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Orchard Green Dental Practice

Inspection Report

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Date of inspection visit: 15 October 2015
Date of publication: 19/11/2015

Overall summary

We carried out an announced comprehensive inspection on 15 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

The Orchard Green Dental Practice is located in the London Borough of Bromley. The premises are laid out over the ground floor of a converted residential building. There are two treatment rooms, a dedicated decontamination room, a waiting room with reception area, staff kitchen, and a toilet.

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

The staff structure of the practice is comprised of a principal dentist (who is also the owner), two associate dentists, a hygienist, two dental nurses, a receptionist, who also works as the practice administrator, and a trainee dental nurse.

The practice opening hours are from Monday to Friday from 9.00am to 5.00pm.

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

Summary of findings

The inspection visit took place over one day and was carried out by a CQC inspector and dentist specialist advisor. Additional phone calls to members of staff were made on two subsequent days by the CQC inspector.

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

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection, although some improvements could be made regarding the storage of dental equipment and waste.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review the practice's protocol for the storage and disposal of sharp instruments.
- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review the practice's protocols for recording in the patients' dental care records, or elsewhere, the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review the storage of dental care records to ensure they are stored securely.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems and protocols which were used to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting potential abuse. There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We found the equipment used in the practice was well maintained and checked for effectiveness.

The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. However, there were some improvements that could be made to the infection control protocols in relation to the storage of dental instruments and the disposal of sharps. The principal dentist confirmed to us that both of these issues had been addressed after the inspection.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. The practice maintained appropriate dental care records and details were updated appropriately. The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Clinical staff worked towards meeting professional standards and completing continuing professional development (CPD) standards set by the General Dental Council (GDC). Staff told us they were well-supported by the principal dentist through informal supervision and ad hoc staff meetings.

Are services caring?

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

We received positive feedback from patients through comment cards and from the practice's own patient satisfaction survey. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times.

We found that dental care records were stored securely in locked cupboards in the reception area; however some filing cabinets had been left unlocked and unattended on the day of the inspection. Further action should be taken to maintain patient confidentiality at all times.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. Patients were invited to provide feedback via a satisfaction survey and the results of these surveys had been analysed and acted on.

Summary of findings

There was a complaints policy which was displayed in the waiting room. Two complaints had been received by the practice in the past year. The principal dentist had followed the complaints policy and had carried out relevant investigations and recorded the outcome of these. We found that actions had been taken to improve the quality of care in response to complaints.

Are services well-led?

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

The practice had clinical governance and risk management protocols in place. These were disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. Feedback from staff and patients was used to monitor and drive improvement in standards of care.

However, we noted that some records related to staff recruitment had not been kept and there was no formal recruitment policy. We discussed this with the principal dentist who assured us that these documents would now be completed and kept on file.

Orchard Green Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 15 October 2015. The inspection took place over three days with a site visit on 15 October and follow up phone calls on 19 and 20 October with members of the dental nursing team, who had not been present during the site visit. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

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

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. Three incidents or accidents had been recorded in the past year. There was a policy for staff to follow for the reporting of these events and we saw that this policy had been followed in these cases. Incidents had been appropriately recorded and investigated. Actions taken at the time and any lessons that could be learnt to prevent a recurrence were noted and discussed with individual members of staff. A record of wider staff discussions was also kept if the investigation of the incident led to a change in protocols. For example, an incident involving a needlestick injury in February 2015 had led to a discussion amongst the dentists about the protocols for giving local anaesthetic to patients. They had tried to identify if any further actions could be taken to reduce the risk of injury to staff or patients.

