DCE Davies (Highgate) Limited

Highgate Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 February 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

Highgate dental practice is located in the centre of Beverley, East Riding of Yorkshire. It provides private dental care and treatment for adults and children. Parking is available locally. The practice also offers a dental care plan where patients pay a monthly subscription.

The practice currently has two principal dentists, three associate dentists, eight dental nurses (one of which is a trainee), four receptionists and a practice manager.

One surgery is located on the ground floor and a timetable is in place to help access to all patients who struggle to climb the stairs. Three surgeries are located on the first floor where the decontamination room and office is located. One surgery is located on the second floor and each floor has a separate waiting area.

The practice is open:

Monday & Wednesday 8:00 – 16:45

Tuesday 08:15 – 18:15

Thursday 08:15 – 16:45

Friday 08:00 – 14:45

Saturday 09:30 – 11:30

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'.

Summary of findings

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.

On the day of inspection we received 68 CQC comment cards providing feedback and spoke with two patients. The patients who provided feedback were positive about the care and treatment they received at the practice. They told us they were involved in all aspects of their care and were very pleased with the service. They found staff to be caring, compassionate and friendly and described the treatment to be fantastic. Also the staff had good communication skills, were efficient and patients were treated with dignity and respect in a clean and tidy environment.

Our key findings were:

- Staff had been trained to manage medical emergencies.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Infection prevention and control procedures were in accordance with the published guidelines.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current regulations.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met patients' needs.
- The practice sought feedback from staff and patients about the services they provided.
- The practice risk assessed patients individual needs through an application that collated evidence and supplied the patient with a traffic light system overview of their oral health needs.

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 did not have effective systems and processes in place to ensure that all care and treatment was carried out safely. For example, Buccal Midazolam for the treatment of epilepsy was not available. The adult and child pocket masks and oxygen tubing were out of date as were the needle andsyringes. There were insufficent, recommended amounts of medical emergency oxygen.New equipment was ordered whilst the inspection was taking place and evidence of this was seen.

Staff had received training in safeguarding adults in 2012. However, there was no evidence all staff had received safeguarding children training. The majority of staff were due for up to date training as was the safeguarding lead. Staff were aware how to recognise the signs of abuse and who to report it to. An online training course had been completed by the lead on the day of the inspection and a certificate of this was seen.

The practice had no COSHH assessments in place to risk assess any materials stored on the premises, also there were no practice specific risk assessments in place, however the practice implemented these promptly and evidence was seen by the inspector.

There was a decontamination room and guidance for staff to provide effective decontamination of dental instruments was in place, however there was no evidence when the infection control policy had been reviewed.

Patients' medical histories were obtained verbally before any treatment took place. This provided the dentist with up to date information about any health or medication issues which could affect the planning of treatment. This was not always recorded in the patients' dental care records.

The practice had a recruitment policy to ensure suitably trained and skilled staff met patients' needs. There were sufficient numbers of staff available at all times.

The practice did not have an external legionella risk assessment. However, there was evidence of recent water testing being carried out in line with an internal assessment the practice had implemented.

Are services effective?

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

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). For example, patients were recalled after an agreed interval for an oral health review, during which their medical histories and examinations were updated and recorded also any changes in risk factors were also discussed and recorded.

The practice followed best practice guidelines when delivering dental care. These included guidance from the Faculty of General Dental Practice (FGDP) and NICE. The practice focused strongly on prevention and the dentists were aware of the 'Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Patients dental care records provided information about their current dental needs and past treatment. The dental care records we looked at included discussions about treatment options. The practice monitored any changes to the patients oral health and made referrals for specialist treatment or investigations where indicated in a timely manner.

Summary of findings

Staff were registered with the General Dental Council (GDC) and maintained their registration by completing the required number of hours of continuing professional development (CPD). Staff were supported to meet the requirements of their professional registration.

Are services caring?

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

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which patients understood.

