Eastleigh Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 October 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Eastleigh Dental Practice is located in Cheam, in the London Borough of Sutton. The premises are in a residential property, with the practice located on two floors; patient areas are located on the ground floor only. The practice consists of two treatment rooms (one currently not being used as it is awaiting refurbishment), a decontamination room, a waiting area and reception and a patient toilet. There are also staff toilet facilities, a staff kitchen and offices located on the first floor.

The practice provides mostly private dental services, with a contract to provide a small number of patients with NHS services. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns, bridges, dentures and oral hygiene.

The practice is open from 9am-5.30pm on Monday; 9am-6pm on Tuesday, Wednesday and Thursday and 9am-2pm on Friday. The practice offers appointments on a Saturday where required.

The staff structure of the practice consists of two principal dentists; two dental nurses and a receptionist. One of the principal dentists is registered with the Care Quality Commission (CQC) as a registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

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.

We spoke with three patients on the day of our inspection and received nine completed CQC comment cards. Patients we spoke with, and those who completed CQC comment cards, were very 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:

- The practice had good decontamination procedures for dental equipment and thorough checks of the decontamination equipment were carried out.
- 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).
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients were very positive about their care; they felt listened to, involved in their care and found practice staff helpful and friendly.
- From reviewing comments cards and speaking to patients, we found that all patients felt that they received an excellent and efficient service.
- The practice provided a responsive service; patients were able to access emergency appointments on the day they needed them.
- The practice had a stable leadership structure and staff told us they were well supported by the management team.
- The practice completed a range of risk assessments to identify health and safety risks and regular servicing was undertaken for most equipment.
- We found that the governance arrangements including management of risks, policies and procedures and learning and improving from incidents and accidents were in place.
- Improvements could be made to ensure dental care records were maintained in accordance with current national guidance.

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

- Review the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the security of prescription pads in the practice and ensure there are systems in place to track and monitor their use.
- Review the systems for monitoring and recording stock and X-ray equipment checks.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the risk arrangements and management of the Control of Substances Hazardous to Health to demonstrate compliance with the COSHH 2002 regulations.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Review audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had a number of policies and risk assessments in place for health and safety, which were regularly updated. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

There was evidence that systems for reporting and learning from incidents and safety alerts were in place. The practice had systems in place for the servicing of equipment, decontamination of equipment, management of medical emergencies and dental radiography; however systems for identifying risk in relation to infection control, and sharps management required improvement.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE) and The Department of Health (DH). Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with specialist colleagues and timely referrals were made. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

We found that improvements could be made in the way the practice maintained detailed dental care records. There were systems in place for recording written consent for some treatments, with detailed, tailored proposed treatment plans provided to patients, however patient copies were not always signed. The dental care records we viewed did not consistently record health promotion advice and assessments to monitor patients' oral health. The principal dentist assured us that improvements would be made immediately to ensure dental care records were maintained in accordance with current national guidance.

Are services caring?

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

We received positive feedback from speaking with patients, from NHS Friends and Family Test results and through comment cards that patients were treated with dignity and respect. Patients reported a positive and caring attitude amongst the clinical and administrative staff.

Dental care records were stored securely in the practice and confidentiality was maintained.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. Staff were able to provide a very flexible service to meet the needs of patients. The needs of people with disabilities had been considered in terms of accessing the service; however toilet facilities were not fully accessible for all patients.

There was a clear complaints procedure. The practice had not received any complaints in the last 12 months.

Summary of findings

Are services well-led?

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

Governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings. Staff received appraisals and there was evidence that communications with staff were well-managed. Patient feedback was gathered.

However, improvements were required. We found that the outcomes of some risk assessments and the infection control audits were not acted on in a timely manner and that audits were not always being used effectively to drive improvements. Details recorded in the patients' dental care records could be improved to ensure they contained comprehensive information about patients' current dental needs and past treatment.

Eastleigh Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 7 October 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. This included the practice's statement of purpose and complaints received over the previous 12 months.