We noted that it was the practice policy to offer an apology when things went wrong. We saw an example of a written apology that had been offered following a patient's complaint.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). None of the accidents or incidents had required notification under the RIDDOR guidance.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

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

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, there was a risk assessment and written protocol for what to do in the event of a sharps injury or accident (e.g. related to needles used for injections). There was also a written protocol for using and disposing of sharps. This stated that it was the dentists' responsibility to handle and dispose of needles. Two out of the three dentists used a safety syringe system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. The other dentist took responsibility for re-sheathing any needles; we discussed the possibility that this dentist could use the same safety system as the other dentists in order to further minimise risks.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance supplied by the British Endodontic Society. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.] Two out of the three dentists used the rubber dam routinely; the remaining dentist told us that they usually, but not always, used the rubber dam. We discussed this issue with the dentist to highlight the rationale for routine use of rubber dam and they assured us they would use the dam on all suitable occasions.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. An automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction, were available in line with the Resuscitation Council UK guidelines. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the locations of the emergency equipment.

Staff recruitment

Are services safe?

The practice staffing consisted of a principal dentist, two associate dentists, a hygienist, two dental nurses, a receptionist, who also worked as the practice administrator, and a trainee dental nurse.

The principal dentist described relevant checks that would be carried out prior to employing new members of staff in order to confirm that the person being recruited was suitable for the role. This included the use of an application form, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council (GDC). However, we noted that there was no formal recruitment policy for the principal dentist to refer to during the recruitment process.

We checked four staff files, including two files for members of staff who had been recruited in the past year. We found that the majority of relevant information for these members of staff was held including copies of employment history, qualifications, checks of identity (e.g. copies of passports) and registration with the GDC. However, the information held was not consistent across all of the staff files; for example, we found one case where a copy of employment history was missing.

We found one instance where an email reference had been kept for a newly recruited member of staff. The principal dentist told us that she had obtained a verbal reference for the other new member of staff, but that she had not kept notes in relation to this. They had also told us they had not kept references on file for longer-standing members of staff, although these had been sought at the time of the recruitment.

We found evidence that a copy of a Disclosure and Barring Service (DBS) check for all members of staff was kept. However, we found that these were not always carried out by the practice prior to employment. The principal dentist told us they had sometimes relied on information from DBS applications made by staff in relation to employment at other services.

Monitoring health & safety and responding to risks

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

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

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

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

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The principal dentist was the infection control lead. The practice had carried out practice-wide infection control audits every six months, with the most recent one having been completed in October 2015.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

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

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. In accordance with HTM

Are services safe?

01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was one decontamination room. It was well organised with a clear flow from 'dirty' to 'clean'. The principal dentist demonstrated how they used the room. They showed a good understanding of the correct processes. A manual cleaning process was used. Staff wore appropriate protective equipment, such as heavy duty gloves and eye protection was used. There was an instrument-washing sink with appropriate detergent and water temperature checks were carried out. A second sink was used to rinse instruments. Following inspection of cleaned items, they were placed in an autoclave (steriliser).

Instruments were pouched and stored until required, after they had been sterilized. All pouches were dated with an expiry date in accordance with current guidelines. However, we found that some items (e.g. hand pieces and impression trays) were being stored unpouched or unlidded in drawers in both of the treatment rooms. We discussed the risk of aerosol re-contamination in relation to these items with the principal dentist. The principal dentist told us that hand pieces were usually pouched and the items seen would not have been used without going through the correct process. They confirmed that all of the items would be either pouched or stored in lidded containers prior to use.

The principal dentist showed us that systems were in place to ensure that the autoclaves were working effectively. These included the automatic control test and steam penetration tests. It was observed that the data sheets used to record the essential daily validation were complete and up to date.

The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account national guidance on colour coding equipment to prevent the risk of infection spread.

Clinical waste was segregated and the practice used a contractor to collect dental waste from the practice. However, we noted that although sharps bins were in use, these were stored on the floor. These need to be stored above floor level, out of the reach of children, and preferably attached to a wall. The principal dentist told us they were unaware of this requirement and had followed the advice of their waste contractor. However, they would now review this protocol and ensure that sharps bins were stored off the floor.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an appropriate contractor in 2011. The practice had followed advice as a result of this assessment. For example, they carried out periodic checks of the water temperature in line with advice received.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and autoclave (steriliser) had all been inspected and serviced in 2015. Portable appliance testing (PAT) had also been completed in accordance with good practice guidance on a yearly basis. PAT is the name of a process during which electrical appliances are routinely checked for safety.

