to reach a decision to proceed with the treatment they needed.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We gathered patients' views from 48 completed cards and looked at the results of the practice's patient survey in November 2015. These were based on 116 responses. All the information we reviewed was positive. Patients described the dentists and the other members of the practice team as professional, courteous and caring and confirmed they were treated respectfully.

The waiting rooms on the ground and first floors were separate from the reception area which helped provide privacy when reception staff were dealing with patients. Staff told us that if a patient needed or wanted more privacy to discuss something they would take them into another room. We saw that the reception computer screens were not visible to patients and that no personal information was left where another patient might see it.

The practice had a confidentiality policy and this was covered during the induction and ongoing training staff completed.

Involvement in decisions about care and treatment

We saw evidence that the practice recorded information about each patient's treatment options, and that they discussed the risks and benefits of these with them. Review appointments were arranged to provide additional opportunities for patients to discuss their treatment before making decisions. The practice told us that they had identified treatment planning as an area they wanted to build on to ensure this was consistent across the practice. Dental nurses confirmed that the dentists explained things to patients clearly and gave them time to consider their options. This was supported by several patients in the CQC comment cards. Many commented on how their dentist provided clear explanations about the treatment they needed while others mentioned having their concerns and opinions listened to

The practice let rooms in the basement to dental technicians who did most of the crown, bridge and denture work for the practice. Staff told us this enabled the technicians to be involved in discussions with patients such as the best colour shades for them to help them make decisions about this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We gathered patients' views from 48 completed cards and looked at the results of the practice's patient survey in November 2015. These were based on 116 responses. All the information we reviewed was positive. Patients described being treated as individuals and receiving care and treatment which met their needs.

We discussed the appointment booking system with reception staff. They explained that they always booked 30 minutes for a new patient's first appointment or longer if the patient said they had pain or other dental problems. Ongoing appointments were booked according to the treatment needed and the dentists either came to the reception desk with the patient to tell them how long was needed or used the instant messaging on the computer system. They told us they would book longer appointments if patients needed additional time due to mobility or communication difficulties.

A dental nurse told us they felt patients had a good experience at the practice because of staff continuity and focus on patients' needs. They said this started with reception staff who were knowledgeable and responsive in the way they dealt with patients' questions or concerns.

The practice did not routinely visit patients at home. However, we learned that in a very few cases the dentists did do this together with a dental nurse. The example we were given related to a very elderly patient who was a long standing patient. The visit was for a check-up only and no treatment was needed. Any treatment would have been arranged to take place at the practice.

Information was available for patients in a practice information pack which was sent to all new patients by post. This included an overview of the practice, details about each of the dentists, questions and answers about oral health, information about the charges for treatment and dental payment plans and arrangements for emergency treatment outside practice hours. The practice had additional leaflets aimed at patients on its computer system which could be printed when needed. The practice also provided a wide range of information on its website and social media page.

The practice let rooms in the basement to technicians who carried out most of the practice's denture, crown and bridge work. They explained this made it easier to have discussions about shade taking and complex work. They were also able to offer a one hour repair service to patients.

Tackling inequity and promoting equality

The practice had an equality and diversity policy available for staff. The policy had been reviewed during 2016 and this was used as an opportunity to discuss the topic again with staff.

Staff told us that they had very few patients who were not able to converse confidently in English but that if needed they would use an interpreter service. The practice had an induction hearing loop to assist patients who used hearing aids. A member of staff had completed British Sign Language level one training although they had not yet needed to use this at the practice. Information for patients could be provided in large print if needed. A magnifying glass was available for patients who might find this helpful.

There were steps into the building from the car park but the practice provided portable ramps to assist patients unable to walk up these. There was level access throughout the ground floor where four of the treatment rooms were located. Staff confirmed that patients who had difficulty climbing stairs had their appointments on the ground floor. There were two waiting rooms including one on the ground floor. There was a wheelchair accessible patient toilet with grab rails and a call bell. The practice provided a wheelchair so patients did not necessarily need to bring their own in their car. Parking spaces for patients with limited mobility were sited nearest to the entrance.

Access to the service

The practice was open from 8.30 am to 5pm Monday to Friday. Information from patients confirmed they were able to make appointments easily although one commented that this was not always the case. Several patients mentioned getting appointments at short notice or being accommodated if they needed to change an appointment. The practice's patient survey in November 2015 showed that 78% of patients were seen on time for their appointments, 5% were seen early and 14% waited up to 10 minutes; only 3% responded that they had waited longer than 10 minutes. The reception staff described how they tried to meet patients' needs when booking appointments. For example, fitting workers in to suit their

Are services responsive to people's needs?

(for example, to feedback?)

working hours, seeing diabetic patients as soon as possible after they had received their insulin in the mornings and planning appointments for children and young people with school and university holidays in mind.

The practice provided its own out of hours emergency cover on weekdays with the dentists and dental nurses taking part in an on-call rota. The practice also co-operated in an on-call rota with other local private dental practices at the weekends. Information about this was provided in the practice information pack and website. Staff told us patients with pain or other urgent dental needs would be seen the same day and that children in pain would be seen as soon as a dentist was free. Each dentist had an hour of protected time each day for emergency appointments.

The telephone system included a quick service option for patients wanting to cancel an appointment for that day. This helped to keep the two telephone lines free for patients who needed to speak to reception staff.

