Plymouth Community Dental Services Limited

Scott Dental Access Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of Scott Dental Access Centre on 16 June 2015 to ask the practice the following five key questions; are services safe, effective, caring, responsive and well-led?

- We found that this practice was providing safe care in accordance with the relevant regulations. There were appropriate infection control procedures in place to minimise the risk and spread of infection.
- We found that this practice was providing effective care in accordance with the relevant regulations. Patient's needs were assessed and care was planned and delivered in line with current best practice guidance for example from the National Institute for Health and Care Excellence.
- We found that this practice was providing caring services in accordance with the relevant regulations. Patients told us they were treated with dignity and respect and involved in treatment planning.
- We found that this practice was providing responsive care in accordance with the relevant regulations. The practice had procedures in place to take into account any comments, concerns or complaints.
- We found that this practice was providing well-led care in accordance with the relevant regulations. Staff told us they felt well supported and comfortable to raise concerns or make suggestions. There were appropriate governance arrangements in place.

The Scott Dental Access Centre is provided by Plymouth Community Dental Services Limited, a subsidiary company of the Plymouth Community Healthcare Community Interest Company (CIC). It provides NHS dental treatment for patients with complex needs, children and non-registered patients. General dentistry and orthodontic treatment are provided.

The staff structure of the practice consists of three dentists (two male, one female), three dental nurses, one therapist, and one receptionist. The practice is open from 8.45am – 5pm Monday to Friday. Outside of these hours a service is provided by Devon Doctors.

We spoke with five patients who used the service on the day of our inspection and reviewed 25 CQC comment cards that had been completed by patients prior to the inspection. The patients we spoke with were complimentary about the service. They told us they found the staff to be friendly and informative. They felt they were treated with respect. The comments on the

Summary of findings

CQC comment cards were also very complimentary about the staff and the service provided. During the inspection we spoke with five members of staff, including the principal dentist.

The director of Plymouth Community Dental Services is the 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'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

The 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.

There were systems in place to help ensure the safety of staff and patients. These included policies for safeguarding children and adults from abuse, maintaining the required standards of infection prevention control and maintenance of equipment used at the practice and the maintenance of the premises itself. The practice assessed risks to patients and managed these well. We found training and equipment to respond to medical emergencies. In the event of an incident or accident occurring, the practice documented, investigated and learnt from it. The practice followed procedures for the safe recruitment of staff, this included carrying out DBS checks, and obtaining references.

Are services effective?

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

The practice followed guidance issued by National Institute for Health and Care Excellence (NICE) for example, in regards to prescribing antibiotics and dental recall intervals. Patients were given appropriate information to support them to make decisions and obtain informed consent for the treatment they received. The practice kept detailed dental care records of treatments carried out and monitored any changes in the patient's medical and oral health.

Staff were supported by the practice in continuing their professional development (CPD) and were meeting the requirements of their professional registration. Records showed patients were given health promotion advice appropriate to their individual oral health needs such as smoking cessation and dietary advice.

Are services caring?

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

The patients we spoke with told us they were treated with dignity and respect. They told us that staff were kind, informative and attentive to their needs. Comment cards were very positive about the service provided by the practice. We observed that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

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 at the practice and emergency appointments were available on the same day. There was sufficient well maintained equipment, to meet the dental needs of their patient population. There was a complaints policy clearly publicised in the reception area. We saw that the practice responded to complaints in line with the complaints policy and demonstrated shared learning when things went wrong.

Are services well-led?

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

The principal dentist had a clear vision for the practice that was shared by the staff. Staff felt supported by the principal dentist and there were regular meetings where staff were given the opportunity to give their views of the service. There were good governance arrangements and an effective management structure. Appropriate policies and procedures were in place, and there was effective monitoring of various aspects of care delivery. Staff guidance was provided via policies

Summary of findings

and procedures distributed on the company's intranet service. There was provision for induction and training for staff.

Scott Dental Access Centre

Detailed findings

Background to this inspection

We carried out an announced inspection on Tuesday 16 June 2015. This inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

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.

