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Smile Style Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 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

Smilestyle Dental Care was registered with the Care Quality Commission (CQC) in November 2014 to provide dental services to patients in north Nottingham and the surrounding areas. The practice provides both NHS and private dental treatment, with approximately 90% being NHS patients. Services provided include general dentistry, dental hygiene, teeth whitening, crowns and bridges, and root canal treatment.

The practice is open Monday from 9:00 am to 5:00 pm; Tuesday from 08:00 am to 5:00 pm; Wednesday from 09:00 am to 5:00 pm; Thursday from 09:00 am to 5:00 pm; Friday 09:00 am to 4:30 pm. The practice is closed each day from 1:00pm to 2:00 pm for lunch.

Access for urgent treatment outside of opening hours is usually through the NHS 111 telephone line.

The practice has three dentists; one hygienist/ therapist; four dental nurses, three of whom are trainee dental nurses; and one practice manager.

The practice did not have a registered manager at the time of our inspection. A registered manager is a person who is registered with the Care Quality Commission (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. The practice manager informed CQC shortly after the inspection that an application to be the registered manager had been submitted.

Summary of findings

We received feedback from 20 patients about the services provided. We saw that most of the feedback was positive. However, there were four negative comments. Two related to the dentist not running to time, one to not always seeing the same dentist and the fourth to computer problems. All of the negative comments we received also came with positives from the same patients about the quality of the treatment, and the friendliness of the staff. Most patients said they were very happy with the dental service they received. Patients said they were treated well at the practice, and that staff were approachable. Dental staff explained treatments including the costs, and patients were able to ask questions.

Our key findings were:

- The practice had systems for recording accidents, significant events and complaints.
- Learning from any complaints and significant incidents were recorded and learning was shared with staff.
- All staff at the practice had received whistle blowing training and were aware of these procedures and the actions required.
- Patients said they were satisfied with the dental service they received.
- Patients said they were treated with dignity and respect.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients. However, patients said that on occasions thee were not enough dentists, and appointments had been cancelled at short notice as a result.
- Staff had been trained to deal with medical emergencies.
- Emergency medicines, an automated external defibrillator (AED) and oxygen were readily available. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The practice involved patients in making decisions about their treatment
- Options for treatment were identified and explored and discussed with patients.

Patients' confidentiality was maintained.

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 recorded accidents and significant events and learning points were shared with staff.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

Staff had been trained in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

The practice had the necessary emergency equipment including an automated external defibrillator (AED) and oxygen.

Recruitment checks were completed on new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

Infection control procedures followed published guidance (HTM 01-05) to ensure that patients were protected from potential risks.

Equipment used in the decontamination process was regularly maintained and regular frequent checks were carried out to ensure equipment was working properly and safely.

X-rays were carried out safely in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

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

Patients were assessed before any treatment began. This included completing a medical history form or updating one for returning patients who had previously completed a medical history form.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of recalls, wisdom tooth removal and the use of antibiotics.

Dentists discussed the risks of alcohol and tobacco on patients' oral health.

Patients said that appointments had been cancelled due to dentists not being available. In response to this the practice had appointed two additional dentists to work at the practice.

There were clear procedures for referring patients to secondary care (hospital or other dental professionals).

Are services caring?

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

Staff were aware of the need for confidentiality and worked ways to protect patients' privacy and information.

Patients were treated with dignity and respect.

Staff were open and welcoming to patients at the dental practice.

Patients said they received good dental treatment.

Summary of findings

Patients said they were involved in discussions about their dental care, and were able to express their views and opinions.

Are services responsive to people's needs?

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

Patients said the appointments system was accessible and met their needs.

Patients who were in pain or in need of urgent treatment were usually seen the same day.

The practice was accessible to patients with restricted mobility. There was level access, and a ground floor treatment room and toilet facilities.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, and the practice leaflet.

Are services well-led?

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

There was a clear management structure, with a practice manager to organise and lead activity.

The practice was carrying out audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

Patients were able to express their views and comments.

Staff said they could speak with the practice manager or a dentist if they had any concerns.

Smile Style Dental Care

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 2 October 2015. The inspection team consisted of one Care Quality Commission (CQC) inspector, a dental specialist advisor and a manager from NHS England who was observing the inspection process. Before the inspection we reviewed information we held about the provider together with information that we asked them to send to us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with five members of staff, including members of the management team.

