Smile Care Paignton Ltd

Smile Dental Care Paignton

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 24 January 2017 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

Smile Dental Care Paignton is located in the coastal town of Paignton, Devon. The practice provides primary dental care services. The practice provides NHS care. There are three dental surgeries (one situated on the ground floor and two on the first floor). There is level access from the street. Approximately 4,000 patients are registered at the practice.

The staff structure of the practice consists of two permanent dentists and a locum dentist. The practice is seeking to appoint an additional third full-time permanent dentist. There is a practice manager, one qualified dental nurse and three trainee dental nurses registered on a training course to achieve their dental nursing qualification. The practice also employs a receptionist and a cleaner.

The practice is open from Monday to Friday from 8.30am to 5.00pm. There is an answer phone message directing patients to emergency contact numbers when the practice is closed.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008

Summary of findings

and associated Regulations about how the practice is run. The practice manager is also the registered manager at a separately registered dental practice approximately one mile away from Smile Dental Care Paignton.

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

Nine patients provided feedback directly to CQC about the service. All were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received.

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 systems in place to reduce and minimise the risk and spread of infection.
- There was a lead staff member for safeguarding patients. All staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from the practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- Appointment text/phone reminders were available on request 48 hours prior to appointments.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Staff received training appropriate to their roles and were supported in their continued professional development by the management team.
- Staff we spoke with felt supported by the management team and were committed to providing a quality service to their patients.
- Staff at the practice took safeguarding concerns seriously. The dentist on duty and practice manager were able to describe scenarios where they had raised concerns about the welfare and safety of patients to the relevant authorities for advice and in order to keep patients safe. This included the referring dentist attending multi-disciplinary team meetings with other healthcare professionals to share information and devise an agency wide action plan to support vulnerable patients.

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

- Carry out a premises risk assessment for legionella.
- Design, implement and review a system for a stock rotation system to ensure items remain within date.
- Provide locum staff with all relevant induction information.
- Design, implement and review a system to ensure the correct mounting of radiographs.
- Secure the premises to the rear of the practice and install adequate housing for the compressor and suction.

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?

No action

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

The practice had systems to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies. There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies. The practice was committed to attending external multi-disciplinary meetings with other community based health care professionals to discuss vulnerable or at risk patients registered at the practice to keep them safe. There was an annual training plan to ensure staff training in safeguarding was appropriately maintained.

Infection control processes were safely managed. Equipment used in the practice was checked for effectiveness. Staff recruitment was robust to ensure applicants had the skills and aptitudes necessary for the roles they were employed for.

Are services effective?

No action

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

No action

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

We received positive feedback from nine patients. The practice also received patient feedback via internal surveys and through the NHS Choices website. Feedback at the inspection was positive although there was negative feedback via NHS Choices. Patients said that the staff were kind and caring and that they were treated with dignity and respect at all times.

We found that dental care records were stored securely and patient confidentiality was well maintained.

Summary of findings

Are services responsive to people's needs?

No action

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.

There was a complaints policy in place. Complaints were addressed in a timely way and resolutions aimed to the satisfaction of the complainant. Systems were in place for receiving more general feedback from patients, with a view to improving the quality of the service. This included patient testimonials sent directly to the practice.

The culture of the practice promoted equality of access for all. The practice had level access from the street and one ground floor treatment room for patients who had mobility difficulties. Plans were in place to improve the range of seating in the waiting area to provide better facilities for patients who needed raised seating.

Are services well-led?

No action

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

The practice had clinical governance and risk-management structures in place. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in the abilities of the managers to address any issues as they arose.

Smile Dental Care Paignton

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 24 January 2017. The inspection was carried out by a CQC inspector and dentist specialist advisor.

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

Nine patients provided feedback about the service. We also looked at comments about the practice left about patient experiences on-line via NHS Choices. At the inspection patients were positive about the care they received from the practice. Via NHS Choices there were two negative comments made in the last 12 months.

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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system for reporting and learning from incidents. There had been no significant events related to patients, visitors or staff in the past year.

We discussed the investigation of incidents with the practice manager. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

Whole staff team meetings were held at least monthly. Team meetings were recorded and we looked at a sample of team meeting minutes. The records were detailed but lacked sign off when actions resulting from previous team meetings had been addressed. We discussed this with the practice manager who said they would amend the meeting minute template to capture this information for future meetings.