We informed the NHS England local area team that we were inspecting the practice; however we did not receive any information of concern from them. The practice sent us their statement of purpose and a summary of complaints they had received in the last 12 months. We also reviewed further information on the day of the inspection.

We spoke with five patients who used the service on the day of our inspection. We reviewed 25 CQC comment cards that had been completed by patients prior to the inspection. We also spoke with five members of staff, including the principal dentist. We reviewed the policies, toured the premises and examined the cleaning and sterilisation of dental equipment.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and reported them internally and externally where appropriate.

There was a clear understanding and reporting of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) and COSHH (Control of Substances Hazardous to Health). There had been no reportable incidents in the last 12 months. There was a nominated health and safety lead for the service.

The practice complied with relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS). Minutes showed that a clinical governance meeting took place every month which discussed these items and provided staff with the necessary information and actions to take.

Reliable safety systems and processes (including safeguarding)

There were reliable safety processes in place. These included systems which ensured the safe use of rubber dams (A rubber dam or dental dam is a rectangular sheet of rubber or latex used by dentists, especially for root canal treatment or for tooth-coloured fillings.) Rubber dams used by the practice were made of rubber and not latex, in order to safeguard against latex allergies. The use of rubber dams had been risk assessed, in order to ensure their safe use for patients.

Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included for example use of radiography equipment, sharps storage and security of the premises.

The safeguarding policy had been reviewed annually and most recently in December 2014 and contained up to date contact details of the local authority and other relevant agencies. Safeguarding guidance was also displayed in each of the three treatment rooms. Staff knew how to identify report and respond to suspected or actual abuse.

Staff understand the reporting system for raising concerns, such as safeguarding, whistleblowing, complaints and feel confident to do so and, fulfil their responsibility to report concerns. One of the dentists was a vulnerable adult safeguarding lead at the practice and another was the child safeguarding lead. Both of these had received level three safeguarding training which met current practice. All staff had received safeguarding training as part of their mandatory annual training.

During our visit we found that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental records contained patient's medical history that was obtained when people first signed up at the practice and was updated every time patients visited the practice for a check-up or treatment. The clinical records we saw were well structured and contained sufficient detail enabling another dentist to know how to safely treat a patient.

Medical emergencies

There were arrangements in place to deal with on-site medical emergencies. Staff had received emergency first aid training. The practice had a medical emergency kit which included emergency medicines and equipment. We checked the medicines and we found that all the medicines were within their expiry date. The emergency equipment including an automated external defibrillator (AED – a device used to restart a patient's heart in the event of a cardiac arrest) and oxygen. Staff had been trained to use the emergency equipment. There was a system in place for checking the medical emergency kit. This included checking the expiry dates of medicines in the kit.

The practice complied with the guidance for emergency equipment recommended by the Resuscitation Council UK and with the guidance on emergency medicines from the British National Formulary (BNF).

Medical alerts and national institute for health and care excellence (NICE) updates had been shared with staff. For example, in December 2014 the minutes of staff meetings had discussed NICE guidance regarding drug allergy diagnosis, the management of drug allergy in adults, children and young people and different oral health approaches.

Staff recruitment

The practice had a policy for the safe recruitment of staff. We looked at two staff files. We saw that appropriate background checks had been completed prior to

Are services safe?

recruitment. Employment contracts and photographic proofs of identity and proofs of address were on file. Disclosure Barring Service background checks (DBS) had been completed. It was the dental practice's policy to request a DBS check for all staff.

Staff files also included training, registration updates, employment history, absences, appraisals and correspondence.

There were sufficient numbers of suitably qualified and competent staff, and the provider considered how the service used the skills of other members of the dental team.

Monitoring health & safety and responding to risks

The practice had arrangements in place to deal with foreseeable emergencies. A Health and Safety Policy was in place. The practice had a risk management process which was continually being updated and reviewed to ensure the safety of patients and staff members. For example, we saw risk assessments for fire safety, manual handling, use of visual display screens and environmental building issues. The assessments were reviewed annually and included the controls and actions to manage risks.