During our inspection visit, we reviewed policy documents and staff records and checked dental care records to confirm our findings. We spoke with four members of staff, which included the principal dentists, one dental nurse and the receptionist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We reviewed the practice's decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Twelve people provided feedback about the service. Patients we spoke with and those who completed CQC comment cards were very positive about the care they received from the practice. They were highly complementary 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

The practice had a system in place to report and record incidents and accidents in the practice which staff were familiar with; however they did not have an incident reporting policy in place. The records we reviewed showed appropriately recorded accidents relating to staff injuries. The staff were aware of the need to report incidents as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR) and we saw a policy in place regarding RIDDOR, although staff had never needed to use this. We were told that if an incident occurred they would be discussed in the monthly staff meeting.

Significant event forms were available for staff to use and these had been recently updated. There had been one reported significant event within the last year, which had occurred within the previous month. A detailed risk assessment had been completed and mitigating actions were put in place. This was shared with all staff during an urgent staff meeting.

We were told that if incidents arose where people who use services were affected, the practice would inform them where something had gone wrong, give an apology and inform patients of any actions taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults, which had been updated annually. The policies included contact details for the local authority safeguarding team. This information was easily accessible to staff in a central folder.

The principal dentist was the safeguarding lead for the protection of vulnerable children and adults. All staff had completed safeguarding training for adults and children to level three. Staff were able to describe potential signs of abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager. A whistleblowing policy for the practice was available.

Most dental care records were electronic and held securely, and X-rays were stored securely. The practice had recently commenced the use of a digital X-ray scanner so X-rays were also stored electronically.

During procedures such as root canal surgery and fillings, the practice used rubber dams. (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.) To prevent wrong-site surgery, the practice had protocols in place where the dentist double-checked the dental care records and X-ray with the dental nurse.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. The practice had some procedures for the safe handling of sharps, including dentists re-sheathing needles using a one-handed technique; however the practice had not undertaken a sharps risk assessment and we noted that sharps containers were kept on the floor in the treatment room. The practice advised us this was due to advice from an external infection control specialist and reported that they would risk assess their current sharps management and change the location of sharps boxes shortly following the inspection.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received annual training in emergency resuscitation and basic life support. Staff were aware of the practice protocols for responding to an emergency and we saw the updated medical emergencies protocol which was available for staff to refer to.

The practice had a range of emergency equipment in accordance with guidance issued by the Resuscitation Council UK and a first aid kit was available. The practice stocked a full range of relevant emergency medicines. Oxygen and an automated external defibrillator (AED) were available in the practice; however paediatric defibrillator pads were not available. (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 oxygen and emergency

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medicines were checked weekly and we saw records of this. The defibrillator was new, and the practice were to commence weekly checks for this. All emergency equipment and medicines were stored securely but were accessible in an emergency.

Staff recruitment

The practice staffing consisted of two principal dentists (one was the clinical lead and the other dentist lead on management of the practice), two dental nurses and a receptionist. All staff who were employed by the practice had a range of information in their personnel files including criminal records checks, evidence of professional registration and identification.

The practice had a thorough, updated recruitment policy in place. The practice had recruited the receptionist in 2015. We found that they had completed identity checks, disclosure and barring service (DBS) checks and had evidence of two written references, a full employment history, Hepatitis B status and a signed contract and confidentiality agreement. There was an induction programme and checklist for new staff.

Monitoring health & safety and responding to risks

The practice had a range of health and safety risk assessments and policies in place that were updated annually. Policies covered various topics such as health and safety, fire risk, lone working and waste management. A health and safety risk assessment was carried out every two years, the most recent being in May 2015. Actions resulting from this risk assessment had been implemented or were in the process of being implemented.

A fire risk assessment was undertaken annually; the last being in March 2015. Some of the risks and subsequent actions had not been completed as we were told they were linked to refurbishment of the building that was due to commence in December 2015. Staff had not completed fire safety training, however they had completed fire drills, with a log of drills seen. The last fire drill was in March 2015. The practice had a record showing that smoke alarms and fire extinguishers were checked monthly and fire extinguishers were serviced annually.