Comments we received from the 68 CQC comment cards providing feedback were positive about the care and treatment received in the practice. Patients' told us they were involved in all aspects of their care and were very pleased with the service. They found the staff to be caring, compassionate, and friendly and described the treatment as fantastic. Also the staff had good communication skills, were efficient and they were treated with dignity and respect in a clean and tidy environment. Patients we spoke with on the day confirmed this.

We observed patients being treated with respect and dignity during interactions at the reception desk and over the telephone.

Are services responsive to people's needs?

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

Patients could access routine treatment and urgent care when required. The practice offered on the day access for patients experiencing dental pain which enabled them to receive treatment quickly.

The practice had a mobile ramp for patients with mobility needs and we observed reasonable adjustments had been made to accommodate patients. The practice had a wheelchair for patients to use getting to and from their cars and around the practice more easily.

The downstairs surgery was used by all dentists as required to accommodate their own patients.

The practice had a complaints process for patients who wished to make a complaint; however this was not accessible in every waiting room and only a flow chart was in place in the downstairs waiting room. No information was available about who to complain to externally, however the full policy was available on the practice website. Staff recorded complaints and cascaded learning to staff. They also had patient advice leaflets available in the waiting room.

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. The practice manager and principals were responsible for the day to day running of the practice.

Staff reported that the registered manager and principals were approachable; they felt supported in their roles and were freely able to raise any issues or concerns with her at any time. The culture within the practice was seen by staff as open and transparent. Staff told us they enjoyed working there.

The practice had undertaken a patient satisfaction survey in November 2014 by an external organisation Denplan as part of the Excel service the practice provided. The practice also had a feedback box available that was reviewed as required and information was shared on the website. The practice was also undertaking the NHS Family and Friends Test.

Summary of findings

The practice held monthly staff meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions.

The practice undertook various audits to monitor their performance and help improve the services offered. The audits included infection prevention and control, patient dental care records and X-rays. Action plans and learning outcomes were in place and each audit was clinician specific. A full copy and overview was given to each clinician to review and this was discussed at clinical meetings.

Highgate Dental Practice

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was carried out on 9 February 2016 and was led by a CQC Inspector and a specialist advisor.

We informed NHS England area team and Healthwatch North Yorkshire that we were inspecting the practice; however we did not receive any information of concern from them.

The methods that were used to collect information at the inspection included interviewing staff, observations and reviewing documents.

During the inspection we spoke with three dentists, four dental nurses (including the lead dental nurse), two receptionists and the registered manager. We saw policies, procedures and other records relating to the management of the service. We reviewed 68 CQC comment cards that had been completed.

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 policies and procedures in place to investigate, respond to and learn from significant events and complaints. Staff were aware of the reporting procedures in place and encouraged to raise safety issues to the attention of colleagues and the registered manager.

Staff had an understanding of the process for accident and incident reporting including their responsibilities under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The staff told us any accident or incidents would be discussed at practice meetings or whenever they arose. We saw the practice had an accident book which had no entries recorded in the last 12 months; evidence of historical events had been processed in accordance with the practice policy. The practice recorded significant events, although there was no incidents within the past 12 months.

The registered manager told us they did not have a system in place to receive alerts from the Medicines and Healthcare products Regulatory Agency (MHRA), the UK's regulator of medicines, medical devices and blood components for transfusion, responsible for ensuring their safety, quality and effectiveness. This was addressed during the inspection and the practice signed up to alerts using the online system.

Reliable safety systems and processes (including safeguarding)

We reviewed the practice's safeguarding policy and procedures in place for safeguarding adults and children using the service. They included the contact details for the local authority safeguarding team, social services and other relevant agencies. One of the dental nurses was the lead for safeguarding. This role included providing support and advice to staff and overseeing the safeguarding procedures within the practice.

We saw all staff had received safeguarding training in vulnerable adults. Staff could easily access the safeguarding policy. The dentists and safeguarding lead demonstrated their awareness of the signs and symptoms of abuse and neglect. They were also aware of the procedures they needed to follow to address safeguarding concerns.

The practice had a dental trauma form to review and follow up any concerns raised from children that may be at risk. The practice had protocols in place to review record and discuss any concerns they found through out the process. We believe this to be notable practice as this shows they were pro-active in identifying patient risks.