The practice had a comprehensive business continuity plan to deal with emergencies that could disrupt the safe and smooth running of the service. The plan covered what to do in the event of computer failure, fire or staffing issues. The plan included contact details of who to contact in event of an incident that affected the continuity of the business.

Risks to safety from service developments and disruption are assessed, planned for, and managed in advance. There were systems in place to report physical hazards or defects to the Plymouth Community Healthcare provider. For example, a blocked patient toilet in June 2015 had been reported and resolved within 24 hours, so limited the disruption for patients.

A fire evacuation drill had taken place in July 2014. A fire assessment audit had taken place in May 2014 and had been repeated in June 2015. The findings of this audit had been implemented. These findings included the checking on a quarterly basis of all fire equipment such as extinguishers. A full audit cycle was in place.

Infection control

The Department of Health published in November 2009 a document called Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). It was up-dated in 2013. It set out in detail the processes and practices essential to prevent the transmission of infections and provide clean safe care.

Premises and equipment were clean, secure, properly maintained and kept in accordance with current legislation and guidance such as HTM 01-05 and National Patient safety Agency (NPSA) guidance. For example, the practice demonstrated they had followed the safe sharps directive to keep patients and staff safe.

The practice had a dedicated decontamination room in line with HTM01-05, which was used to sterilise all equipment used during patient consultations. There were two doors into this room, one of which came from the receptionist's office. This door was kept locked and signage displayed not to use it, in order to prevent cross contamination.

There was a lead dental nurse who was responsible for infection control who showed us the cleaning process for instruments. There was a flow of work (right to left) which was meant to ensure that once cleaned, instruments would not be re-contaminated.

We saw that staff moved items in accordance with the correct direction of flow. Lidded boxes of dirty instruments were brought from treatment rooms and placed on a work surface to the right of the washer disinfector, then placed in the machine for its cleaning cycle. Then staff brought them out and put them back in the same place on the right hand side of the washer disinfector, where an illuminated magnifying lamp was fitted.

Staff checked each item under this lamp and if there was no visible dirt, placed them on trays and put them in the autoclave to be sterilised. After this, they placed them on a work top in the clean area of the room and did not return them to the dirty side.

Staff bagged the sterilised instruments and stamped them with the date of expiry. All the packs we saw were within their expiry date. We saw there had been an annual audit of expiry dates; the most recent was January 2015.

The clinical waste bins had been placed in the dirty area of this system in order to protect the cleanliness of the room.

Are services safe?

Staff carried out daily checks on the machines to ensure they were working effectively. Any problems were reported to the Estates Department. We saw that responses from them were prompt and effective.

The practice used an Infection control audit template recommended by the infection prevention society (IPS) the last such audit had been completed in May 2015 and achieved an overall score of 98%. The practice had a schedule in place to repeat the audit every six months in line with Department of Health recommendations. Actions from the May 2015 audit included the storage of PPE in accordance with manufacturer's instructions. We examined a storage cupboard and saw that this had been implemented.

Guidance from the Department of Health currently stated that decontamination processes in dental practices should be audited every six months. The next audit was planned to take place in November 2015. This showed that recommendations set down by the Department of Health in HTM01-05 were being followed.

A contract cleaner carried out cleaning duties at the practice. They cleaned the toilets, communal areas and floors of the entire practice. Signed off cleaning schedules showed that this took place on a daily basis when the practice was closed. Dental nurses cleaned clinical work surfaces and the decontamination room. Written cleaning schedules were also in place for this and showed they were being followed.

We observed the practice was clean and tidy. There was a cleaning plan, schedule and checklist, which we saw were completed. Cleaning equipment and materials were stored appropriately in line with Control of Substances Hazardous to Health (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health.

