Lyndhurst Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 March 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Lyndhurst Dental Practice is a dental practice providing mainly private treatment and was established in 1975.

The practice is situated in a large detached Victorian villa occupying the ground floor and lower ground floor. Level disabled access is to the ground floor where there is one surgery. There is an external stairway to the lower ground floor where there are a further four surgeries. Off street parking is available and there are local bus and train links.

The practice employs four dentists, four dental hygienists, seven dental nurses and three reception staff. There were also staff employed for property maintenance, maintaining accounts and an administration assistant.

Several dentists have enhanced skills and provide more complex treatments such as dental implants, specialized gum treatments and complex root canal treatments.

The practice opens: Monday to Friday 8am 1pm and 2pm - 5.30pm. Saturday: Closed, Sunday: Closed.

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. If patients called the practice when it was closed, an answerphone message gives the telephone number patients should ring depending on their symptoms.

One of the principal dentists is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The inspection was carried out by a lead inspector and a dental specialist adviser.

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 44 patients. In addition we spoke with two patients on the day of our inspection. Feedback from patients was positive about the quality of care, the caring nature of all staff and the overall high quality of customer care. They commented that staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Effective leadership was provided by the principal dentists.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- Infection control procedures were effective and the practice followed published guidance.
- The practice had effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a policy and procedure in place for recording adverse incidents and accidents.
- The dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD) by the principal dentists.
- Staff we spoke with felt well supported by the principal dentists and were committed to providing a quality service to their patients.

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

- Review the dispensing protocols for the antibiotic amoxycillin in line with dispensing guidelines issued by the British Pharmacology Society.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had effective arrangements in place for infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays).

We found that all the equipment used in the dental practice was properly maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

The practice carried out and reviewed risk assessments to identify and manage risks.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency.

Are services effective?

No action

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

The dental care provided was evidence based and focused on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals.

The staff received professional training and development appropriate to their roles and learning needs.

Staff where appropriate were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

The practice held electronic and paper records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. Records seen showed patients were recalled in line with national guidance and screened appropriately for gum disease and oral cancer.

They monitored any changes in the patient's oral health and made referrals as appropriate to other primary and secondary care providers such as for specialist orthodontic treatment or hospital services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition. (DBOH).

Summary of findings

Are services caring?

No action

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

We reviewed 44 completed CQC comments and received feedback on the day of the inspection from two patients about the care and treatment they received at the practice.

Patients commented the quality of care was very good. Patients commented on the friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection and security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

No action

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

Patients could access treatment and urgent and emergency care when required.

The practice provided patients with written information and had developed a practice information pack.

The practice had experienced very few requests for treatment by patients whose first language was not English but provided patients with written information in a language they could understand and had access to telephone interpreter services if required.

The practice had carried out an access assessment and patients who had mobility difficulties or used a wheelchair, could be treated in the surgery at ground floor level which was fully accessible. although they may have required some assistance to negotiate the entrance door.

There was a portable hearing loop available, information and forms were available and could be printed in large print when required.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

No action

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

We found effective leadership was provided by the principal dentists. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice.

The practice maintained a comprehensive system of policies and procedures using a commercially available dental clinical governance system which had been recently introduced by the principal dentists. The same company also carried out a range of compliance audits.

Policies and procedures were reviewed on a regular basis although we found that some information needed to be updated.

Summary of findings

Staff told us they felt well supported and could raise any concerns with the principal dentists and colleagues. All the staff we met said they were happy in their work and had clearly defined roles within the practice.

The practice assessed risks to patients and staff and carried out a programme of audits as part of a system of continuous improvement and learning, although we noted that the audit for infection control was last carried out in January 2016.

The practice had systems in place to seek and act upon feedback from patients using the service.

Lyndhurst Dental Practice

Detailed findings

Background to this inspection

This inspection took place on 13 March 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector, and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

We informed the NHS England area team we were inspecting the practice and we did not receive any information of concern from them.

During the inspection, we spoke with the principal dentists, associate dentists, dental nurses, reception and other staff working in the practice. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment.

We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records.

We also reviewed policies, procedures and other documents. We reviewed 44 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

To get to the heart of patients experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff. The lead dental nurse explained an incident relating to two patients with the same name. Although there was no harm or wrong treatment given to patients, the practice reviewed their processes, put a flag on all patients notes where they had the same name as another patient and all staff were made aware of the changes. This demonstrates learning and improvement from incidents is implemented.

We discussed with staff the action they would take if a significant incident occurred, they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their Duty of Candour. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

Procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

There was a procedure for when and how to notify CQC of incidents which cause harm. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice received national patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England. Where relevant these alerts were shared with all staff by one of the principal dentists.

Reliable safety systems and processes (including safeguarding)

We spoke to the lead dental nurse for infection control about the prevention of needle stick injuries. They explained the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases.

The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The practice used either a special safety syringe for the administration of dental local anaesthetics or metal recapping blocks to prevent needle stick injuries from occurring. The dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU directive on the use of safer sharps.

