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Jivadental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 07 October 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

Jivadental is located in the London Borough of Kingston-upon-Thames. The premises are situated in a high-street location. There are two treatment rooms, a decontamination room, an X-ray room, a reception room with waiting area, an administrative office, a staff room, two store rooms and patient toilets. These are situated on the first floors of the building.

The practice provides private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges. The practice also offers implants, endodontic treatments, and conscious sedation.

The staff structure of the practice consists of a principal dentist, two associate dentists, a hygienist a head dental nurse, a dental nurse and a practice manager. There is also a specialist implantologist who works at the practice, when required.

The practice opening hours are Monday to Wednesday from 9.00am to 5.00pm, Thursday from 10.00am to 7.00pm, Friday from 9.00am to 4.00pm and Saturday from 9.00am to 1.00pm.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual registered person.

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.

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

Thirty-four 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.
- 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.
- There were effective arrangements in place for managing medical emergencies.
- 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 provider 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 protocols for conscious sedation, taking into account guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry, in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.
- Review the practice's recruitment policy and procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review its current audit protocols to ensure audits of key aspects of service delivery are undertaken at regular intervals and where applicable learning points are documented and shared with all relevant staff.
- Review its responsibilities to respond to the needs of patients with disability and the requirements of the Equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

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 in place 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 any potential abuse. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. Improvements could be made to ensure recruitment checks were suitably completed before commencement of staffs' employment.

We found the equipment used in the practice was well maintained and checked for effectiveness.

The practice carried out conscious sedation techniques in line with current, good practice guidelines. However, further improvements could be made through the use of written protocols, more frequent recording of checks during sedation, and the use of separate consent forms. The principal dentist was responsive to our feedback in this area and assured us that these processes would now be instigated.

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 General Dental Council (GDC). 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 told us they were well supported and supervised by the principal dentist. Staff engaged in continuous professional development (CPD) and were meeting all of the training requirements of the General Dental Council (GDC).

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 patients through comment cards and by speaking with patients on the day of the inspection. 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 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 generally had good access to appointments, including emergency appointments, which were available on the same day.

The culture of the practice promoted equality of access for all. The practice was not wheelchair accessible as the treatment room was situated on the second floor. The practice had made some adjustments to the building to support people with limited mobility and redirected patients, who needed full wheelchair access, to other local practices. The practice had not carried out a full Disability Discrimination Act audit at the time of the inspection, but confirmed they would now do so with a view to identifying any further reasonable adjustments that could be made at the practice to improve patient access.

There was a complaints policy in place. Four complaints had been received within the past year. These had been recorded and appropriately investigated. Patient feedback was also used to monitor the quality of the service provided.

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. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. Further improvements could be made through the inclusion of a regular, dental record keeping audit to monitor the quality of the service.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist or practice manager. They were confident in the abilities of the principal dentist and practice manager to address any issues as they arose.

Jivadental

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 07 October 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

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

Thirty-four 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 and accidents. There was an incident reporting policy and an accidents reporting book. Staff understood the process for accident 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.

The practice manager and principal dentist were aware of the Duty of Candour. They told us they were committed to operating in an open and transparent manner; they would always inform patients if anything had gone wrong and offer an apology in relation to this. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

The practice had a well-designed safeguarding policy which referred to national guidance. The practice manager was the named practice lead for child and adult safeguarding. Information about the local authority contacts for safeguarding concerns was displayed in the administrative office and held in a safeguarding policy folder.

Staff 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. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to an appropriate level.

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. There was a written protocol for staff to follow in the event that they did experience a needle stick injury. The practice also followed a protocol to minimise needle stick injuries during the administration of local anaesthetics. The dentist used a 'safer sharps' system where a sliding, protective sheath covered the needle between use, and also during disposal of the syringe. The principal dentist told us they disposed of the syringes themselves, directly after use, in the sharps box located in the treatment room.

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 rubber, used in dentistry to isolate the operative site from the rest of the mouth. Rubber dam should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in patients' dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction, 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 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.

Staff received annual training in using the emergency equipment.

Staff recruitment

The staff structure of the practice consists of a principal dentist, two associate dentists, a hygienist a head dental nurse, a dental nurse and a practice manager. There is also a specialist implantologist who works at the practice, when required.

There was a recruitment policy in place 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 a check of registration with the General Dental Council. Clinical staff were asked to provide information about their immune status in relation to Hepatitis B.