The dental water lines were maintained in accordance with current guidelines to prevent the growth and spread of Legionella bacteria. Flushing of the water lines was carried out in accordance with current guidelines and supported by an appropriate practice protocol. A Legionella risk assessment had been carried out by an appropriate contractor and documentary evidence was provided to support this. Legionella is a germ found in the environment which can contaminate water systems in buildings.

There were hand washing facilities in each treatment room and staff had access to good supplies of personal protective equipment (PPE), such as gloves and masks for patients and staff members. Staff and patients we spoke with confirmed that staff wore protective aprons, gloves and masks during assessment and treatment in accordance with infection control procedures.

Equipment and medicines

The practice met the requirement of relevant legislation to ensure that the premises and equipment had been properly purchased, used and maintained such as Sharps regulations 2013, HTM 07-01 (healthcare waste). There was a waste contractor in place, which included a contract for clinical waste.

We found that all of the equipment used in the practice was maintained in accordance with the manufacturer's instructions. This included the equipment used to clean and sterilise the instruments and X-ray equipment. Portable appliance testing (PAT) was completed in accordance with good practice guidance. There were no other medicines stored on the premises apart from the ones in the emergency kit.

There were sufficient quantities of instruments/equipment to cater for each clinical session which took into account the decontamination process.

Radiography (X-rays)

The practice maintained suitable records in the radiation protection file demonstrating the maintenance of the x-ray equipment. The practice had a radiation protection supervisor (RPS). They were named on x-ray guidance information in each of the three surgery rooms. X-ray audits were undertaken at least on an annual basis.

The audits looked at issues such as the maintenance of X-ray equipment, quality of images and the radiography training staff had undertaken. This was done to ensure X-rays that were taken were of the required standard. We saw that local rules relating to the X-ray machine were displayed in accordance with guidance**.** We saw there were continuous professional development (CPD) records related to radiography for all staff that undertook radiography tasks.

Are services safe?

The practice met the requirement of relevant legislation to ensure that premises and equipment are properly purchased, used and maintained such as, Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Routine checks on radiography equipment were carried out. In October 2014 a routine test had been performed to ensure images were being read correctly by the x ray scanner. Equipment had been serviced and maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic and paper records of the care given to patients. We reviewed the information recorded in ten patients' dental care records about the oral health assessments, treatment and advice given to patients. We found these were comprehensive and included details of the condition of the teeth, soft tissues lining the mouth and gums. These were repeated at each examination in order to monitor any changes in the patient's oral health. Patients were asked to complete a questionnaire updating the practice on their medical history each time they visited the practice for a check-up or treatment.

Records showed assessment of the periodontal tissues was undertaken and recorded using the basic periodontal examination (BPE) screening tool. (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). BPE scores were noted in the records and the dentist planned treatment around the score that was achieved.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the dentists used current National Institute for Health and Care Excellence (NICE) guidelines to assess each patient's risks, needs and to determine how frequently to recall them. The practice also showed compliance with the Delivering Better Oral Health Tool-kit. 'Delivering better oral health' is an evidence based toolkit to support dental teams in teams in improving their patient's oral and general health.

Staff told us that discrimination on the grounds of age, disability, gender reassignment, pregnancy and maternity status, race, religion or belief were avoided when making care and treatment decisions.

Health promotion & prevention

Patients medical histories were updated regularly which included questions about smoking and alcohol intake. Appropriate advice was provided by staff to patients based on their response to the questionnaire. We saw the practice provided preventive care advice on tooth brushing and oral health instructions as well as smoking cessation, fluoride application, alcohol use, and dietary advice.

For three years the practice had participated in an oral health outreach programme to local schools in socially deprived areas of Plymouth. 24 schools in total had signed up to the fluoride varnish project provided by the practice. The total number of children in each class and the number of children with fluoride varnish applied was promoted and monitored. Parental consent was always sought. The percentage uptake varied from school to school from 85% in one school to 37% in another. The total number of children registered with a dentist, or given tooth decay warning letter was also monitored. The figures had been captured in a September 2014 audit and another audit was planned for September 2015.