The practice had arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations, however they had not completed a COSHH risk assessment, a policy and product information was not in place. COSHH products were stored securely in the practice.

The practice had a comprehensive business continuity plan in place, which was updated annually. The plan contained details of actions in response to staff absence, and a variety of catastrophes. A buddying system was evident with a local dental practice in the event of any incident affecting the business.

The practice had measures in place in response to patient safety alerts and Medicines and Healthcare products Regulatory Agency (MHRA) alerts. If there were any alerts we were told these were sent through to the principal dentist, which were then printed and kept in an accessible folder. We saw examples of alerts and evidence that alerts were actioned when required.

Infection control

There were systems in place to reduce the risk and spread of infection. There were a range of infection control policies in place, however it was not clear which policies staff were to refer to as some of these were out-dated and not utilised within the practice. The main updated policy we were shown did not include detailed underpinning procedures in relation to decontamination of dental instruments, hand hygiene, use of personal protective equipment, the segregation and disposal of clinical waste, sharps safety and dealing with spillages in order to support staff to carry out their roles. However, staff told us that they referred to the guidance on decontamination and infection control issued by the Department of Health for day to day infection control measures.

One of the principal dentists was the infection control lead. Staff had not completed annual infection control training, although core continuing professional development training for decontamination had been completed by clinical staff.

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

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been implemented to ensure the safe movement of instruments between the treatment room and the decontamination room which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. The surgery had clearly marked 'dirty' and 'clean' areas. The surgery had dedicated sinks for cleaning used dental instruments and for hand washing, although a few days prior to the inspection the practice had had an incident with the hand washing sink so that it was out of order. The practice had risk assessed this and put in place measures to use the sink used to clean dental instruments as the hand washing sink, with adequate hand washing signs and hand wash facilities available.

They had also implemented a system for used dental instruments to be taken to the decontamination room and washed prior to undergoing decontamination procedures. Decontamination was carried out in the dedicated decontamination room. The decontamination room had a clear flow from 'dirty' to 'clean'. Dental nurses wore appropriate personal protective equipment, such as heavy duty gloves and eye protection which were changed weekly.

Thorough decontamination protocols were displayed on the wall in the decontamination room. Following manual cleaning in the decontamination room, equipment was checked with an illuminated magnifier for any debris during the cleaning stages. If any debris was noted, the items would be re-cleaned. The items were then placed in the autoclave. After sterilisation in the autoclave the items were pouched and date stamped. The date stamps indicated an expiry date, identifying how long they could be stored for before the sterilisation became ineffective. All sterilised dental instruments we checked were in date. The practice had a robust system of daily, weekly and quarterly logs used by the dental nurses, for the checking of the autoclave. There were also testing strips attached to the log books.

Clinical areas and decontamination rooms were clean; however some surfaces in the treatment room appeared cluttered. The practice had sealed floors and work surfaces in the decontamination room but the floors were not fully sealed in the treatment room. Cleaning was carried out by practice staff daily. A clear schedule was in place for areas to be cleaned between patients, daily, weekly and monthly and we saw a number of cleaning logs to confirm these checks were being carried out. The practice took into account national guidance on colour coding equipment, to prevent the risk of cross-infection.

We saw adequate hand washing facilities including hand soap and paper towels by all hand washing sinks. Sufficient stocks of personal protective equipment (PPE) including gloves and eye protection were available for staff.

The practice completed six-monthly infection control audits, the most recent being in July 2015, and a decontamination risk assessment was also completed in December 2014. However, we noted that areas of risk had not been summarised and an action plan was not developed from the audit in July 2015.