Prior to the inspection we asked the practice to send us information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of the staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and found there were no areas of concern.

During the inspection we spoke with one dentist, the practice manager, two dental nurses and one receptionist. We reviewed policies, procedures and other documents. We received feedback from 20 patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were procedures for investigating, responding to and learning from accidents, significant events and complaints.

We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice manager said that there had been no RIDDOR notifications made, although they were aware how to make these on-line. We saw the minutes of staff meetings which showed that health and safety matters had been discussed, and learning points shared.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) and informed health care establishments of any problems with medicines or healthcare equipment. The practice manager demonstrated how the alerts were received and information was shared with staff if and when relevant.

Reliable safety systems and processes (including safeguarding)

The practice had a joint safeguarding vulnerable adults and children policy. The policy had been reviewed in February 2015. The policy identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. Posters with the relevant contact phone numbers were on display in staff areas of the practice. The practice manager was the identified lead for safeguarding in the practice and had received enhanced training in child protection to support them in fulfilling that role. Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children having completed on-line training during 2015. There had been no recorded safeguarding incidents at the practice on file.

The practice had a policy and procedure to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy provided information and guidance for staff to identify and risk assess each potentially hazardous substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin.

Discussions with the dentist identified the dentists were routinely using rubber dams when completing procedures such as root canal treatments and was evidenced in the notes seen. Best practice guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth during treatment.

Medical emergencies

The dental practice had two sets of emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in two secure locations, one upstairs and one down. Discussions with staff identified that all staff members knew where to find them. The medicines were as recommended by the 'British National Formulary' (BNF). We checked the medicines and found them all to be in date. We saw the practice had a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

Resuscitation Council UK guidelines suggest the minimum equipment required includes an AED and oxygen which should be immediately available. The practice had oxygen and two automated external defibrillators (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed all staff had completed basic life support and resuscitation training in January 2015. This training had included the use of the AED.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training, and medical emergencies had been discussed in team meetings. Staff were also aware of the

equipment for use in a medical emergency and how to use it. Staff were able to describe the actions to take in relation to various medical emergencies including if a patient collapsed in the practice.

Staff recruitment

We looked at the personnel files for six staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff personnel files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all members of staff had received a DBS check, and in the records we sampled all had been completed within the last five years. We discussed the records that should be held in the personnel files with the practice manager, and saw the practice recruitment policy and the regulations had been followed.

Documentation suggested there were usually sufficient numbers of suitably qualified and skilled staff working at the practice to meet the needs of the patients. However, we were informed by patients that sometimes there were not enough dentists and appointments had to be cancelled.

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example: local rules for the use of X-ray machines and a legionella risk assessment.

The practice had put in place specific policies and procedures to manage other identified risks. For example: Fire safety policies and procedures and COSHH procedures.

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire extinguishers had been serviced annually with the last service in August 2015

The practice had a health and safety law poster on display in the staff room. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

Staff training records identified that staff had received up-to-date training in health and safety matters throughout 2015.

Infection control

Infection control within dental practices should be working towards compliance with Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' This document sets out clear guidance on the procedures that should be followed; records that should be kept; staff training; and equipment that should be available. Following HTM 01-05 would comply with best practice.

The practice had an infection control policy which had been updated and reviewed in September 2015. The policy described how cleaning should be completed at the premises including the treatment rooms and the general areas of the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. Records showed staff training in infection control had been completed on 12 February 2015.

An infection control audit had been completed on 8 June 2015 with a score of 93%. An action plan had not been developed as the staff responsible had left the practice following the audit. Consequently a further audit was completed on 22 September 2015 with a score of 97%. An action plan was in the process of being completed. The records showed that six monthly audits were happening routinely.

The practice used sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) The bins were located out of reach of small children. The health and safety executive (HSE) had issued guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013', and the practice were following the guidance.

Are services safe?

We saw that dentists were using the safety plus safe sharps system. This system complied with the sharps regulations 2013.

The practice had a clinical waste contract, and waste matter was collected on a regular two weekly basis. Clinical waste was appropriately segregated, and stored securely while awaiting collection. The clinical waste contract also covered the collection of amalgam (dental fillings) which contained mercury and was therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids.

