Same Day Teeth (West Midlands) Limited

Changing Faces Dentistry and Facial Rejuvenation at Same Day Teeth (West Midlands) Ltd

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 March 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

Changing Faces Dentistry and Facial Rejuvenation at Same Day Teeth (West Midlands) Ltd is a dental practice providing general dental services on a private basis. The service is provided by two dentists and a clinical dental technician. They are supported by a dental therapist/ hygienist and two dental nurses. A consultant anaesthetist visits the practice on an ad hoc basis to provide conscious sedation for nervous patients.

Summary of findings

Conscious sedation involves techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation.

The practice is located in a multi-storey building and shares the building with other businesses. The whole dental practice is located on the ground floor to accommodate patients with mobility difficulties. There is wheelchair access to the practice with accessible toilet facilities (although these were out of use on the day of our visit).

The premises consist of a reception area, waiting room, two treatment rooms, a dental laboratory, an X-ray room, a decontamination room and two offices. Opening hours are from 9am to 5pm on Monday to Friday. The practice is also open on alternate Saturdays from 9am to 5pm.

The principal dentist and the clinical dental technician (CDT) operate the practice as a limited company. They are both joint directors and the principal dentist is the registered manager. 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.

Thirty-five patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients on the day of the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff were helpful, friendly and professional.

Our key findings were:

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had systems to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding and the management of medical emergencies. We identified some areas of improvement and these were actioned promptly.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation; however, the dental care records were not sufficiently detailed to record this.
- The practice had a structured plan in place to audit quality and safety.
- Staff received training appropriate to their roles.
- Patients told us they found the staff helpful and friendly. Patients commented they felt involved in their treatment and that it was fully explained to them.
- Patients were able to make routine and emergency appointments when needed.
- The practice had a complaints process in place.
- No complaints had been received by the practice in the last 12 months.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping. However, learning points and action plans were not always documented.
- There were no dentists available on the day of our visit as they were involved in other professional commitments on the day of our inspection.

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

- Review stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes ensuring recruitment checks, including references, are suitably obtained and recorded.
- Review the practice's audit protocols of various aspects of the service, such as radiography and dental care records at regular intervals to help improve the quality of service. The practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

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.

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There were separate forms for reporting accidents and incidents. Accidents in the previous 12 months to our inspection had been documented.

The practice had systems to assess and manage risks to patients, whistleblowing, complaints, safeguarding, health and safety and the management of medical emergencies. It had a recruitment policy to help ensure the safe recruitment of staff; however, not all of the staff files contained two references as stated in the practice's own policy.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit and we were assured these would be actioned promptly.

Are services effective?

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

The dentists followed national guidelines when delivering dental care. These included the Faculty of General Dental Practice (FGDP) and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

The practice monitored any changes to the patients' oral health. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping required improvement in order to be in line with guidance issued by the FGDP.

Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. They commented they were treated with kindness and respect while they received treatment. Patients described staff as caring and professional. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding. Many patients had already recommended this practice to their own family and friends.

Are services responsive to people's needs?

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

Summary of findings

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Patients were able to contact staff when the practice was closed and arrangements were subsequently made for these patients requiring emergency dental care.

No complaints had been made in the last 12 months.

The practice offered access for patients with disabilities; was located on the ground floor with accessible toilet facilities.

Are services well-led?

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

There was a clearly defined management structure in place and staff we spoke with felt supported in their own particular roles.

There were several systems in place to monitor the quality of the service including various audits. The practice used various methods to successfully gain feedback from patients. Staff meetings took place on a regular basis and the practice used several methods to obtain feedback from its patients and staff.

The practice carried out audits such as radiography and dental care records at regular intervals to help improve the quality of service. However, not all audits had documented learning points with action plans.

Changing Faces Dentistry and Facial Rejuvenation at Same Day Teeth (West Midlands) Ltd

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 inspected Changing Faces Dentistry and Facial Rejuvenation at Same Day Teeth (West Midlands) Ltd on 22 March 2016. The inspection team consisted of one Care Quality Commission (CQC) inspector and a dental practice manager specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed Healthwatch that we were inspecting the practice. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the clinical dental technician (CDT) and two dental nurses. We spoke with patients and reviewed CQC comment cards which patients had completed. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had arrangements for staff to report incidents and accidents. The most recent accident was recorded in September 2015. We were told they were discussed informally with staff members at the earliest opportunity. However, we found no evidence that incidents/accidents were discussed during practice meetings in the minutes we reviewed.