The practice had an on-going contract with two clinical waste companies and a waste pre-acceptance audit had been completed. We saw records of waste consignment notices for the last two years since the practice had been in operation. This included the collection of clinical waste including amalgam, X-ray developer, extracted teeth and safe disposal of sharps. We were shown a secure, locked area outside of the practice where waste was stored. We saw that all staff had Hepatitis B immunization records in their files. All clinical staff were required to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. The practice had a dedicated dental water line folder. Practice staff followed recommended guidelines to assure dental water line safety, although we noted that although the water lines were flushed at the beginning and the end of the day, they were not flushed in between patients in line with guidance. An annual water-safe review was carried out, the last being November 2014 and a Legionella risk assessment and certificate were available. Following the risk assessment which identified areas of high risk, all staff had received the recommended Legionella training and weekly and monthly checks of the temperature were being completed. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings.)

Equipment and medicines

We found that most of the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor and autoclave had all been serviced. We saw the recent

Are services safe?

pressure vessel certificate dated May 2015. Portable appliance testing (PAT) was completed in July 2015 in accordance with good practice guidance. (PAT is the name of a process during which electrical appliances are routinely checked for safety.) The dental chair had been serviced in July 2015. The practice had a new oxygen cylinder, defibrillator and operating microscope. Servicing of this equipment was not yet required.

The practice was well stocked with single use equipment, however the practice did not have a clear system for the re-ordering and monitoring of stock and dental materials kept in the refrigerator.

Prescription pads were stored securely, however there was no system to track and monitor the use of prescriptions within the practice. The practice stocked a small range of dispensed medicines and these were stored securely, with a log to record the batch numbers. We saw the practice had an updated prescribing and dispensing policy available.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X-ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the treatment room as well as in the file. An external radiation protection advisor (RPA) gave support to the practice and one of the principal dentists was the radiation protection supervisor (RPS). The folder contained an inventory of equipment with evidence of the installation of the digital X-ray scanner in 2015, the critical examination pack and the Health and Safety Executive (HSE) notification certificate. However, although the scanner was tested daily, no image testing had been completed since the scanner had been installed.

All clinical staff had completed radiation training with evidence of certificates in the radiation protection file and staff certificate files. We saw that a recent radiography audit had been undertaken with areas for improvement, but no actions following the audit had been documented.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection we checked eight dental care records to confirm the findings and discussed patient care with two dentists and one dental nurse. Dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The quality assurance and justification of X-ray images were recorded in the dental care records.

The dentists were aware of and complied with National Institute for Health and Care Excellence (NICE) guidance in relation to deciding appropriate intervals for recalling patients and antibiotic prophylaxis.

The dental care records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool in both adults and children over the age of seven. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) If scores were indicative of advanced gum disease, dentists carried out a full charting.

We checked with the dentists the information recorded in eight dental care records regarding the oral health assessments, treatment and advice given to patients. We noted that improvements could be made to the dental care records to ensure they included an assessment of the patients' gum health, dental decay and soft tissues (including lips, tongue and palate) and did not include details of discussions with regards to treatment options being discussed. We also noted that there was limited record of oral hygiene advice, and no record of dietary advice or smoking cessation advice which had been given. Not all the dental care records we checked contained a clear diagnosis or treatment plan and X-ray findings were not reported with adequate detail.

Health promotion & prevention

Staff told us they discussed oral health with their patients, for example, effective tooth brushing, oral hygiene, prevention of gum disease and dietary advice. Staff were aware of the Department of Health, Delivering better oral health toolkit, however it was not clear if this was being followed. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.) From dental care records we saw, there was some evidence that the practice promoted maintenance of good oral health. Dental care records we viewed however, did not record patients' smoking status or record smoking cessation discussions and we did not see from dental care records that the practice prescribed high fluoride toothpastes or provided fluoride varnish applications.

We observed that the practice provided targeted health promotion materials, by issuing these and discussing them directly with patients during consultations.

Staffing

The practice benefited from employing a range of experienced staff. One principal dentist was the lead clinician and a second principal dentist led management of the practice. The lead dentist had a dental nurse that normally worked with them, to ensure continuity of care. The practice had an agreement with a dental staffing agency if they were not able to provide cover for periods of absence. A local dental surgery was utilised to provide dental cover for all patient emergencies whilst the practice was closed when the principal dentists were on leave.