The practice had two dedicated decontamination rooms that had been organised in line with HTM 01-05. The decontamination rooms were defined as one dirty and one clean. To reduce the risk of cross contamination and infection there was a flow of instruments from the dirty room into the clean room after cleaning in a washer disinfector. A washer disinfector being a machine for cleaning dental instruments similar to a domestic dish washer.

Staff wore personal protective equipment during the process to protect themselves from injury. These included heavy duty gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display within the decontamination rooms for staff reference. The instruments were cleaned rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments).

The practice had three autoclaves, two were designed to sterilise non wrapped or solid instruments, and the third was used for sterilising hollow and wrapped instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising was maintained and serviced regularly in accordance with the manufacturer's instructions. The practice carried out daily, weekly and monthly checks on the equipment. There were records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

In each of the staff files we saw, there was documentary evidence to demonstrate that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People (staff) who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. A needle stick injury is a puncture wound similar to one received by pricking with a needle.

The practice had a policy for assessing the risks of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. This was to ensure the risks of Legionella bacteria developing in water systems had been identified and measures taken to reduce the risk of patients and staff developing Legionnaires' disease. Records showed that the practice was recording water temperatures regularly to monitor the risks associated with Legionella. In addition the practice was flushing the water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. The practice used a concentrated chemical liquid for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing.

Equipment and medicines

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had taken place within the last two years. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

Medicines used at the practice were stored and disposed of in line with published guidance. Medicines were stored securely and there were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Emergency medicines and oxygen were available, and located centrally and securely ready for use if needed.

Are services safe?

Prescription pads at the practice were numbered and a log was kept. Numbered prescription pads were stored securely when not in use.

Radiography (X-rays)

The dental practice had five intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth. X-ray equipment was located in each treatment room. X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The practice had a radiation protection file which contained documentation to demonstrate the X-ray equipment had been maintained at the intervals recommended by the manufacturer.

The local rules identified the practice had a radiation protection supervisor (RPS) (one of the dentists) and a radiation protection advisor (RPA) (a company specialising in servicing and maintaining X-ray equipment). However, the RPA was not identified by name in the local rules. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only. Following the inspection the practice manager sent us documentary evidence of the RPA and confirmation the local rules had been updated to include this information. Staff members authorised to carry out X-ray procedures were clearly identified. The measures in place protected people who required X-rays to be taken as part of their treatment.

Emergency cut-off switches for the X-ray machines were located away from the machines and were clearly labelled.

We discussed the use of X-rays with a dentist. This identified the practice monitored the quality of its X-ray images and had records to demonstrate this. The practice was moving towards using digital X-ray images, as digital X-rays had advantages over conventional X-rays. For example digital X-rays rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional X-rays.

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. The local rules identified that the general practice policy would be to defer any X-rays until after the birth. Patients' notes showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice recorded information about the assessment, diagnosis, treatment and advice of dental healthcare professionals provided to patients. We reviewed the dental records for several patients for each dentist. The dental records seen were detailed, comprehensive and followed guidance from the Faculty of General Dental Practice (UK) (FGDP).

A medical history was taken for every patient at every examination or pain appointment. This was signed by both the dentist and the patient and kept on file. The medical history records included any health conditions, current medicines being taken and whether the patient had any allergies. If the dentist wanted to take an X-ray and the patient was of child bearing age, the possibility of being pregnant was also discussed. For returning patients the medical history focussed on any changes to their medical status.

We saw that dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Records showed that treatments had been relevant to the symptoms or findings, treatment options were explained and that adequate follow up had been arranged.

We spoke with a dentist, and a dental nurse who said that each patient had their dental treatment and diagnosis discussed with them. Treatment options and costs were explained before treatment started. Feedback from five patients made specific reference to being involved in discussions about treatment options. Patients we spoke with in the practice said treatment options were discussed and explanations given. Where relevant, information about preventing dental decay was given to improve the outcome for the patient. The patient notes were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Discussions with the dentist showed they were aware of NICE guidelines, particularly in respect of recalls of patients, anti-biotic prescribing and wisdom tooth removal. A review of the records identified that the dentist were following NICE guidelines in their treatment of patients.

Health promotion & prevention

We saw there was a range of literature in the waiting room and reception area about the services offered at the practice. There were also leaflets about ways to improve patients' oral health including advice and support to stop smoking.