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

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

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A radiation protection file, in line with these regulations, was present. This file was well maintained and complete. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health

Are services safe?

and Safety Executive. The maintenance log was within the current recommended interval of three years with the next service due in 2016. We saw evidence that staff had completed radiation training.

We observed that the Orthopantomogram (OPG; a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth in a two-dimensional representation) machine was located in a corner of a hallway between the treatment rooms. It was not fully enclosed. We asked the principal dentist about arrangements regarding patients or staff walking in the vicinity during an X-ray. They showed us their written protocol which instructed staff to check the toilet, inform the staff and display a sign in the waiting area in order to prevent people moving through the area during an X-ray. This information was also displayed on the wall next to the OPG.

A copy of the most recent radiological audit was available for inspection. This demonstrated that a high percentage of radiographs were of grade one or two (the higher) standards. We checked a sample of individual dental care records to confirm the findings. These records showed that dental X-rays were justified every time. The principal dentist told us that they were aware that not all of the X-rays were graded, in line with the quality assurance process recommended in the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). They assured us that the issue would be highlighted with relevant staff to ensure that they recorded the grade of X-rays on every occasion.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The principal dentist described how they carried out patient assessments using a typical patient journey scenario. The practice used a pathway approach to the assessment of the patient which was supported by the use of computer software. The assessment began with a review of the patient's medical history and patients were also asked to complete a social history (for example, exploring current diet and alcohol intake). This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained in detail. The dental care record was updated with the proposed treatment after discussing options with the patient. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentist and the hygienist told us they were aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentist also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting area; including information aimed at engaging children in good dental hygiene practices. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and X-ray training.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. Staff told us they had been engaged in yearly appraisals which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

Working with other services

The principal dentist explained how they worked with other services, when required. Dentists were able to refer patients internally to the hygienist. They could also refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each

Are services effective?

(for example, treatment is effective)

patient. Notes of these discussions were recorded in the dental care records. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed.

Staff were aware of the Mental Capacity Act 2005. They could explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from forty-eight patients. They described a positive view of the service. The practice had also carried a patient survey in 2015 which indicated a high level of satisfaction with care. Patients commented that the team were friendly, kind and respectful. Patients were happy with the quality of treatment provided. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. Staff understood the importance of data protection and confidentiality and had received training in information governance. The receptionist told us that people could request to have confidential discussions in an empty treatment room, if necessary. They also ensured that paper records remained out of view behind the reception desk and were filed promptly after use.

There were additional systems in place to make sure that patients' confidential information was protected. Dental care records were kept electronically and in a paper format. Electronic records were password protected and regularly backed up. Paper records were stored in locked cupboards behind the reception desk or in lockable filing cabinets in the hallway between the reception area and treatment rooms. We noted that the filing cabinets were lockable, but the key remained in the lock throughout the day. These records could potentially have been accessed by people as they moved between the reception and treatment rooms. The principal dentist told us that this was an oversight and that the cabinets would now be locked and the receptionist would be the key holder during opening hours.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the private and NHS dental charges or fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We checked a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with the principal dentist and the hygienist on the day of our visit. They told us they worked towards providing clear explanations about treatment and prevention strategies. The patient feedback we received via comments cards, together with the data gathered by the practice's own survey, confirmed that the majority of patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The principal dentist told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The principal dentist told us the local population was mainly English speaking, although some practice staff spoke additional languages, which had been used to aid communication with patients on some occasions. They were aware that it was possible to organise a telephone translation service, although had never needed to do so. They were able to provide large print, written information for people who were hard of hearing or visually impaired.

The principal dentist had considered the needs of people with limited mobility and carried out an access audit in 2004. The majority of the practice was wheelchair accessible with treatment rooms on the ground floor. The audit had recommended the installation of a ramp to enable all wheelchair users to smoothly access the practice at the main entrance. However, the costs had been prohibitive and the principal dentist had assessed that this was not reasonably practical. The principal dentist told us that some wheelchair users did visit the practice and were aided to access the practice by their carers. They also directed patients to a local community service that was fully wheelchair accessible, if necessary.