We checked the staff recruitment records, including those for two members of staff who had been recruited within the past year. We found that the practice had followed its recruitment policy and retained relevant documents. However, we noted that although references had been requested for the two, newest members of staff, these had not yet been obtained. We discussed this issue with the principal dentist who assured us that references would now be obtained prior to employing new members of staff.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check prior to employment. (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 asked the principal dentist about their arrangement with the visiting implantologist who worked with the dentists on complex cases. We saw that the principal dentist had collated relevant information, including background checks such as a DBS and copies of relevant qualifications, registration with the General Dental Council, and training certificates. However, there was not a formal agreement in place to clearly outline the respective roles and responsibilities of the implantologist and principal dentist when they worked on a treatment plan together. We discussed this with the principal dentist who assured us that such an agreement would now be formalised in a written contract.

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 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 and practice manager via email. These were disseminated at staff meetings, where appropriate.

There was a business continuity plan in place. There was an arrangement in place to use one of the provider's other practice locations for emergency appointments in the event that the practice's own premises became unfit for use.

Infection control

There were effective systems in place 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 practice had carried out practice-wide infection control audits every six months and found high standards throughout the practice. We noted that the last audit had been completed in August 2016.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment rooms, decontamination room and toilets. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the head dental nurse to demonstrate the end-to-end process of infection control procedures at the practice. The protocols showed that 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)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written

guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment rooms had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The dental water lines were maintained 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. A Legionella risk assessment had been carried out by an external contractor. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 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. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were placed in an ultrasonic bath and then were manually cleaned. All items were then inspected under a light magnification device. Items were then pouched and then placed in an autoclave (steriliser), used on the vacuum cycle, and stored appropriately, until required. All of the pouches we checked had a sterilisation expiry date.

We saw that there were systems in place to ensure that the autoclave and ultrasonic bath was working effectively. These included, for example, the automatic control test and steam penetration test for the autoclave, as well as the 'foil' test for the ultrasonic bath. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme. There was a cleaning schedule for staff to follow which described daily, weekly and monthly tasks.

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.)

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 X-ray equipment had all been inspected and serviced. For example, a Pressure Vessel Certificate for the dental compressor and autoclave had been issued within the past year, in accordance with the Pressure Systems Safety Regulations 2000.

Portable appliance testing (PAT) had been completed in accordance with good practice guidance in August 2014 and monthly visual inspections had been carried out thereafter. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The principal dentist demonstrated that they correctly wrote out private prescriptions.

The principal dentist also carried out conscious sedation on site. (Conscious sedation is a technique in which the use

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

The practice kept small stocks of the medicines used in intravenous conscious sedation, (e.g. Midazolam and the reversal agent Flumazenil). The batch number and expiry dates of Midazolam along with the amounts used were recorded during each episode of conscious sedation in each patient's dental care record. At the time of the inspection, the practice had ordered replacement stock for Flumazenil and confirmed with us that no sedation treatments were planned while this was on order.

We found that the practice was meeting the standards set out in the guidelines published by the Standing Dental Advisory Committee: "Conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry" (Department of Health 2003). The principal dentist was aware of the updated guidance issued in 2015 and was working towards achieving the standard outlined in the 2015 guidance.

We checked the dental care records for some patients who had undergone intra-venous or nasal sedation to confirm our findings. We found that patients had important checks prior to sedation; this included a medical history and blood pressure. The principal dentist told us that during the sedation procedure, vital sign checks were also carried out at regular intervals, although we noted a record of these checks was not consistently kept. These checks included pulse, blood pressure and the oxygen saturation of the blood. The processes carried out were in line with current good practice guidelines demonstrating that sedation was carried out in a safe and effective way. However, further improvements could be made through the use of a separate consent form for sedation, a written sedation protocol for staff to follow, and more frequent recording of vital signs, such as oxygen saturation of the blood, during the period of sedation.

Radiography (X-rays)

There was a well-maintained radiation protection file 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 necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules.

We saw evidence in the staff records which showed they had completed radiography and radiation protection training.

Audits on X-ray quality were undertaken at regular intervals.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The principal dentist described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. 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.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included details of the costs involved. The dentist provided each patient with the opportunity to further discuss their treatment plan in the consulting room. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of 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 were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (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 principal dentist was aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting).

They told us they held discussions with their patients, where appropriate, around effective tooth brushing, smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

There was a hygienist working at the practice. Where required, the dentists referred patients to the hygienist to further address oral hygiene concerns.