We saw examples in patients' notes that advice on smoking cessation, alcohol and diet had been discussed. With regard to smoking dentists had highlighted the risk of periodontal disease and oral cancer. Patients' alcohol consumption was recorded where relevant as this could have an effect on dental health.

Public Health England had produced an updated document in 2014: 'Delivering better oral health: an evidence based toolkit for prevention'. Following the guidance within this document would be evidence of up to date thinking in relation to oral healthcare. Discussions with dentists showed they were aware of the Department of Health 'Delivering better oral health' document and used it in their practice.

Staffing

The practice had three dentists; one hygienist/ therapist; four dental nurses, three of whom are trainee dental nurses; and one practice manager. Prior to the inspection we checked the registrations of all qualified dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

Some patients said that appointments had been cancelled at short notice due to the unavailability of their dentist, and this had on occasion been more than once. On the day of the inspection only one dentist was working. One was on holiday and the third had been moved to work at another practice owned by the provider. We were informed by patients and staff that it was not uncommon for a dentist to be moved to work at another practice, and this had left Smilestyle Dental Care short of dentists. Documentation seen at the practice supported that this had happened, and on the day of our inspection, as already identified one dentist was working at another practice.

An additional (fourth) dentist was due to start working at the practice the week after the inspection.

We reviewed staff training records and saw staff were maintaining their continuing professional development

Are services effective?

(for example, treatment is effective)

(CPD). CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: Safeguarding vulnerable adults and children and the Mental Capacity Act (2005)

The practice appraised the performance of its staff with annual appraisals. We saw evidence in staff personal files that appraisals had been taking place, with several having been completed within the last month. We also saw evidence of new members of staff having an induction programme. We spoke with three members of staff who said they had received an annual appraisal with the practice manager.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment in the practice. For example referral for treatment at the dental hospital if the problem required more specialist attention, such as a difficult wisdom tooth. Following treatment by the 'other' dental professional(s) the practice monitored patients after their treatment. This was to ensure they had received satisfactory treatment and had the necessary after care after treatment at the practice.

The practice did not provide a conscious sedation service, and patients who required this service were also referred to other practices that provided that service. This would particularly apply to nervous patients who required sedation to help them relax.

Consent to care and treatment

We saw evidence that patients were given treatment options and consent forms which they signed to signify their consent with the agreed treatment. For NHS patients this was through the standard FP17 DC form. This being the form all NHS patients' sign, being both the 'personal dental treatment plan' and the consent to treatment form.

Discussions with the dentist showed they were aware of and understood the use of Gillick competency for young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge. The practice consent policy provided information about Gillick competencies.

The practice had a consent policy to offer information and guidance to staff with regard to consent.

The consent policy had a description of competence or capacity and how this affected consent. The policy linked this to the Mental Capacity Act 2005 (MCA). Staff training records showed staff had completed training with regard to the MCA 2005 during August and September. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Discussions with two members of staff identified their awareness and understanding of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we took time to observe how the staff spoke with patients and whether they treated patients with dignity and respect. Our observations were of patients being treated politely, and courteously. Feedback from patients was positive with several commenting the staff treated them with dignity and respect.

Reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area, particularly when other patients were present. They said that a private unused treatment room was usually available if needed.

We observed a number of patients being spoken with by staff and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely either under lock and key or password protected on the computer.

We received feedback from 20 patients. Half made specific comments about being treated with dignity and respect. Several patients spoke about how staff put them at ease, and were open, approachable and friendly.

Involvement in decisions about care and treatment

Feedback we received on the day of the inspection was positive about the dental practice. Patients said they were very pleased with the dental treatment they received, and they thought all the staff were very helpful and professional. Patients also said that any treatment was explained clearly to them including the cost. Feedback from every patient we spoke with identified they felt involved in the decision making process, and were able to ask questions and discuss with the dentists the treatment options.

The practice website clearly described the range of services offered to patients. The practice offered both private and NHS treatments and both sets of costs were clearly displayed in the practice.

Dental care records we reviewed demonstrated that staff recorded the information they had provided to patients about their treatment and the options open to them. Patients we spoke with said that dental staff always explained things clearly, and in a way that they could understand. Patients received a written treatment plan which clearly outlined their treatment and the cost involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a routine appointment system, however, when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. Feedback from patients was generally good, although we received comments about delays with being seen by the dentists in the practice. We were told that it was not uncommon to wait 10 to 15 minutes past the appointment time, and on occasions as much as 25 minutes. Patients also said that appointments had been cancelled at short notice due to the dentist not being available. An additional (fourth) dentist was due to start working at the practice the week after the inspection. Following the inspection the practice manager confirmed by e mail that the newly appointed dentist had started at the practice on 5 October 2015. In addition they informed us another dentist had been recruited and was due to start work at the practice on the 23 November 2015.