Reliable safety systems and processes (including safeguarding)

The practice manager 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 safeguarding policy reviewed in the last 12 months. The policy referred to national and local guidance. Information about the local authority contacts for safeguarding concerns was held in a file in the staff room. The staff we spoke with were aware of the location of this information. There was evidence in staff files showing that all staff had been trained in safeguarding adults and children to level two. The safeguarding lead had been trained to an enhanced level three.

When we spoke with the staff at the practice is was clear that all staff took safeguarding concerns seriously. The dentist on duty and practice manager were able to describe scenarios where they had raised concerns about the welfare and safety of patients to the relevant authorities for advice in order to keep patients safe. This included the referring dentist attending multi-disciplinary team meetings with other healthcare professionals to share information and devise an action plan to support vulnerable patients.

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, we asked staff about the prevention of needle stick injuries. The practice had a current policy on the re-sheathing of needles, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex-free rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Medical emergencies

The practice had arrangements to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in with the emergency equipment in an area accessible only to staff. This was available for the dental practice to use; the staff were aware of its location and how to use it. (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 practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

No action

Are services safe?

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use each day the practice was open.

Staff recruitment

The staff structure of the practice consisted of two permanent dentists and a locum dentist (the practice was advertising for a full-time permanent dentist). There was a practice manager (who was also a qualified dental nurse), a dental nurse (temporary appointment) and three trainee dental nurses on a course to achieve their qualification. There was a receptionist and cleaner.

There was a recruitment policy which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and where relevant a check of registration with the General Dental Council.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment. We saw evidence that all members of staff had a DBS check. (The 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 looked at five staff files. All required information was included in the files we viewed.

Monitoring health & safety and responding to risks

There were arrangements to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated at suitable points in the premises. The practice carried out annual fire drills.

There were arrangements 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. COSHH products were securely stored.

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS). Relevant alerts were discussed during monthly staff meetings which facilitated shared learning.

The practice suction unit and compressor were located at the rear of the premises. (A dental suction system collects blood, saliva, and other debris generated during dental procedures. A dental air compressor pressurises atmospheric air to power equipment used in dental procedures). The housing of the suction and compressor equipment was not secure and posed a risk to the public and practice staff. This was because there was no door to the shed that housed the equipment and the external boundary to the rear of the premises was open; as a result of significant repairs that were needed to the fencing surrounding the rear of the premises. The lack of suitable maintenance to the rear of the premises also meant that storage of waste bins in this area and pest control baited traps could be accessed by the public. Staff told us that daily checks on the suction unit and compressor were hazardous as the shed housing the equipment was liable to rain penetration. The practice manager was aware of the situation and showed us quotes sourced to replace the suction and compressor housing and to make repairs to the security of the outside fences. Following the inspection the practice manager sent us evidence of receipts for purchases of a new shed and fencing for the premises, which would secure the premises and provide suitable housing for the compressor and suction units. We were told that the timescale for installation for both shed and fence was during March 2017.

Infection control

There were systems to reduce the risk and spread of infection within the practice. 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 lead infection control nurse carried out bi-annual audits of infection control processes at the practice using a recognised industry assessment tool.

We observed that the internal premises appeared clean, tidy and clutter free. There were written schedules in each treatment room for cleaning between patients, at the end of each surgery session and for deep cleaning. There was also a written cleaning schedule for the cleaner, who worked in non-clinical areas.

No action

Are services safe?

Clear zoning demarked clean from dirty areas in all of the treatment and decontamination rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment and decontamination rooms.

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice 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)'.

The dental nurse explained the decontamination in the purpose built decontamination room and dental surgeries. The dental nurse described the process they followed to ensure that the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building.

We checked the contents of the draws in two of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

Instruments were manually cleaned in the treatment room then inspected under an illuminated magnification device and then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

The practice carried out checks of the autoclave to assure that it was working effectively. Twice daily checks when the practice was open included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

The segregation of dental waste was in line with current guidelines laid down by the Department of Health. Clinical waste bags and municipal waste were stored in locked bins outside the property which was unfenced and therefore unsecure. The practice manager told us that repairs to the fences were scheduled to be completed in March 2017. The practice used a contractor to remove dental waste from the practice. Waste consignment notices were available for inspection.

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. (People 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 risks of blood borne infections.)