Concerns & complaints

The practice had a complaints policy and procedure which was also available in large print. The procedure explained who patients should contact about concerns and how the practice would deal with their complaint. It contained contact details for the General Dental Council and the Dental Complaints Service, national organisations that patients could raise their concerns with

We looked at several complaints records from the previous 15 months. These showed that the practice responded promptly to complaints and gave apologies when things had gone wrong. In some cases refunds had been provided either as a gesture of goodwill or to support an apology.

We noted two complaints where information about how they were managed was incomplete. The practice agreed to review these to ensure their complaints process had been followed. We discussed the benefits of a system to monitor the progress of any complaint to avoid this and the practice manager devised a format for an individual complaint front sheet before the end of the inspection.

Are services well-led?

Our findings

Governance arrangements

The partners held the responsibility for clinical leadership and delegated responsibility for the day to day management of the service to the practice manager. The practice manager was also the named lead for infection prevention and control and safeguarding. They had worked at the practice for over 10 years as a dental nurse before taking on their current role six months before this inspection. They told us they viewed the inspection as an opportunity to develop their learning and development in this role.

The practice had a range of policies, procedures and risk assessments to support the management of the service. These reflected national guidance from organisations such as the General Dental Council (GDC) and the British Dental Association (BDA). The practice manager told us that as they were new to the role they were working their way through each policy to familiarise themselves with them and update them as necessary. We saw that policies were dated and signed so that staff knew the most recent version was in use.

The practice was part of a national dental payment plan organisation which also provided different levels of quality assurance scrutiny for member practices. Buckingham House took part in the highest level of this quality monitoring process. We saw the results of the most recent quality monitoring visit by this organisation in October 2015. The practice had achieved 100% scores in all of the areas assessed.

The practice had 25 staff and the partners and practice manager recognised the importance of effective communication to keep staff informed and ensure information reached people who needed it. The partners and practice manager met twice a week and a range of other meetings took place. These included informal daily coffee break meetings and breakfast meetings twice a week. Meetings for the whole practice and separate ones for the dentists, dental nurses and reception team were held every month. Notes of the meetings were made for future reference and so staff who were not present could update themselves.

Leadership, openness and transparency

From our conversations with the practice team we learned that staff felt valued and supported by the partners and practice manager. Staff told us they enjoyed working at the practice and said it was a happy place whilst also being professional. They said that they got on well and that patients noticed this. We saw from the minutes of meetings that social activities were arranged and staff birthdays celebrated.

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

Management lead through learning and improvement

Staff we spoke with told us that the practice supported them to develop their knowledge and skills. Dental nurses and reception staff received annual appraisals and had personal development plans identifying learning needs. Reception staff told us they were enrolled on an NVQ level three Business and Administration course funded by the practice. They appreciated this support and the recognition of their value to the team. Whilst none of the dental nurses had completed enhanced training to enable them to fulfil extended duties some told us this was covered in their PDPs. For example two staff said they hoped to start radiography training during the next year. Staff told us that the partners supported and encouraged staff to take part in a variety of training opportunities which they often funded. These included attendance at specific courses and at various national conferences.

The practice used a variety of audits to monitor the quality of treatment and the overall service provided. These included audits regarding the grading of X-rays, infection prevention and control, and clinical record keeping. All of these areas were also assessed by the national dental payment scheme organisation during their quality assurance visits.

We confirmed that clinical records had been audited by the practice team in November 2013 and May 2015 and by the

external organisation in May 2014 and October 2015. The practice score for the external audit in October 2015 was 100%. The dentists used their monthly meetings for peer review and discussions about best practice. Topics had included consistent record keeping practice, safe sharps use and using a rubber dam for root canal treatments. The practice hoped to begin hosting peer review sessions for local dentists in the near future lead by the specialist dentist who carried out dental implants there.

The practice told us they had identified a need to improve the consistency and content of the treatment plans they provided for patients. They explained that this was an area they were currently working on during their various meetings. Several individual members of staff spoke about this during the day showing a good awareness of this shared aim.

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

The practice recognised the value of obtaining patients view and used patient surveys and a suggestions box to ask them for feedback. They also used social media to keep patients informed about the practice and to provide information about maintaining good dental health. The practice had displayed their November 2015 survey results in the waiting rooms. We looked at the scores given by 116 patients and the additional comments they had made. These echoed the positive comments made in CQC comment cards and did not include any suggestions for improvement. However, the practice told us that a patient had commented separately about access to the building for people who used wheelchairs. The patient had told them the ramp they had provided was not satisfactory. In response to this the practice had purchased a new ramp which was more suitable. They told us the patient had thanked them for doing this. The practice told us that they spoke to patients by telephone after some appointments to check that they felt alright and that they had been happy with their appointment and treatment.

Members of the practice team had opportunities to raise and issues and contribute their ideas in a variety of ways including structured and informal meetings and annual appraisals. The practice carried out an annual staff survey. We saw from the minutes that the July 2016 staff meeting was used to share and discuss the results of the 2016 survey with staff. The discussions covered the areas staff thought needed to be improved and identified how these could be addressed. Throughout the notes of this meeting reference was made to the practice manager's open door policy. When we spoke with staff several of them specifically mentioned that there was an 'open door' approach to communication at the practice. They said they could always speak with the practice manager and partners about anything they needed to.

The practice planned to set up a patient group to contribute their feedback and ideas to future discussions about the practice.