Access to the service

The practice opening hours were from Monday to Friday from 9.00am to 5.00pm. The principal dentist told us they had trialled both later opening hours and weekend opening, but that low uptake had suggested that this was unnecessary for meeting the needs of the local population.

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

Reception staff told us that there were generally appointments available within a reasonable time frame, although there were occasions where waiting times for a routine appointment could be up to a month in advance. The feedback we received from patients confirmed that they could generally get an appointment when they needed one. However, there was some, limited feedback in the comment cards and from the practice's own satisfaction survey which indicated that not all patients were happy with the time delay for appointments. We discussed this issue with the receptionist and principal dentist. They told us they were aware of this feedback and that this had led to a review of the dentists' working practices. The principal dentist had adjusted their working practice so that they now saw more NHS patients as well as private patients. The receptionist commented that this adjustment was a recent innovation but that it appeared to be having a positive impact in terms of reducing waiting times for appointments. The principal dentist would continue to monitor the patient feedback for signs of improvement following this change.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area and on the practice website. There was a complaints policy which described how the practice handled formal and informal complaints from patients.

There had been two complaints recorded in the past year. These complaints had been responded to in line with the practice policy. A record was kept of what had occurred, actions taken at the time, as well as wider changes that were implemented to policies and protocols to prevent

Are services responsive to people's needs?

(for example, to feedback?)

problems from recurring. For example, we found evidence in staff meeting minutes that a review of the system for managing emergency appointments had been implemented following a patient complaint.

Patients had received a written or verbal response following the investigation of any complaint. We noted some examples where the records showed that an apology had been offered.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. The principal dentist had implemented suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them.

We noted one instance where the practice lacked a written policy which had led to some inconsistencies in recording relevant information. This was in relation to staff recruitment. There were some documents missing from the staff files we reviewed; in some cases references for staff had not been kept. We discussed this with the principal dentist at the time of the inspection. We were satisfied that references had been sought, but that a record of these had not been routinely kept. They assured us that they would now keep a record of references for new members of staff and would set out this requirement in a formal recruitment policy.

There were staff meetings approximately every three months to discuss key governance issues. For example, we saw minutes from meetings where issues such as complaints, fire safety, infection control and staff training had been discussed. This facilitated an environment where improvement and continuous learning were supported.

Leadership, openness and transparency

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

We spoke with the principal dentist about their vision for the practice. They told us they aimed to provide a patient-focused and friendly service where the quality of care was maintained to a high standard and staff were well supported in their roles.

Staff told us they enjoyed their work and were supported by the principal dentist. They received regular appraisals which commented on their own performance and elicited their goals for the future.

Learning and improvement

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice had a programme of clinical audit and risk assessments in place. These included audits for infection control, clinical record keeping and X-ray quality which showed a generally high standard of work. Areas for improvement were identified through the auditing programme. For example, an audit of the clinical recording keeping carried out in July 2015 identified the need to improve the recording of medical histories. This had been discussed at a staff meeting and a further audit in six months' time would determine if improvements had been made.

Risk assessments were being successfully used to minimise the identified risks. For example, we saw evidence of actions taken following a Legionella risk assessment. However, there were some areas where we observed that further risk-reduction strategies could be implemented. These included reviewing the protocols for the disposal of sharps and storage of dental instruments following decontamination. The principal dentist confirmed to us that both of these issues had been addressed after the inspection.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey and through the 'Friends and Family Test'. The majority of feedback was positive about the quality of care received. The receptionist had carried out an analysis of the feedback received in the past three months and acted on the feedback from patients. For example, they had improved the display of the complaints policy and raised concerns with the principal dentist about waiting times for routine appointments. The principal dentist had responded to this feedback by adjusting their working practices to include a larger proportion of NHS patients.

Staff told us that the principal dentist was open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums to give their feedback.