Tackling inequity and promoting equality

The practice was accessible to patients who may have difficulty accessing services due to mobility or physical issues. There was a ground floor treatment room, which provided level and step free access from the street to the treatment room. This was to assist patients with mobility issues, using wheelchairs or mobility scooters and parents with prams or pushchairs. The practice had a ground floor toilet, which was accessible for patients.

The practice had good access to all forms of public transport. Car parking was available outside the practice in a free car parking area, or street parking was available nearby, if the car park was full.

Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients who were particularly nervous or anxious.

Access to the service

The practice was open on:

Monday to Friday from 9:00 am to 5:00 pm.

However, the practice was open later in the evening in the period running up to Christmas on a trial basis. Consequently the practice was open until 7 pm on Monday and Wednesdays and 6 pm on Thursdays. Comments from patients identified this was very welcome, as it allowed patients to be seen after work or outside of school hours.

The arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays were displayed in the waiting room area and in the practice leaflet. Access for urgent treatment outside of opening hours was usually through the NHS 111 telephone line.

Concerns & complaints

The practice had a complaints procedure that explained the process to follow when making a complaint. This information was not available on the practice website, although it was available in the practice and in the practice leaflet. Staff said they were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that there had been a number of formal complaints received in the past 12 months. Records within the practice showed that the complaints had been handled in a timely manner, and evidence of investigation into the complaints and the outcomes were recorded. We saw that patients had been given an apology for the distress caused.

Feedback from patients identified they were satisfied with the dental services provided. None of the patients we spoke with had ever made a complaint or felt the need to make a complaint.

Are services well-led?

Our findings

Governance arrangements

We saw that clinical audits were planned throughout the year. For example six monthly infection control audits had been completed in June 2015 and September 2015. We saw evidence of one dentist having the quality of their X-rays audited in June; other dentists had not been in post long enough to be audited. Other audits, meetings and training through the year included: consent, health and safety and emergency procedures.

The policies and procedures we saw had mostly been reviewed and updated within the past 12 months, thus ensuring that the information and guidance was current and up-to-date.

Leadership, openness and transparency

A newly appointed practice manager was in post in the practice. We saw minutes of meetings where information was shared and issues discussed. There was evidence of organisation and planning, and there were systems and processes in place to deliver the service.

Staff said there had been an improvement following a reorganisation at the practice, which had seen a change in the management structure. The was an open and transparent culture at the practice which encouraged honesty. Staff said they were confident they could raise issues or concerns at any time with the practice management team without fear of discrimination. Staff told us that they could speak with the practice manager or a dentist if they had any concerns. Staff members said they felt part of a team. Several staff members said that support had improved and they felt able to raise any concerns with the manager.

Staff were aware of how to raise concerns about their place of work under whistle blowing legislation. We saw that the practice had a whistle blowing policy, and all staff had access to the policy.

Learning and improvement

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Documentation at the practice showed that training opportunities were available to all staff, and this was encouraged by the management team. Staff said they had good access to training, mostly in-house, but some external training too.

Staff training records showed that staff were following a training programme which was being monitored by the practice manager. Examples of training courses completed during 2015 included: basic life support and use of the defibrillator, infection control, safeguarding, radiology and X-rays. These all being core elements of the dental service, and demonstrating that staff were encouraged to refresh and update those core skills.

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

The practice had the NHS Friends & Family box in the waiting room. There had been 12 responses in the last month. Analysis of the Friends & Family (F&F) information showed mostly positive comments. The practice manager had put a 'you said we did' poster on display in the waiting room. This was to inform patients what action had been taken by the practice in response to comments from patients through F&F.

The practice completed its own patient surveys twice a year, with 100 patients per dentist targeted for a survey. The results were analysed and improvements made where appropriate. We saw documentary evidence of the surveys and the analysis.

The practice reviewed feedback from patients, and held regular staff meetings, which were fully minuted. The practice manager had responsibility for the day to day running of the practice and was fully supported by the practice team. There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.