Staff members we spoke with all understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The CDT and dental nurse were responsible for obtaining information from relevant emails and forwarding this information to the rest of the team. The practice also had arrangements in place for staff to report any adverse drug reactions via the Yellow Card Scheme.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The dental nurse had received enhanced safeguarding training and was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding. We also saw evidence that safeguarding was discussed with all staff during a team meeting in November 2015. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. We were told that rubber dam kits were available at the practice and that all dentists used them when carrying out root canal treatment.

The practice had a system for raising concerns. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were aware of 'never events' and had processes to follow to prevent these happening. For example, they had a process to make sure they did not extract the wrong tooth.

Staff we spoke with understood the duty of candour regulation. The intention of this duty is to ensure that staff members are open and transparent with patients in relation to care and treatment.

The practice had a written procedure for the safe use of needles and other sharp instruments which described safe processes for handling these. We were told that the dentists always re-sheathed used needles but the dental nurses dismantled them. The dentists should be responsible for dismantling them so that fewer members of the dental team handle used sharp instruments. This reduces the risk of injury to other staff members posed by used sharp instruments.

Medical emergencies

The arrangements for dealing with medical emergencies in the practice were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an Automated External defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in

Are services safe?

this area. However, we did not see any evidence of the dental hygienist/therapist's training. The practice emailed us after our visit with evidence that this staff member had attended appropriate training in December 2015.

The practice undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. We saw records since January 2015 to confirm this. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge and the temperature was monitored daily.

All staff we spoke with were aware of the location of this equipment and equipment and medicines were stored in purposely designed storage containers.

The AED did not contain any pads for children. The clinical dental technician told us they would contact the manufacturer to ensure that the adult pads were safe to use on patients of all ages.

Staff recruitment

The practice had a policy for the safe recruitment of staff. We looked at the recruitment records for six members of the practice team. The records we saw contained evidence of staff identity verification, dental indemnity and copies of their General Dental Council (GDC) or General Medical Council (GMC) registration certificates. Some of the files also contained immunisation status, induction plans and employment contracts. The practice's recruitment policy stated that two references for each prospective employee must be sought; however, not all staff members had two references. There were not any curricula vitae. There were Disclosure and Barring Service (DBS) checks present for five out of the six staff files we viewed. 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 vulnerable adults.

The practice had a system in place to monitor the professional registration of its clinical staff members. We reviewed a selection of staff files and found that certificates were present and had been updated to reflect the current year's membership.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that the fire extinguishers had been serviced in February 2016. We saw evidence that fire alarms were tested weekly by the landlord. Fire drills took place annually. We saw evidence that a fire risk assessment took place in February 2016 by an external company. We noted that there were some actions that had been recommended at the time of the risk assessment. Some of these had been completed and others had not. Staff were aware of these outstanding actions and assured us that they were working through them.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them. We were told that any new dental materials were discussed at the next practice meeting so that learning could be shared with all staff members.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. However, some improvements were required. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed. We saw evidence that infection control had been discussed with staff in staff meetings.

We reviewed a selection of staff files and saw evidence that all clinical staff (apart from the anaesthetist) were immunised against Hepatitis B to ensure the safety of patients and staff. We found that a risk assessment had been completed where there was a gap in assurance around this.

We observed the treatment rooms and the decontamination room to be visually clean and hygienic. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were clean and free from clutter. Patient dental care records were computerised and the keyboards in the treatment rooms had water-proof covers. The clinical areas had sealed flooring which was in good condition.

Are services safe?

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance, an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

Sharps bins were appropriately located and out of the reach of children. We observed waste was separated into safe and lockable containers for fortnightly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in a locked container but this was not enclosed or secured to a wall. We discussed this with the CDT and they assured us they would make arrangements for this. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and these were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument.

The CDT informed us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All clinical and non-clinical areas were cleaned daily by staff at the practice.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every six months in line with current guidance. Action plans were not documented subsequent to the analysis of the results. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A risk assessment process was carried out by an external contractor in February 2016. We saw evidence that the practice recorded water temperatures on a monthly basis to check that the temperature remained within the recommended range. However, the last water temperature check took place six weeks ago. Staff were aware of this and assured us the next one would be carried out as soon as possible. They also tested the water quality every three months and we saw evidence that the results were clear in January 2016.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray equipment and autoclaves.