We observed that there were health promotion materials available for staff. 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 all of the 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, infection control and radiography and radiation protection training. Staff involved in carrying out conscious sedation had completed relevant training courses.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

The practice manager told us that staff had not been engaged in a formal appraisal process. They noted that in a small, dental team there were regularly opportunities to discuss performance, request additional supervision or training. This informal system had been successful at tracking the needs of staff. The staff team had grown in the past year and they had now set a target for completing formal appraisals within the next six months.

Working with other services

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

The principal dentist and practice manager explained how they worked with other services, when required. The

Are services effective?

(for example, treatment is effective)

dentist was 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 more complex orthodontics.

We reviewed the systems for referring patients to specialist consultants in secondary care. 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. We spoke with the principal dentist about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign fee estimate documents which also gave details of the treatments to be provided.

All of the staff we spoke with 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).

The dentist we spoke with 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, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received, and the patients we spoke with, all made positive remarks about the staff's caring 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. Patients who were nervous about dental treatment indicated that their dentist was calm, worked with them, listened to their concerns, and gave them reassurance throughout the processes of the dental 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 the doors were closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in an electronic format. Records stored on the computer were password protected and regularly backed up.

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 dental charges or fees.

Staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients 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.

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' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told that patients could book an appointment in good time to see the dentist. The feedback we received from 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.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and practice policy documents. The practice had a website which reinforced this information. New patients were given a practice leaflet which included advice about appointments, opening hours and the types of services that were on offer.

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. There was an equality and diversity policy which staff were following.

Staff spoke a range of different languages, which supported some patients to access the service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired.

The practice was not wheelchair accessible as the treatment room was on the second floor of the building. The principal dentist had made some adjustments, including installing hand rails around the practice. However, they had not been able to make any further, reasonable adjustments to the fabric of the building due to the restricted site and agreement with the freeholder. They had a system in place for referring patients with limited mobility to an alternative, wheelchair accessible practice in the local area.

The practice had not carried out a full Disability Discrimination Act audit at the time of the inspection to identify what further reasonable adjustments could be made at the practice to support equality of access for all. The principal dentist told us that such an audit would now be carried out and acted on.

Access to the service

The practice opening hours are Monday to Wednesday from 9.00am to 5.00pm, Thursday from 10.00am to 7.00pm, Friday from 9.00am to 4.00pm and Saturday from 9.00am to 1.00pm. The practice displayed its opening hours on their premises, on the practice website and in the practice information leaflet available in the waiting area.

We asked the practice manager about access to the service in an emergency or outside of normal opening hours. Calls from patients were redirected to a member of staff's mobile phone so that they could assess the urgency of need. The principal dentist then contacted the patient directly to discuss their concerns. The dentist saw the patient on the same day, if necessary, or gave further information on how to access out-of-hours emergency treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the waiting room. The staff we spoke with were aware of the contents of the complaints policy. Four complaints had been received in the past year; they had been appropriately managed in line with the practice's policy.

The practice periodically assessed patient satisfaction through the use of a survey and a suggestions box situated in the waiting area. The practice manager periodically reviewed the feedback received from these sources. A recent review had demonstrated a high level of satisfaction and some minor concerns regarding waiting times. The practice manager had responded to this feedback and set a date to carry out a full, waiting times audit with a view to understanding the concerns fully prior to making any changes.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There was a comprehensive system of policies, protocols and procedures in place covering all of the clinical governance criteria expected in a dental practice. The systems and processes were maintained in an orderly fashion with files that were regularly reviewed and completed. Staff were aware of the practice policies and acted in line with them. They told us that they held regular, team meetings to discuss any concerns related to protocols or individual patients. These were arranged as and when they were needed.

Records related to patient care and treatments were kept accurately and staff records were generally well maintained.

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 found staff to be hard working, caring and committed to their work and overall there was a strong sense that staff worked together as a team. Staff told us they were well supported by the principal dentist in relation to career and training goals.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control and X-ray quality. Audits were repeated at appropriate intervals to evaluate whether or not quality had been maintained or if improvements had been made.

The auditing system demonstrated a generally high standard of work with only small improvements required. We saw notes from meetings which showed that results of audits were discussed in order to share achievements or action plans for improving performance.

We noted that the practice had not carried out an audit of clinical record keeping at the time of the inspection. We discussed this with the principal dentist and practice manager who told us that such an audit would be now be carried out.

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).

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

The staff we spoke with told us the principal dentist was open to feedback regarding the quality of the care.

Patients were invited to give feedback through the use of a suggestions box in the waiting area and regular patient satisfaction surveys. The practice manager demonstrated how they reviewed and acted on this information. For example, recent suggestions had led the practice manager to plan for a full waiting times audit with a view to improving the appointments system.