The dental water lines were monitored to prevent the growth and spread of legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. There was a practice policy reviewed during December 2016 to minimise the risk of legionella. The practice carried out weekly testing of water temperatures. The practice kept a record of the outcome of these checks. Water samples had been sent for analysis at a laboratory on 20 January 2017 and the results had been negative for the presence of harmful bacteria. The practice manager told us that she had raised to the provider a concern that the practice did not have a legionella risk assessment for the premises carried out by a competent person. The practice manager expressed concern that the poor state of repair of the shed housing the suction unit posed a risk because of the potential that rain water could enter the suction water line. Following the inspection the practice manager spoke with us to confirm that a legionella risk assessment by a competent contractor had been booked and was scheduled during March 2017.

Equipment and medicines

The equipment used at the practice was regularly serviced. For example, we saw documents showing that the air compressor, fire equipment and x-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance in January 2016. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

No action

Are services safe?

The expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly. We found some out of date needles and syringes, root canal gel and temporary bonding cement in two surgeries. The practice manager removed and replaced the items during the inspection. She told us that she would bring this up at the next staff meeting with a plan to action amendment of stock control check lists to ensure this did not occur again.

There was a system to monitor the issuing of patient prescriptions. We saw prescription pads were stored securely and there was a log of all prescriptions issued and to whom.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in January 2015, within the three yearly recommended maintenance cycle.

We saw evidence that the dentists had completed radiation training in the last 12 months.

We looked at seventeen patient records. These included when patients had x-rays taken as part of diagnosis for treatment. We saw that two x-rays had been filed incorrectly as they were either rotated or flipped in the record. This increases the potential risk for wrong site tooth surgery/extraction when x-rays are incorrectly mounted in patients' records. We raised these findings with the practice manager who told us this would be raised in the next monthly staff meeting with an action plan agreed for introducing a system to ensure x-rays were correctly mounted.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with a dentist and asked them to describe to us how they carried out their assessments. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and checking for 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.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. Treatment plans were printed for each patient on request, which included information about the NHS costs involved. Patients were referred to the practice information leaflet or posters in the waiting are for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of seventeen dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The dentist told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussions with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. Dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the reception area. 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 the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and x-ray training. Staff told us that practice manager and the company they worked for were supportive and invested in their staff through regular training opportunities to promote clinical excellence at the practice.

The majority of dental nurses at the practice were unqualified. The practice manager was a qualified dental nurse and there was one other qualified dental nurse. Three were trainees. These trainees were working toward their dental nurse qualification but a qualified dental nurse was leaving the practice later in the year. We expressed concern to how dental nurses would be supervised by competent senior dental nurses when the practice manager was away from the practice. The practice manager told us that the dental nurse training provider provided her with monthly updates on each trainee's progress and that the trainees were scheduled time to work with the qualified dental nurse in the practice. She also said an advert was currently in the local press to recruit a senior dental nurse for when the current dental nurse leaves. In the meantime the practice manager said there were qualified dental nurses at the practice's sister site less than one mile away who were able to come to the practice to oversee the trainee's performance if required.

There was a comprehensive written induction programme for new staff to follow and we looked at four staff induction records to confirm this. The practice used a locum dentist and locum dental nurses to cover staff shortages. The locum dentist had worked at the practice for some time. We found that information for locum staff was brief and, for

No action

Are services effective?

(for example, treatment is effective)

example, did not cover key aspects of working in the practice, such as the fire protocol, information about safeguarding contacts or where emergency equipment was kept. The practice manager said that locum staff were told this information verbally. They also said the locum induction information list would be reviewed and revised to ensure that locum staff had written information about the practice.

Working with other services

The practice had suitable arrangements for working with other health professionals to ensure quality of care for their patients.

Staff at the practice explained how they worked with other services, when required. The dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent by post to the hospital with full details of the dentist's findings and a copy was stored on the practice records system. We looked at three examples of referral letters. These were comprehensively completed and referrals took place in a timely way to avoid delay to treatment. The receptionist kept an electronic record noting the dates when referrals were made, when the appointment had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at seventeen patient electronic records and saw consent to treatment was suitably recorded in the patient dental care records.

All of the staff were aware of the Mental Capacity Act 2005. (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). Clinical staff had completed formal training in relation to the MCA in 2015. The dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met. Examples were given of times when patients were referred to advocacy services in order to support patients with treatment options and to give informed consent to treatment.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The four comments cards we received and interviews with five patients were positive regarding the staffs' caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and the dentists could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in a dedicated lockable staff only area. There were also electronic records for x-rays and charting.