The dentists told us they routinely used a rubber dam when providing root canal treatment to patients. A rubber dam is a small square sheet of latex (or other similar material if a patient is latex sensitive) used to isolate the tooth operating field to increase the efficacy of the treatment and protect the patient in line with guidance from the British Endodontic Society.

The practice had a whistleblowing policy which staff were aware of. Staff told us they felt confident they could raise concerns about colleagues without fear of recriminations.

The practice was not aware of their responsibility to register with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register. This was brought to the attention of the registered manager and the providers on the day of the inspection and efforts to register and comply with their requirements was seen accordingly.

Medical emergencies

The practice had procedures in place for staff to follow in the event of a medical emergency and all staff had received training in immediate life support including the use of an Automated External Defibrillator (AED). (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).

The practice kept medicines and equipment for use in a medical emergency in the decontamination room. There was evidence the medical oxygen cylinder being serviced, however there was insufficent recommended amounts available within the practice. Buccal Midazolam, used for the treatment of epilepsy, was not available on the day of the inspection and syringes, adult and child medical oxygen masks were out of date. This was brought to the attention of the registered manager and an order was placed for them immediately. Evidence of this was seen on the day of the inspection.

Are services safe?

All staff knew where these items were kept. We saw the practice kept logs which indicated the medical oxygen cylinder and medical emergency medicines were checked weekly. A more robust process needed to be reviewed to ensure all equipment was checked thoroughly. This would ensure the equipment was fit for use and the medication was within the manufacturer's expiry dates.

The practice provided domiciliary care to some patients who could no longer come to the practice. No risk assessments were in place for this service and no provision of medical emergency equipment and medicines was in place. This would ensure safe systems of work in line with the guidelines for the Delivery of a Domiciliary Oral Healthcare Service 2009. A review of further domiciliary care was discussed on the day of the inspection to stop these services to reduce the risk.

Staff recruitment

The practice had a policy for the recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. All staff recruitment files we reviewed on the day of the inspection supported this process had been followed.

We saw all staff had been checked by the Disclosure and Barring Service (DBS). 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. The practice did not have a system in place to review the need for staff to be reviewed or assessed if they required an up to date check and not all clinical staff had enhanced DBS checks in place, however new systems and reviews for all staff DBS checks were implemented and evidence of this was seen.

We saw all staff had their own personal indemnity insurance (professionals are required to haveinsurance in place to cover their working practice). In addition, there was employer's liability insurance which covered employees working at the practice.

Monitoring health & safety and responding to risks

The practice had no evidence of undertaking any risk assessments to cover the health and safety concerns that arise in providing dental services generally and those that were particular to the practice. This was adress and evidence of this was seen. The practice had a Health and Safety policy which included guidance on fire safety and manual handling of clinical waste. We saw the policy had been reviewed in January 2016.

The practice did not have a Control of Substances Hazardous to Health (COSHH) risk assessment completed for any materials used on the premises. COSHH was implemented to protect workers against ill health and injury caused by exposure to hazardous substances - from mild eye irritation through to chronic lung disease. COSHH requires employers to eliminate or reduce exposure to known hazardous substances in a practical way. We brought this to the attention of the registered manager during the inspection and this was implemented accordingly, evidence of this was seen.

The registered manager had no evidence of a fire risk assessment being completed for the practice. We observed the fire extinguishers had been checked in August 2015 to ensure that they were suitable for use if required. There was evidence that fire drills had been undertaken six monthly; this, and other measures should be taken to reduce the likelihood of risks of harm to staff and patients. The practice booked an assessment to be completed as soon as possible.

Infection control

The practice had a decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05), decontamination in primary care dental practices. All clinical staff were aware of the work flow in the decontamination area from the 'dirty' to the 'clean' zones.

There was a separate hand washing sink for staff, in addition to two separate sinks for decontamination work. The procedure for cleaning, disinfecting and sterilising the instruments was clearly displayed on the wall to guide staff. We discussed with staff appropriate personal protective equipment when working in the decontamination area; this included disposable gloves and protective eye wear.