Staff files contained evidence of immunisation as recommended by Public Health England (PHE). For example, against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva). Staff who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. One member of staff was awaiting a booked occupational health appointment for checking immunity. There were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

The dentists explained that root canal treatment was carried out where practically possible using a rubber dam. 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 and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

One of the principal dentists acted as the point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol were in place for staff to refer to in relation to children and adults who may

be the victim of abuse or neglect. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff on each floor .

The practice held training sessions each year for the whole team so they could maintain their competence in dealing with medical emergencies. We saw documentary evidence which demonstrated regular checks were carried out to ensure the equipment and emergency medicines were in date and safe to use. Records showed all staff had completed training in emergency resuscitation and basic life support. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

The practice had systems in place for the recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status, professional registration and a recent Disclosure and Barring Service (DBS) check for clinical staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. However we found that a person recently recruited to a clinical role did not have a DBS check before commencing in post.

The practice had a system in place for monitoring staff had up to date professional indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and ongoing.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies.

The practice maintained a system of policies and risk assessments which included radiation protection, fire safety, general health and safety and those pertaining to all the equipment used in the practice. The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Records seen showed fire safety had recently been reviewed following advice from the local fire authority and an action plan put in place to address this. Firefighting equipment such as fire extinguishers were regularly checked.

The practice had a business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a documented infection control policy which was reviewed and included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

It was demonstrated through direct observation of the cleaning process and a review of practice protocols that the practice had followed the guidance about

decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05).' We observed the essential quality requirements for infection control set out in HTM 01-05 were being met. We were shown the audit of infection control processes carried out in January 2016 which confirmed compliance with HTM 01-05 guidelines. A further audit was due. The practice had included provision of an annual statement in relation to infection prevention control as required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. This was dated 17 March 2016.

We saw the dental treatment room currently in use, waiting areas, reception and toilets were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and bare below the elbow working was observed.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The lead dental nurse we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria in line with current HTM 01 05 guidelines. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We saw a Legionella risk assessment had been carried out at the practice by a competent person in September 2016. The recommended procedures contained in the report were carried out and logged appropriately. These included the monitoring of water temperatures and microbiological testing of samples of the water supply. These measures ensured patients and staff were protected from the risk of infection due to Legionella.

The practice had two separate decontamination areas, one on each floor, for instrument processing. The lead dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The lead dental nurse also explained the systems in place to ensure safe infection control practices for implant procedures. The dentist who provided implant treatment used a single use surgical drape pack system for the treatment room. These surgical drapes were used to cover all non- essential areas of the treatment room and the patient. Included in the pack were surgeon and nurse gowns, head covers for both staff and patients to prevent the spread of infection during the procedure. The dentists also used sterile single use bags of irrigant which are used as a coolant for the dental drills during the procedure.

The practice used a combination of manual scrubbing using the two sinks method, an automated washer disinfector for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were either pouched or stored un-pouched in accordance with HTM 01- 05 guidelines until required. All pouches were dated with an expiry date in accordance with current guidelines. Un-pouched instruments were dated with an expiry date of one week in accordance with HTM 01-05 guidelines.

We were shown the systems in place to ensure the autoclave and washer disinfector used in the decontamination process were working effectively. We saw the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date. We also noted the essential validation checks for the washer disinfectors including the residual protein tests were carried out and the results recorded.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. Clinical waste was stored in a locked room outside

the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured they were protected from the risk of infection from contaminated dental waste.

We also saw general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Equipment and medicines

There were systems in place to check all equipment had been serviced. Records seen showed contracts were in place to ensure annual servicing and routine maintenance.

Equipment checks were carried out in line with the manufacturer's recommendations. For example, the four autoclaves had been serviced and calibrated in March and December 2016. The practice X-ray machines had been serviced and calibrated as specified under current national regulations in March2016. Portable appliance testing (PAT) had been carried out in June 2016, although the practice could not provide an equipment inventory which would help ensure all relevant equipment was checked.

The practice also dispensed their own medicines as part of a patients' dental treatment for certain oral surgery procedures. These medicines were a range of antibiotics and pain killers. The dispensing procedures were generally in accordance with current dispensing guidelines, except for the antibiotic amoxycillin. The principal dentists assured us that the procedures for dispensing amoxycillin would be addressed as soon as practically possible. Medicines were stored according to manufacturer's instructions in a locked wall mounted metal cabinet. NHS prescription pads were stored in the cabinet overnight to prevent theft or misuse by staff or unauthorised persons.

We observed the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and spillage.

Radiography (X-rays)

We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. We also saw a copy of the local rules.

We saw a radiological audit had been carried out for each dentist in 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. These findings showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records seen demonstrated the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment. The records we saw were detailed, accurate and fit for purpose.

During the inspection we noted the dentist used dental loupes during examinations and whilst providing treatment. Dental loupes provide a dentist with a degree magnification which aids visual acuity and aids correct diagnosis and treatment of dental conditions.

Health promotion & prevention

The practice was very focused on the prevention of dental disease and the maintenance of good oral health.

To facilitate this aim the practice appointed four dental hygienists to work alongside of the dentists in delivering preventative dental care.