Staff told us they received appropriate continuing professional development (CPD) and training from the practice and were given time to attend courses. We reviewed some staff files and saw some evidence of training certificates. The training covered the mandatory requirements for registration issued by the General Dental Council (GDC). The practice ensured they had up to date details of registration with the GDC for all dental staff and had a record of all CPD activities undertaken by practice staff.

Working with other services

Most referrals were to other specialist colleagues for orthodontic and periodontal treatment that could not be done in-house and for procedures where sedation was required. Referrals were made to secondary care for complex cases requiring oral surgery. We saw that the practice had appropriate referral criteria in place, but they were not able to provide us with an example of a recent referral letter that had been sent.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

The practice did not always ensure signed, valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were not consistently recorded in the dental care records, however a copy of the signed consent form was kept by the dental practice for some procedures. Patients were given a copy of their treatment plans and costs but these were not signed by them.

We saw evidence that dental staff had an understanding of the requirements of the Mental Capacity Act 2005 (MCA), and all staff had received MCA training. Staff could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received nine CQC comments cards and found that 100% of feedback was highly positive about the practice. Patients felt that the service provided exceptional care, staff were patient friendly and highly professional. The patients we spoke with all commented positively on their experience at the practice with both the clinicians and reception staff and felt it was a very efficient service. The majority of patients who provided feedback had been with the dental practice for a number of years.

Patients who reported some anxiety about visiting the dentist commented that the dental staff were good about providing them with reassurance by clearly explaining procedures. The practice had alerts on the computer system to indicate if patients were anxious so they could provide the appropriate support. Parents reported they were pleased with the level of care their children received. Positive comments about how the practice dealt with patients with mobility difficulties were also provided.

NHS Friends and Family Test data collected by the provider showed that 100% of respondents would recommend the practice.

We observed that clinical and administrative staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking to patients on the telephone.

Patients indicated they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke with and feedback from comments cards indicated no concerns about confidentiality and we noted there had been no complaints or incidents related to confidentiality. Dental care records were stored securely.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the dental fees for the range of procedures that the practice offered. CQC comments cards and patients we spoke with indicated that all patients felt involved in their care and felt they were always given adequate information about their treatment and fees. Staff told us that they took time to explain the treatment options available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Staff told us they had enough time to treat patients and that patients could always book to see the dentist of their choice. The practice were able to book longer appointments for patients who needed them, such as those with a learning disability. We found that the service was very flexible and was able to adapt to needs of the patients, to accommodate emergency appointments. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled to receive treatment. Patients we spoke with reported they had been able to access emergency appointments the same day.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice had policies in place for equal opportunities and equality and diversity. The practice was wheelchair accessible via a portable ramp through the back entrance and front access was via shallow steps and a hand rail. The dental chair was height adjustable. The waiting room was large enough for wheelchairs and push chairs, however the toilet facilities were not suitable for people with wheelchairs or mobility difficulties.

Access to the service

The practice was open from 9am-5.30pm on Monday; 9am-6pm on Tuesday, Wednesday and Thursday and 9am-2pm on Friday. The practice offered appointments on a Saturday where required. The practice displayed its opening hours on their premises. Patients were also given a practice newsletter which included the practice contact details and opening hours.

We asked dental and reception staff about access to the service in an emergency or outside of normal opening hours. The practice directed patients to the out-of-hours provider contracted by NHS England. The out-of-hours provider operated between 5pm and 10pm on weekdays and 10am-10pm at weekends and bank holidays. The practice answerphone message, newsletter and signs in the practice gave details on how to access out-of-hours emergency treatment. The practice answerphone also provided the direct contact details for the principal dentists in the event of an emergency.

All patients we spoke with and all CQC comments cards reviewed were positive about their experience of getting an appointment, including emergency appointments.