We found instruments were being cleaned and sterilised in line with published guidance (HTM01-05). The dental nurses were knowledgeable about the decontamination process and demonstrated that they followed the correct procedures. For example, instruments were placed in an ultrasonic bath, examined under illuminated magnification and sterilised in an autoclave. Sterilised instruments were

correctly packaged, sealed, stored however we found not all instruments were dated with an expiry date. For safety, instruments were transported between the surgeries and the decontamination room in lockable boxes.

We saw records which showed that the equipment used for cleaning and sterilising had been maintained and serviced in line with the manufacturer's instructions. Appropriate records were kept of the decontamination cycles of the autoclaves to ensure that it was functioning properly.

We saw from staff records that all staff had received infection control training in at various intervals during 2014 and 2015.

There was adequate supplies of liquid soap, paper hand towels in the decontamination area and surgeries. The poster describing proper hand washing techniques was displayed above all the hand washing sinks. Paper hand towels and liquid soap was also available in the toilet.

We saw the sharps bins were not always being used correctly and not located appropriately in all surgeries. Safer sharps systems were in place however this protocol was not always followed. This was brought to the attention of the registered provider and this was addressed Immediately. Clinical waste was stored securely for collection. The registered provider had two contracts with authorised contractors for the collection and safe disposal of clinical waste.

The recruitment files we reviewed showed all clinical staff had received inoculations against Hepatitis B. It is recommended that people who are likely to come into contract with blood products or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of acquiring blood borne infections.

The practice did not have an external legionella risk assessment in place; however the practice had implemented an in house assessment and water testing was being carried out. Legionella is a term for particular bacteria which can contaminate water systems in buildings. Evidence the assessment had been booked was provided to the inspector to ensure all safe systems of work could be reviewed as soon as possible.

Equipment and medicines

We saw that Portable Appliance Testing (PAT) – (PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use) was undertaken annually. There was also an electrical installation condition report that had been completed in January 2016.

The practice displayed fire exit signage. We saw the fire extinguishers had been checked in August 2015 to ensure that they were suitable for use if required.

We saw maintenance records for equipment such as autoclaves, the compressor and X-ray equipment which showed they were serviced in accordance with the manufacturers' guidance. The regular maintenance ensured that the equipment remained fit for purpose.

Anaesthetics were stored appropriately and a log of batch numbers and expiry dates was in place. Other than emergency medicines the practice held a selection of antibiotics. These were stored securely and surgery logs were in place to know what stock had been used.

Some dental materials and an emergency medicine were stored in the fridge but no evidence of any temperature checks were in place on the day of the inspection. This was brought to the attention of the registered manager on the day of the inspection to implement as soon as possible.

Radiography (X-rays)

The X-ray equipment was located in each of the surgeries and a separate room for dental panoramic radiographs. X-rays were carried out safely and in line with the rules relevant to the practice and type and model of equipment being used.

We reviewed the practice's radiation protection file. Local rules were in place and stated how the X-ray machine needed to be operated safely.

We saw all staff were up to date with their continuing professional development training in respect of dental radiography. The practice also had a maintenance log which showed that the X-ray machine had been serviced regularly. The registered manager told us they undertook 18 monthly audit cycles of the X-rays taken. This was provided as part of the practice Denplan Excel and each clinician had a full report including action plans and learning outcomes in November 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

New patients to the practice were asked to complete a medical history form which included their health conditions, current medication and allergies prior to their consultation and examination of their oral health with the dentists. The practice recorded the medical history information within the patients' dental care records for future reference. In addition, the dentists told us they discussed patients' lifestyle and behaviour such as smoking and alcohol intake and where appropriate offered them health promotion advice or referred them to the dental hygienists for more detailed advice.

The dental care records we looked at showed that at all subsequent appointments patients were always asked to review and update a medical history form. This ensured the dentist was aware of the patients' present medical condition before offering or undertaking any treatment. The dental care records showed that dental examination appointments included checks for oral cancer and gum disease.