The dentists explained that patients at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

The waiting room and reception area on the lower ground floor at the practice contained information about how to make a complaint, an oral cancer awareness poster and how to provide feedback through NHS Choices.

Patients reported they felt well informed about their dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council (GDC).

The practice had two principal dentists, two associate dentists and four hygienists who were supported by seven dental nurses who covered decontamination duties. There were also reception and other staff for the property maintenance and accounts as well as cleaning.

No action

Are services effective?

(for example, treatment is effective)

We were shown evidence of completed training carried out. A record of all training completed by staff was available in staff files. Training was individual to their identified development needs to ensure they had the right skills to carry out their work. Training included basic life support and infection prevention and control. Practice meetings were a forum for continuing professional development and usually an hour of the meeting was devoted to this. We were shown evidence of the topics covered at each meeting.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the GDC. Records showed professional registration and professional indemnity was up to date for all staff. Dental nurses were covered under the provider policy.

Working with other services

Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice.

However, the practice did not need to refer many patients to other centres because of the skills of clinicians working in the practice. One of the principal dentists explained how they would work with other services when required. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as oral surgery or orthodontics. This ensured that patients were seen by the right person at the right time.

Consent to care and treatment

We spoke with three dentists about how they implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options. The dentist told us patients should be given time to think about the treatment options presented to them and explained that in certain situations patients would be brought back to the practice to discuss complex treatment options. This process made it clear that a patient could withdraw consent at any time.

The dentist explained how they would obtain consent from a patient who suffered with any cognitive impairment that may mean they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16 years. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

We reviewed dental care records to corroborate our information. Feedback in CQC comment cards confirmed patients were provided with sufficient information to make decisions about the treatment they received.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We obtained the views of two patients on the day of our visit. These provided a positive view of the service the practice provided.

During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

Treatment rooms were situated away from the main waiting areas and we saw doors were always closed when patients were receiving or discussing treatment during consultations. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were maintained in paper form. Computers used by reception staff were password protected and regularly backed up to secure storage with paper records stored in locked filing cabinets that were not accessible by the public. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception.

Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

The provider told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs.

The dentist we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

Patients were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

The practice provided patients with information to enable them to make informed choices. They had also developed a practice information welcome pack for new patients, which gave a range of information about the services available and the staff who offered them.

Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

During our inspection, we looked at examples of information available to patients. We saw the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details, arrangements about how to make a complaint, provide feedback about services and information about maintaining good oral health. We observed the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for the dentist.

The dentist decided how long a patient's appointment needed to be and considered any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made reasonable adjustments as far as possible, to help prevent inequity for patients that experienced limited mobility or other barriers which may hamper them from accessing services. The practice had one ground level surgery for people with mobility difficulties.

Both English and Polish were spoken at the practice. If it became clear that a patient had difficulty in understanding information about their treatment, they could access interpreter services.

The practice had a portable 'hearing loop' which would assist patients with hearing issues.

Access to the service

The practice displayed its opening hours in the practice information pack and on its website.

There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. This was provided by an out-of-hours service. The number was available in the practice information pack and answerphone.

The 44 CQC comment cards seen reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the practice manager they ensured these were responded to appropriately and in a timely manner.

The practice had received one verbal complaint in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient. The principal dentist and dental nurse told us that complaints made would be investigated and the outcome discussed amongst the team and implemented for the safety and well-being of patients.

No action

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. The governance arrangements were managed by the principal dentists and lead dental nurse who were responsible for the day to day running of the practice.

We saw risk assessments and the control measures in place to manage those risks, for example infection control and substances hazardous to health. Staff we spoke with were aware of their roles and responsibilities within the practice.

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We saw risk assessments and the control measures in place to manage those risks for example, use of equipment and infection control. Lead roles, for example in infection control, supported the practice to identify and manage risks and helped ensure information was shared with all team members.

The practice maintained a comprehensive system of policies and procedures using a commercially available dental clinical governance system which had been recently introduced by the principal dentists. The same company also carried out a range of compliance audits.

Policies and procedures were reviewed on a regular basis although we found that some contained out of date information. For example the recruitment policy still referred to Criminal Record Bureau checks as opposed to a check through the Disclosure and Baring Service. The lead professional for infection control is one of the dental nurses but the policy stated (policy 29) that it was one of the principal dentists.

The practice had a regular programme of meetings covering a wide range of topics areas. Time was also provided for educational activity. Notes and actions were written up as appropriate.

Leadership, openness and transparency

Effective leadership was provided by the principal dentists. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards seen and the patients we spoke with reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal dentists.

There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. All the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

The practice had a statement of purpose that described their vision, aims and objectives.

The service was aware of and complied with the requirements of the Duty of Candour. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Learning and improvement

We found the practice carried out a number of clinical audits which included infection control and X-ray quality. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed.

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Records showed professional registrations were up to date for all staff and there was evidence continuing professional development had taken place.

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

The practice had systems in place to seek and act upon feedback from patients using the service.

No action

Are services well-led?

The practice gathered feedback from patients through an annual survey and results of the last survey in 2016 were positive.