Dental nurses at the practice were also trained as oral health educators, in order to provide them with the skills to carry out this outreach programme. These oral health educators maintained a portfolio of schools and liaised with their head teachers over the implementation and success of the programme.

Staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. One of the dentists had attended the British Dental Association conference in May 2015. This covered medical emergencies, radiology and ethics. Dental nurses had attended nurse's forums which had received presentations on the latest developments in dentistry.

Staff are supported to deliver effective care through opportunities to undertake training, learning and development and through meaningful and timely supervision. Staff had received annual appraisals from their line managers. The lead nurse manager carried out nurses appraisals. The clinical lead carried out the dentist's annual appraisals.

The learning needs of staff had been identified. One dentist told us he had been provided with the time and resources to complete an extra qualification in post graduate dental studies including orthodontics, oral medicine and special

Are services effective?

(for example, treatment is effective)

care dentistry. One of the dentists held an honorary fellowship at the local medical dental school, which enabled them to keep staff at the practice up to date with the latest developments in dentistry.

Another dentist told us that they had requested training in conscious sedation training (which was delivered at another service) which had been provided.

The practice maintained a programme of professional development to ensure that staff were up to date with the latest practices. This was to ensure that patients received high quality care as a result. The practice used a variety of ways to ensure development and learning was undertaken including both face to face and e-learning. Examples of staff training included core issues such as health and safety, safeguarding, radiography, medical emergencies and infection control. We reviewed the system in place for recording training that had been attended by staff working within the practice. We also reviewed information about continuing professional development (CPD) and found that staff had undertaken the required number of CPD hours.

Working with other services

Effective arrangements were in place for working with other health professionals to ensure quality of care for the patient. The service worked closely with maxilla-facial surgery department at the local hospital for patients who required oral surgery. The service also liaised with orthodontics at the local hospital for patients who required braces.

There were clear guidelines for referring patients to specialist colleagues based on current guidelines. The practice had referred patients to special care general anaesthetic services. This included patients protected under the mental capacity act 2005 (MCA) The MCA is a legal framework which protects patients who need support to make important decisions. The practice had liaised with Independent Mental Capacity Advocates (IMCA) when appropriate. IMCA is a type of advocacy introduced by the MCA. The MCA gives some people who lack capacity a right to receive support from an IMCA in relation to important decisions about their care.

When people had been referred to another dental service, such as a specialist in conscious sedation, all information that was needed to deliver their on-going care was appropriately shared in a timely way through secure couriers.

Consent to care and treatment

Patients' who used the service were given appropriate information and support regarding their dental care and treatment. We spoke with five patients who used the service and reviewed 25 comments cards. Patients told us they had been given clear treatment options which were discussed in an easy to understand language by practice staff. Patients told us they understood and consented to treatment. This was confirmed when we reviewed patient records and found signed consent forms for treatments.

Practice dentists had received training on the MCA and had talked with staff about implications it

had for staff and patients. Staff were aware of how they would support a patient who lacked the capacity to consent to dental treatment. They explained how they would involve the patient and carers to ensure that the best interests of the patient were met. This meant where patients did not have the capacity to consent, the dentist acted in accordance with legal requirements and that vulnerable patients were treated with dignity and respect.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients were treated with kindness, dignity, respect and compassion while they received care and treatment.

The service treated a high proportion of children including children with challenging behaviour. We spoke with two families during our inspection who told us the dentists were experienced in dealing with children and were very patient and considerate. The dentists told us they deployed various strategies such as providing children with stickers, offering flavourless toothpaste, using background music, and providing more time for patients according to individual need.

The practice provided services to some hard to reach groups including homeless patients and asylum seekers. Staff told us these patients were contacted via mobile phone or via local charities such as the salvation army hostel in Plymouth where they were staying.

The practice had access to a language line telephone translation service to assist communication with any patients who found it difficult to communicate in English.