There was evidence that patient dental care records had been audited to ensure they complied with the guidance provided by the Faculty of General Dental Practice. The last audit was undertaken in September 2015; an action plan and learning outcomes were in place for each clinician.

The dentists told us they always discussed the diagnosis with their patients and, where appropriate, offered them any options available for treatment and explained the costs.

Patients' oral health was monitored through follow-up appointments and these were scheduled in line with the National Institute for Health and Care Excellence (NICE) recommendations. We saw from the records we looked at the dentists were following the NICE guidelines on recalling patients for check-ups.

Patients requiring specialist treatments that were not available at the practice, such as oral surgery, were referred to other dental specialists. Their oral health was then monitored at the practice after the patient had been referred back. This helped ensure patients had the necessary post-procedure care and satisfactory outcomes.

Health promotion & prevention

The patient reception and waiting areas contained a range of information that explained the services offered at the practice and the private fees for treatment. Staff told us they offered patients information about effective dental hygiene and oral care in the surgeries and had a dental hygienist therapist to help support this.

The dentists told us they offered patients oral health advice and provided treatment in accordance with the Department of Health's policy, the 'Delivering Better Oral Health' toolkit, this included fluoride applications. Fluoride treatments are a recognised form of preventative measures to help protect patients' teeth from decay.

Patients were given advice regarding maintaining good oral health. Patients who had a high rate of dental decay were also provided with a detailed diet advice leaflet which included advice about snacking between meals, hidden sugars in drinks and tooth brushing. Patients who had a high rate of dental decay were also prescribed high fluoride toothpastes to help reduce the decay process.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentists and saw in dental care records that smoking cessation advice was given to patients who smoked. The practice had an application called DEPPA available in each surgery to discuss patient risk factors in more details. A full and detailed questionnaire was discussed and a patient specific risk assessment was collated and a copy given to the patient. We believe this to be notable practice as the information is patient specific and tailored to raise awareness of individual treatment needs.

The practice also provided care and information to children including prevention advice through play and provided sessions to local schools. Two of the dental nurses held an oral health education certificate to provide these sessions to schools. We believe this is notable practice because it demonstrates a commitment to tackling oral health inequalities utilising the different skills within the practice.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. The induction process included reviewing the practice policies,

Are services effective?

(for example, treatment is effective)

the location of emergency medicines and arrangements for fire evacuation procedures. The practice supplied each new member of staff with a practice indication folder that covered the practice policies and protocols.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in house training for medical emergencies and infection control to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. The practice also attended an external training day each year to cover CPD topics for staff. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff told us they had annual appraisals during which training requirements were discussed. We saw evidence of completed appraisal documents. Staff also told us they could approach the registered manager or practice manager at any time to discuss continuing training and development as the need arose.

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 and in line with NICE guidelines, where appropriate. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including orthodontics and sedation.

The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records. The practice manager kept a log of the referrals which had been sent and when a response had been received.

The practice had a process for urgent referrals for suspected malignancies. We also saw when a patient was referred internally to see the dental hygiene and therapist a detailed treatment plan was documented to ensure the hygiene and therapist was aware of treatment required.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. Staff were clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

Staff had completed training and had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment.

Staff ensured patients gave their consent before treatment began and a treatment plan was signed by the patient. We saw in dental care records that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were given time to consider and make informed decisions about which option they preferred. The practice also gave patients with complicated or detailed treatment requirements more time to consider and ask any questions about all options, risks and cost associated with their treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from the patients was positive and they commented they were treated with care, respect and dignity. They said staff supported them and were quick to respond to any distress or discomfort during treatment. Staff told us they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them.

Patients' dental care records were stored in locked cabinets securely.

A television screen was available in the downstairs waiting room to help relax patients before their appointments this showed a picture of a fire. Staff told us during children's holidays they would play a film or programme utilising this facility.

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. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.

Staff told us how the dentists would provide treatment options including benefits and possible risks of each option.