Computers were password protected and regularly backed up. All staff, including the practice cleaner had signed a practice confidentiality agreement regarding protecting information about patients registered with the practice.

Involvement in decisions about care and treatment

The practice detailed information about services in a practice leaflet available at the reception. The provider also had a website. However it was not currently possible to obtain detailed information about each individual dental practice on the practice website, for example, information about the names of staff who work in the practices. A poster detailing NHS costs was displayed in the waiting area.

We spoke with all four staff on the day of our inspection. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

The patient feedback we received on the day of the inspection confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system to schedule enough time to assess and meet patients' dental needs. The dentists decided on the length of time needed for their patient's consultation and treatment according to patient need. Same day urgent appointments were available for patients registered with the practice. During the inspection we heard one person request an urgent appointment. They were able to be seen and assessed within 20 minutes of this request. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed. Patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they provided written information for people who were hard of hearing and translation services were available for patients speaking English as a second language. There were both female and male dentists to facilitate requests for same gender examinations or treatment.

The practice was designed with patient accessibility in mind. Patients who used a wheelchair could access the practice from the ground level access and there was a ground floor treatment room with an accessible ground floor toilet. The seating in the waiting area was low and the practice manager told us that there were plans to replace seating for patients with some higher robust chairs that would help people who needed raised seating because of restricted mobility.

The practice did not have a hearing loop for patients that were hearing impaired. Staff told us they had not encountered difficulties communicating with hearing impaired patients. The practice manager said consideration of the purchase of a hearing loop would be given and discussed in future staff meetings.

Access to the service

The practice opening hours were from Monday to Friday from 8.30am to 5.00pm. There was an answer phone message directing patients to emergency contact numbers when the practice closed.

The receptionist told us that patients, who needed to be seen urgently, for example because they were experiencing dental pain, were seen on the same day that they alerted the practice of their concerns. The feedback we received via comment cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been seven complaints recorded during 2016 regarding dental work or fees. We looked at the complaints. They were handled in a timely way and resolved to the satisfaction of the patient complaining. Complaints were used as discussion points in staff meetings for any team wide learning as a result of the complaints.

The practice carried out bi-annual patient surveys, in which patients could remain anonymous. The practice also participated in the NHS Friends and Family test where patients were invited to give feedback about the practice. We looked at Friends and Family test results for January 2017. There had been 14 responses to date, with 13 patients indicating they would recommend the practice and one person giving a neutral response.

No action

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. The governance arrangements for this location were overseen by the practice manager who was responsible for

the day to day running of the practice. They were supported by the group's area manager (position currently vacant) and practice owner senior management team. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. All required risk assessments had been regularly reviewed with the exception of a risk assessment of the building for legionella. We found that risks were identified at the practice by the manager but that action to reduce risk, such as providing fencing to secure the rear of the premises and suitable housing for the compressor and suction unit, was not acted upon in a timely way because of delays by senior managers in authorising the action to minimise risks when raised.

Regular staff meetings took place at the practice with records maintained of all staff meetings. Minutes from staff meetings were circulated via a staff communication board.

The practice manager told us about the governance structures and protocols at the practice. For example, a systematic process of induction and staff training was in place for permanent staff.

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 practice manager. They felt they were listened to and responded to when they did so.

We found staff to be dedicated in their roles and caring towards the patients. We found the dentists provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the senior managers. Staff told us their annual appraisals were overdue. The practice manager confirmed this was the case but that staff appraisals were scheduled within four weeks of our visit. We spoke with staff on duty who confirmed this.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. These included infection control, clinical record keeping and x-ray quality. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example, specialist referrals, infection control and record keeping audits.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through the use of bi-annual patient surveys. The last patient survey took place in July/August 2016 and involved 17 patients. Actions had been taken as a result of feedback. For example, results indicated some patients felt frequency of check-ups had not been discussed with them. Staff meeting minutes showed this was discussed in the next staff meeting with the dentists to ensure frequency of return visits was discussed with patients and clearly recorded in dental notes. Records we examined on the day of the inspection had recorded these discussions had taken place with patients.

Staff told us that the management team were open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the management team.

Staff told us they felt empowered to suggest improvements at the practice. For example, we saw that one of the dental

No action

Are services well-led?

nurses had set up, implemented and was overseeing a number of revised check lists for decontamination processes and equipment monitoring to ensure processes were robust, with the approval of the practice management.