The reception desk was in the same area as the waiting room. Staff told us that if patient's wished to speak in private there were rooms available. The practice was very aware of patient confidentiality. Patients we spoke with confirmed this. During our visit we saw that the waiting room often contained no more than one patient waiting for their appointment. We saw that treatment room doors were always closed when a patient was receiving treatment.

Staff took time to interact with patients and those close to them in a respectful, appropriate and considerate manner.

Staff recognised and respected people's diversity, values and human rights. Staff had received equality and diversity training on an annual basis.

Patients told us that staff were sympathetic and caring towards them to ensure that patients who used services, and those close to them, received the support they need to cope emotionally with their care and treatment. During our inspection we noticed that patients knew staff well and there was much friendly interaction between patients and staff. Patients reported that staff responded to pain, distress and discomfort in a timely and appropriate way.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area that gave details of NHS dental charges. We also saw that the practice had a website that included information about dental care and treatments, costs and opening times. The website also contained information regarding how patients could access emergency dental care if required; this information was also available in the patient information leaflet located in the reception area.

Staff told us that treatments, risks and benefits were discussed with each patient to ensure the patients understood what treatment was available so they were able to make an informed choice. The dentist explained what they were going to do and used aids such as models of teeth and a mirror to show patients visually what their teeth or oral cavity required. They were also shown this on a radiograph (x ray) where applicable. Patients were then able to make an informed choice about which treatment option they wanted. Written treatment plans had been provided.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

Services were planned and delivered to meet the needs of patients. The facilities and premises were appropriate for the services that are planned and delivered. Dentists told us where patients asked for particular radio stations or particular music this had been provided. There was a compact disc player available or patients could play music via their own mobile devices during treatment.

Meeting records from September 2014 showed that guidance had been provided to patients following changes in the law around drugs and driving.

Dentists had had training in special care dentistry. Special care dentistry is concerned with the oral health of people who have a disability, or who are affected by other medical, physical, or psychiatric issues. One dentist was being mentored in special care dentistry and another had achieved formal qualification in the subject. There were a high proportion of patients who required special care dentistry.

Appointment times were scheduled to ensure people's needs and preferences (where appropriate) are met. The service was open 8.45am until 5pm Monday to Friday. Outside of those hours the service was provided by Devon Doctors.

The practice made reasonable adjustments for patients such as to the environment, choice of dentist or treatment options to enable people to receive care and treatment. Where patients had requested a male or a female dentist then these wishes had been complied with.

The practice took into account the needs of different people on the grounds of age, disability, sex, gender reassignment, race, religion or belief, sexual orientation, pregnancy and maternity. The practice had an equal opportunities policy which had been reviewed within the last 12 months.

There was evidence that the provider gathered the views of patients when planning and delivering services, for example in the provision of larger chairs in the waiting room. The practice carried out the NHS Friends and Family survey on a monthly basis. There were also blank feedback forms for complaints or compliments in the waiting room.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services that included access to telephone translation services. They also had a communication card with key dental treatments and phrases in a number of different languages that they used to communicate with people whose first language was not English. The building was accessible to wheelchair users.

Staff were able to describe to us how they had supported patients with additional needs such as a learning disability or those who were wheelchair users. For example, staff explained how an intercom on the front door allowed patients who required assistance with opening the front door to summon staff. There were pictures, easy to understand diagrams and models available which dentists used to help explain treatment options to patients.

Access to the service

Patients could access care and treatment in a timely way. Waiting times, cancellations and delays were minimal.

The practice had level access and was entirely based on the ground floor. The front door had to be pulled but had an intercom to summon assistance. Waiting room chairs were robust, comfortable, of varying heights and had arms for support. There were bariatric chairs in the waiting room and in a treatment room. There were male and female toilets adjacent to the waiting room which had disabled access.

There was currently no hearing aid induction loop in place at reception. Reception staff informed us that they would use written means to communicate if required, in larger font sizes. A language translation line service was available.