Concerns & complaints

Information about how to make a complaint was displayed on a notice board and in the practice's welcome folder in the waiting area. The practice reported that they had not received any complaints over the last 12 months or since they had been in operation. There was a recently updated and detailed complaints policy in place. The principal dentist who dealt with complaints was able to clearly describe the practice's complaints process and advised that they would inform patients where something had gone wrong, give an apology and inform patients of any actions taken as a result.

Are services well-led?

Our findings

Governance arrangements

The practice had a management structure in place. One principal dentist was the clinical lead and the second principal dentist led on practice management issues.

There were relevant policies and procedures in place, including a range of health and safety polices. The principal dentists reviewed most policies and procedures annually. Most policies we saw contained comprehensive information to enable staff to carry out their roles, but some policies lacked detail. Staff were aware of these policies and procedures, however they were not easily accessible to all staff. We found a number of policies for the same topic, such as information governance and infection control and it was not clear which policies staff were meant to follow, as some policies had not been updated or removed since the previous provider had been running the practice.

Governance and monitoring of equipment and procedures were well-managed, with the exception of monitoring refrigerator temperatures, X-ray scanner image checks and a system to track prescription pads in the practice.

The practice had completed a range of up to date risk assessments in relation to health and safety, infection control, fire safety and legionella, although action plans were not always identified or completed. We were told that a number of actions were linked to refurbishment of the practice which was due to take place in December 2015. Some risk assessments had not been completed, in relation to control of substances hazardous to health (COSHH) and sharps management. The practice were routinely utilising safety information to monitor risks through the use of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and business risks were identified with mitigating actions in the practice's business continuity plan.

The practice also had systems in place to monitor quality through scheduled audits including record keeping and radiography. During the inspection we found that although dental care records had been recently audited, action plans had not been developed to highlight areas that required improvement. There was not enough evidence to demonstrate that audits were being used effectively to improve quality in the practice.

Staff were being supported to meet their continuing professional development (CPD) standards set by the General Dental Council, and staff records contained information to confirm that dental staff had carried out mandatory CPD. All staff records contained a range of recruitment information and mandatory training certificates to provide assurances that staff could perform competently in their role. Recruitment checks were being carried out in line with guidance. Records, including those related to patient care and treatment, as well as staff employment, were kept securely.

Leadership, openness and transparency

Staff told us that the practice encouraged a team approach and they described a transparent culture which encouraged candour, openness and honesty where any issues were discussed and amended quickly. Staff said that they felt very comfortable about raising concerns with the principal dentists. Staff told us they really enjoyed their work and were well supported.

Staff knew who to report to depending on the issue raised, for example, the principal dentist that led in management of the practice was in day to day charge for safeguarding concerns and complaints and the principal dentist who was the clinical lead was also the infection control lead.

The principal dentists outlined the practice's mission statement for providing good care for patients. They shared with us their Statement of Purpose. We saw that the practice had a whistleblowing policy as well as a range other updated human resources policies to support staff, which had been signed by staff and were visible in staff files.

The principal dentist engaged with staff via staff meetings; although these had not been a regular feature, we saw that three meetings had occurred in the last seven months and were to become monthly. Comprehensive minutes of these meetings were kept and staff signed to say they had read these. From minutes we saw, changes to practice procedures, complaints and areas for improvement were discussed.

Learning and improvement

We were told that clinical staff were up to date with their continuing professional development (CPD). All staff were supported to pursue development opportunities. We saw

Are services well-led?

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

The practice completed annual appraisals for all dental nurses and non-clinical staff. We saw evidence of an appraisal completed after three months of commencing employment for a new member of staff.

The practice had a system in place to report and learn from incidents in the practice and there was evidence that incidents were being used effectively to improve the service. Appropriate audits were carried out in relation to dental care records and radiography; however it was not clear that the practice had implemented action plans to ensure that these audits were driving improvements.

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

The practice had gathered feedback from patients via the monthly NHS Friends and Family Test. Results from recent months were very positive. The practice also had a comments box available in the waiting area.

Staff feedback was gained where the need arose as staff were happy to raise concerns opportunistically or during practice meetings.