Patients were also informed of the range of treatments available in information leaflets in the waiting room. The practice's website provided patients with information about the range of treatments which were available at the practice.

The practice had intra-oral cameras to take picture to show patients specific areas of concern within the patients' mouth. This information was displayed on a patient monitor within the surgery.

One surgery had a television screen mounted on the celling to make patients feel more comfortable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book there were dedicated emergency slots available each day for each dentist. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

The dentists told us they offered patient information leaflets on oral care and treatments in the surgery to aid the patients' understanding if required or requested.

The patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

Reasonable adjustments had been made to the premises to accommodate those with mobility needs.. These included a mobile ramp to access to the premises and an accessible ground floor toilet facility. One surgery was located on the ground floor of the building, the other three were on the first floor and another surgery on the second floor. A surgery timetable was available for the downstairs surgery so all dentists could utilise this room to accommodate their patients each day to see their own dentist.

The practice had equality and diversity policy to support staff had undertaken annual training to provide an understanding to meet the needs of patients.

Access to the service

The practice displayed its opening hours in the premises, in the practice information leaflet and on the practice website.

The opening hours are:

Monday & Wednesday 08:00 – 16:45

Tuesday 08:15 – 18:15

Thursday 08:15 – 16:45

Friday 08:00 – 14:45

Saturday 09:30 – 11:30

The patients told us they were rarely kept waiting for their appointment. Where treatment was urgent patients would be seen the same day and if not within 24 hours. The patients told us when they had required an emergency appointment this had been organised the same day. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the practice emergency mobile phone: whereby each dentist provided a rotation to cover out of hours services. This information was also on the telephone answering machine.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. The registered manager dealt with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the registered manager or lead dental nurse to ensure responses were made in a timely manner.

The practice had received no complaints in the last 12 months; however we saw historical evidence there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within three working days and providing a formal response within 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this. The complaints flow chart was available in the downstairs waiting room, however external organisations contact information was not included. There was also information about the complaints procedure on the practice's website.

Are services well-led?

Our findings

Governance arrangements

The practice was a member of the Denplan Excel scheme. This is a quality assurance scheme that demonstrates a visible commitment to providing quality dental care to nationally recognised standards.

The registered manager was in charge of the day to day running of the service. There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements.

The practice had an approach for identifying where quality or safety was being affected and addressing any issues. Health and safety policies were in place; however no practice risk management process was in place to ensure the safety of patients and staff members.

The practice had governance arrangements in place such as various policies and procedures for monitoring and improving the services provided for patients. For example, there was a recruitment policy, health and safety policy and an infection control policy. Staff were aware of their roles and responsibilities within the practice.

We saw the results of the X-ray, patient dental care record and infection prevention and control audit. All action plans and learning outcomes were in place to continuously improve the procedures and reduce future risks.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

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. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner.

The practice held monthly staff meetings involving all staff members. There were also separate clinical meetings for dentists and dental nurses if the need arose. These meetings were minuted. If there was more urgent information to discuss with staff then an informal staff meeting would be organised to discuss the matter.

All staff were aware of whom to raise any issue with and told us the registered manager and both principles were approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

The practice had quality assurance processes in place to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included audits such as infection prevention and control, dental care records and X-rays.

Staff told us they we encouraged to complete training relevant to their roles to ensure essential training was completed; this included medical emergencies and basic life support, infection prevention and control and radiography.

Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

The practice worked closely with local schools and colleges offering work experience opportunities for anyone wishing to embark on a dental career. The practice had clear policies and procedures in place to support a local work experience programme to help keep visitors safe and raise awareness regarding confidentiality. We think this is notable practice because it demonstrates a commitment to helping potential dental care professionals.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out annual patient satisfaction surveys and a comment box in the waiting room. Patient satisfaction surveys were completed for each dentist in order to aim to identify any specific areas which a dentist could improve.

The registered manager explained that the practice had a good longstanding relationship with their patients.

Are services well-led?

We saw the practice held regular practice meetings which were minuted and gave everybody an opportunity to openly share information and discuss any concerns or issues which had not already been addressed during their daily interactions.