Patients had timely access to urgent treatment. Staff told us they always saw urgent cases within 24 hours at the latest. There was time set aside to cope with emergency appointments. During the inspection, one patient told me their child had required an emergency appointment. They had contacted the practice and the child had been seen by a dentist within two hours.

Patients reported that they are aware of how they can access emergency treatment, including out of normal hours. This was displayed on the front door and on the website.

Concerns & complaints

Are services responsive to people's needs?

(for example, to feedback?)

The complaints procedure was displayed in the waiting room with details of how to escalate a complaint should a patient wish to do so. There were policies in place which ensured patients were told when they were affected by something that goes wrong, given an apology and informed of any actions taken as a result.

Patient's concerns and complaints were listened and responded to, and used to improve the quality of care. There was a complaints system in place, which was publicised, accessible, understood by staff and patients who use the service.

There was openness and transparency in how complaints were dealt with. There had been two complaints in the past 12 months. We saw an example of how a complaint had been dealt with. A patient had lost a filling in their tooth, they had been provided with a temporary dressing which had fallen out. A temporary dressing had been used as an emergency interim measure. The patient had complained when the temporary dressing fell out. An appointment had been offered to install a permanent filling in that tooth. The patient had accepted this and had been satisfied with the outcome.

Information was provided about the steps people can take if they were not satisfied with the findings or outcome once the complaint has been responded to. The practice received a large number of written compliments. We saw that in May 2015 alone a total of six compliments had been received by the practice.

Are services well-led?

Our findings

Governance arrangements

The principal dentist undertook quality audits at the practice. This included audits on health and safety, waste management, infection control, staffing and records. We saw that action plans had been drafted following audits and actions taken as necessary.

The practice had a clear vision and objectives which were displayed in the patient waiting area and in staff areas. The screensaver on staff computers displayed the vision and five values; employee led organisation, based around local people and communities, providing seamless system leadership, where experience exceeds expectations, sustainable, successful and admired.

The service was part of Plymouth Community Dental service, a community interest company (CIC). There was a board of directors which oversaw the management of the practice. The practice had a management team which included a dental clinical lead, dental nurse manager, a business manager and two administration managers. The management team met up together twice a month. One of the directors joined these meetings in a managerial capacity.

We looked at records of these meetings in the last six months. We saw that meetings had discussed delivering better oral health, incidents, complaints and compliments, the MCA, radiography and a hand washing audit. In May 2015 one of the practice dentists delivered a presentation to all staff on delivering better oral health. Dentists had attended a community dentistry conference in October 2014 relevant to specialist dentistry.

Staff were supported and managed and were clear about their lines of accountability. There was a registered manager in post who understood their responsibilities and was supported by the company.

There was an effective approach for identifying where quality and/or safety was being compromised and steps were taken in response to issues. These include audits of radiological images, clinical notes, legionnaires' disease, infection prevention and risks, incidents and near misses and autoclave checks.

Leadership, openness and transparency

The leadership and culture reflected the vision and values, encouraged openness and transparency and promoted delivery of high quality care. Staff told us that the culture of the practice encouraged this positive environment. A whistle blowing policy was in place and staff we spoke with knew where to find it.

Policies and procedures about all aspects of the work of the practice were available to all staff on a computer system. This included admin quick guides, clinical governance and the results of audits.

Twice monthly management meetings included discussions on patient treatment, staffing and operational matters, any training or safety updates. The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and risks were identified, understood and managed.

There were dental meetings once a month, attended by all dentists in the Plymouth Dental Community Service including the Scott Dental Access Centre. The most recent one was May 2015. Items discussed included maintaining performance at each of the practices, patient safety and alerts information and safeguarding matters.

Dental nurses also met up once a month to discuss operational matters. This took place at the same time as the dentist's meeting. Administration meetings took place once a month. Records showed these meetings were minuted appropriately and action taken to ensure the practice remained safe, caring, effective, responsive and well led.