Regular Portable Appliance Testing (PAT) is required to confirm that portable electrical items used at the practice are safe to use. We saw evidence of a recent PAT certificate.

The practice kept a log of medicines that were dispensed to patients so they could ensure that all medicines were tracked and safely given.

There was a separate fridge for the storage of medicines and dental materials. We saw evidence that the temperature was being monitored and recorded regularly.

Are services safe?

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records and corroborated what they told us by viewing a sample of records.

The practice protocol for ensuring that dental materials were within their expiry date required improvement as we found several different expired dental materials on the day of our visit. We were told that there was a stock rotation system at the practice but this needed to be more robust in order to ensure that all expired materials were identified and disposed of in a timely manner. The CDT disposed of all expired materials immediately and assured us that a more robust system would be implemented.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used digital X-rays. Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

We saw that the X-ray equipment was fitted with a part called a collimator which is good practice as it reduces the radiation dose to the patient.

We saw evidence that the practice carried out an X-ray audit in October 2015. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. This audit was only for the OPG and not for the smaller intra-oral X-rays. We did not see any evidence that the results were analysed and reported on with subsequent action plans.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date electronic dental care records but not all were comprehensive and detailed. The dental care records contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP) but the details were not always recorded.

No dentists were available to speak with on the day of our visit. Both of the dentists work at this practice on a part-time basis and both were involved in other commitments at alternative dental practices on the day of our inspection. We spoke with the dental nurse about the dental care provided by the dentists. The dental nurse told us about the oral health assessments, treatment and advice given to patients and some of this information was corroborated by looking at patient care records. We were told that the dentists always checked the soft tissues lining the mouth for any signs of mouth cancer; however, this was not always recorded in the dental care records. Medical history checks were updated by each patient at each visit. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We were told that the dentists always recorded the patients' BPE but we saw that this was not always recorded in the dental care records.

The practice used other guidelines and research to improve their system of clinical risk management. For example, following clinical assessment, the dental nurse told us that the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

The consultant anaesthetist carried out intra-venous (IV) sedation at the practice for patients who were very nervous of dental treatment. We found that staff had put into place robust systems to

underpin the safe provision of conscious sedation. They told us they were acting in accordance with the guidelines published by The Dental Faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists (Standards for Conscious Sedation in the Provision of Dental Care 2015).

The systems supporting sedation included pre and post sedation treatment checks, monitoring of the patient during treatment, discharge and post-operative instructions. We did not see any evidence of staff training for sedation. We were told this training occurred on an annual basis. We were told the anaesthetist carrying out sedation was always accompanied by one dental nurse and a dentist on each occasion.

We were told that patients were always assessed for suitability for IV sedation at a preceding appointment. We were told that all patients undergoing IV sedation had important checks made prior to sedation; this included a detailed medical history and blood pressure measurements.

We were told that the anaesthetist brought their own equipment and medicines for the sedation process. They were responsible for bringing a specific emergency medicine that may be required in an emergency. We discussed this with the CDT as there should be clear roles of responsibility between the practice and the anaesthetist with regard to the provision and storage of medicines and equipment relating to the sedation process.

Health promotion & prevention

The medical history form patients completed included questions about their smoking and alcohol consumption. The dental nurse we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were oral health promotion leaflets available in the practice to support patients to look after their health. Examples included information on gum disease, tooth decay and diet.

The practice was aware of the provision of preventative care and supporting patients to ensure better oral health in

Are services effective?

(for example, treatment is effective)

line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive oral hygiene advice. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran.

Staff told us they were encouraged to maintain the continuous professional development) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC or the General Medical council (GMC).

The CDT monitored staffing levels and planned for staff absences to ensure the service was uninterrupted.

Dental nurses were supervised by the dentists and supported on a day to day basis by the directors. Staff told us that senior staff were readily available to speak to at all times for support and advice.

We were told that the dental nurses were encouraged to carry out further training. Both dental nurses had undertaken additional training which enabled them to take X-rays.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist dental services for orthodontic treatment. There were no dentists available to speak with on the day of our inspection so we were unable to discuss the referral protocols with them. The practice contacted us after our visit and explained that all orthodontic referrals were submitted online via the orthodontic practice's online referral system. All mandatory information requested by the orthodontic practice had to be submitted online, therefore, the dentists could assure themselves that the referral documents were sufficiently detailed with all relevant information.

We also requested a protocol for urgent referrals, for example, patients with suspected oral cancer. This was not available on the day of our visit as there was no dentist. We were told that all information was submitted online so we were not able to view any relevant documents during or after our visit.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began.

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 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.

Staff confirmed individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Patients were given time to consider and make informed decisions about which option they preferred. We saw evidence of customised treatment plans when reviewing dental care records.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Thirty-five patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Patient feedback was positive about the care they received from the practice. They commented they were treated with kindness and respect while they received treatment. They described staff as caring and professional. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding. Many patients had already recommended this practice to their own family and friends.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. We observed that staff members were helpful, discreet and respectful to patients. Staff members we spoke with were aware of the importance of providing patients with privacy. Staff told us if a patient wished to speak in private an empty room was available to speak with them. We were told that all staff had individual passwords for the computers where confidential patient information was stored. The reception area was not always supervised, however, staff always logged out of the computer system to prevent unauthorised access to confidential information.

We were told that the practice appropriately supported anxious patients using various methods. For example, the practice booked longer appointments so that patients had ample time to discuss their concerns with the dentist. They also had the choice of different dentists. Sedation facilities were available at the practice if patients requested this.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment was discussed with them and this information was also provided to them in the form of a customised written treatment plan.

Examination and treatment fees were displayed in the waiting room and on the practice's website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as the practice was on the ground floor. There were toilet facilities available for patients in wheelchairs; however, the toilet was out of use at the time of our inspection.

The practice had an appointment system in place to respond to patients' needs. Patients were usually seen on time. The practice carried out an audit on waiting times and concluded that no action was required because feedback confirmed that patients were satisfied with waiting times.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We were told that dedicated emergency slots were available on a daily basis to accommodate patients requiring urgent treatment.

Patient feedback confirmed that the practice was providing a good service that met their needs.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. We saw evidence that this was discussed during a staff meeting in December 2015. The practice recognised the needs of different groups in the planning of its services. The practice did not currently have audio loop systems for patients who might have hearing impairments although they were considering introducing this. However, the practice used various methods so that patients with hearing impairments could still access the services.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

Access to the service

Feedback from patients confirmed they could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. The registered manager would receive an email alert and arrangements would subsequently be made for a dentist to see the patient.

Opening hours were from 9am to 5pm on Monday to Friday. The practice was also open on alternate Saturdays from 9am to 5pm.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and this included details of external organisations in the event that patients were dissatisfied with the practice's response.

No written complaints had been received at the practice in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

The registered manager was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. There was a policy in place but not all of the actions had been implemented yet.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead and infection control lead.

Learning and improvement

The registered manager monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The registered manager also kept a log of staff members' CPD records to ensure they were meeting GDC requirements. The GDC requires all registrants to undertake CPD to maintain their professional registration.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. However, not all of these audits had action plans. All audits should have documented learning points so that the resulting improvements can be demonstrated. The practice had also carried out audits in other areas such as medical emergencies, patient involvement and consent.

Staff meetings took place every eight weeks and these were open to all staff. We noted that topics such as safeguarding and infection control had been discussed and documented. The minutes of the meetings were made available for all staff and we saw that minutes were present. This meant that staff members who were not present also had the information and all staff could update themselves at a later date.

We were told that the dental nurses would be having annual appraisals where learning needs, concerns and aspirations could be discussed. The dental nurses had their appraisals with the provider in December 2015 and we were told these would take place every 12 months.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. The practice had undertaken patient satisfaction surveys since October 2015 and this was an ongoing process. However, the results had not been analysed and actioned yet. The results from these surveys were cascaded to all staff at practice meetings. There was also a suggestion box in the waiting room for patients to leave comments and suggestions.

The practice had also invested in a customer relations management system which allowed them to communicate better with patients to ensure better customer service. It is a computerised system which allows patients to receive information that is customised to them. It also gives patients the opportunity to complete questionnaires to help improve the service.

Staff we spoke with told us their views were sought and listened to. We were told that both dental nurses had completed dedicated staff satisfaction questionnaires in the last two years.