The provider produced a staff newsletter on an annual basis called "The Extract". We looked at an October 2014 edition of "The Extract" and saw that it included relevant information on changes to oral surgery referrals, two compliments received about staff, no complaints received, staff achievement (2 staff achieved NVQ level 4 in business and admin) and favourable national feedback in the Dentist Magazine Sept 2014. The practice had responsibility for 24 in-school projects in Plymouth in deprived areas of the city, providing fluoride varnishing and screening.

The provider had systems in place to support communication about the quality and safety of services and what actions have been taken as a result of concerns, complaints and compliments.

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Candour, openness, honesty and transparency and challenges to poor practice were the norm.

Management lead through learning and improvement

The practice had acted upon CQC recommendations since its last inspection in August 2014. This included improvements to the decontamination room, six monthly infection control audits, a visit from the Plymouth Community Healthcare CIC infection control team, refurbishment of a cleaning materials storage room and the implementation of new cleaning schedules.

Quality assurance was used to encourage continuous improvement. The practice monitored its activity via a monthly activity report which was shared with all staff. We looked at the May 2015 activity report. The practice recorded all of its activity including such areas as how many patients it had treated in total, how many had complex needs, how many child patients had received minor oral surgery (97 in May).

The practice also monitored referrals received from other practices in the area. In May there had been a total of 79. Waiting lists were monitored. The longest wait for minor oral surgery was seven weeks; the longest wait for special care was four weeks. Action was taken each month to address these and attempt to reduce waiting times. Reporting on telephone calls into the practice showed the busiest day was Tuesdays with an average of 776 calls, in this way the practice could adjust its staffing levels accordingly at peak times.

Audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. Audits included a radiography audit in February 2015. Findings had been compared with previous audits. The audit had found that 96% of all radiographs taken had their justification recorded, in order to improve image clarity for better patient care. At a previous audit this had been 86%, so an improvement of 10% had been achieved. Findings from the audit included a future goal of 100%, to be achieved by individual practitioners taking note of their audit results and focusing on their own performance. A future audit was planned within the next 12 months.

An audit in June 2015 was underway which planned to examine the outcomes of urgent care patients, number of appointments, what sort of treatment they received, check consistency between dentists, improving care for urgent care patients and making better use of patient time.

Record keeping audits had been completed on an annual basis, within the last 12 months to ensure patient details were up to date.

Each patient had a signed treatment plan with a consent form, audited every 12 months. Patients protected under the Mental Capacity Act 2005 (MCA) had received support from their guardian or Independent Mental Capacity Advocate (IMCA) in best interest meetings.

A hand washing audit was done annually, most recently in April 2015. The practice used ultraviolet light to monitor the effectiveness of hand washing.

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

The practice had gathered feedback from patients through NHS Choices, and their own feedback forms. We were shown examples of where patients had made comments on NHS choices. All of the feedback was very positive.

Patients who used the service, the public and staff were engaged and involved. There was a feedback box in the waiting room with blank forms and pens. We looked at 25 comments cards during our visit and saw that patients had made entirely positive comments about the practice and the staff.

One of the dentists told us a new dental therapist had started, and expressed an interest in learning how to extract child patient's deciduous teeth (milk teeth). The practice had provided the staff with the time and resources to visit the local dental medical school together in order for the dentist to train the new dental therapist to undertake this procedure.

The provider had a form which staff could use to provide written feedback or suggestions directly to the dental board of the CIC.

The provider had processes in place to actively seek the views of patients who use the service and those close to them, and was able to provide evidence of how they take these views into account in any related decisions. For

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example, the practice had provided larger chairs in the waiting room in response to feedback and increased staffing levels at peak times at the telephone suite to improve access.

We saw that in May 2015 a total of six compliments had been received by the practice. The friends and family survey for May 2015 showed that 24 patients had responded. All had stated they were either extremely likely or very likely to recommend the service.

Staff reported that the provider valued their involvement and that they feel engaged and said their views were reflected in the planning and delivery of the service. Staff feedback had been received positively. For example, the practice had acted upon this feedback to provide a drinking water machine, shower curtains, and specialist training where an interest had been expressed.