Olivelle & Associates Limited

Budleigh Salterton Dental Practice & Implant Centre

Inspection Report

11 Station Road
Budleigh Salterton
Devon
EX9 6RW
Tel: 01935 442552
Website: www.devendentalimplants.com

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Ratings

Overall rating for this service	No action ✓
Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive?	No action ✓
Are services well-led?	No action ✓

Overall summary

We carried out an announced comprehensive inspection on 13 December 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

Summary of findings

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

Are services responsive?

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

Are services well-led?

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

Background

Budleigh Salterton Dental Practice & Implant Centre is located in the coastal town of Budleigh Salterton, Devon. The practice provides primary dental care services for people who require dental procedures. The practice provides NHS and private patient care. There are three dental surgeries all situated on the ground floor. There is stepped access from the street and a stair lift from street level for people with limited mobility. Approximately 2,785 patients are registered at the practice. The majority of patients are adults.

The staff structure of the practice consists of three dentists (one principle and two associate dentists) and two dental hygienists. There is a practice manager, three dental nurses, one trainee dental nurse and two reception staff.

The practice is open from Monday to Thursday from 9.00am to 5.30pm and from 9.00am to 4.00pm on Fridays. There is an answer phone message directing patients to emergency contact numbers when the practice is closed.

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

The inspection took place over one day and was carried out by two CQC inspectors.

Twenty three patients provided feedback directly to CQC about the service (fifteen comment cards and eight interviews with patients). All patients replied that they were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- There were lead senior staff members for safeguarding patients. All staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from the practice team.
- The practice had implemented clear procedures for managing concerns or complaints.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- Appointment text/phone reminders were available on request 48 hours prior to appointments.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Staff had been trained to handle emergencies.
- The practice appeared clean and well maintained.
- The service was aware of the needs of the local population and was developing ways to take these needs into account in how the practice was run.
- Staff received training appropriate to their roles and were supported in their continued professional development by the management team.
- Staff we spoke to felt supported by the management team and were committed to providing a quality service to their patients.

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

Summary of findings

- Review the practice's recruitment policy and procedures to ensure background checks for staff are consistently received prior to staff employment.
- Review storage of cleaning materials in the practice.
- Reassess the availability of first aid equipment at the practice.
- Improve staff training record keeping.
- Develop strategies for formalising the capture and response to patient feedback.
- Review the arrangements for the cold storage of medicines at the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Staff had good awareness of safeguarding issues, which were informed by and supported by practice policies. Staff were able to illustrate scenarios of when they had identified concerns and raised queries to relevant authorities. We spoke with all nine staff on duty and they confirmed they had received training in safeguarding patients (adults and children). However, staff training records did not accurately reflect that this training had taken place.

Infection control processes for the decontamination and sterilising of dental equipment were safely managed. Storage of general cleaning materials was disorganised.

Staff recruitment was not consistently robust and the details of our findings are included in this report.

Are services effective?

No action

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice.

Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC). New staff had received an induction and were engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

No action

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

We received positive feedback directly from 23 patients. Patients said that the staff were kind and caring and that they were treated with dignity and respect at all times. The practice also received patient feedback in person, via Facebook and the NHS Choices website.

We found that dental care records were stored securely and patient confidentiality was well maintained.

Summary of findings

Are services responsive to people's needs?

No action

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

Patients had good access to appointments, including emergency appointments, which were available on the same day.

There was a complaints policy in place. Complaints were addressed in a timely way and resolutions aimed to the satisfaction of the complainant.

The culture of the practice was to promote equality of access for all. The premises were a converted Victorian house with steps from the road. A stair lift had been provided to help patients who had limited mobility when climbing the stairs. All surgeries were on the ground floor. However, stepped access and narrow corridors prevented the practice from being wheelchair accessible.

The practice did not actively pursue patient feedback. There was a patient suggestion box. The practice did not provide feedback to patients on changes as a result of patient suggestions. Where patients comments were received about the practice this was not formalised as part of an overarching strategy to demonstrate how improvements had been made following patient feedback.

Are services well-led?

No action

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

The practice had clinical governance and risk-management structures in place. However, we found fire risk assessments for the practice were overdue a review. Some first aid equipment was out of date or absent. The cold storage of medicines was not being adequately monitored.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the management team. They were confident in the abilities of the managers to address any issues as they arose.

Budleigh Salterton Dental Practice & Implant Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 13 December 2016. The inspection was carried out by two CQC inspectors who had access to remote advice from a specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with nine members of staff (practice manager, principle dentist, associate dentist, hygienist, three dental nurses, one trainee dental nurse and one receptionist). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Twenty three patients provided feedback about the service. We also looked at written comments about the practice in the practice comments book and comments left about patient experiences on-line via NHS choices. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff. Patients we spoke with on the day of the inspection commented that they were likely to recommend 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.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system in place for reporting and learning from incidents. There had been no significant events related to patients in the past year.

We discussed the investigation of incidents with the practice manager. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We looked at accident records. There had not been any reportable incidents in the past 12 months.

Whole staff team meetings were held every two months and there were weekly clinical staff team meetings. Team meetings were recorded and we looked at a sample of meeting minutes. We saw that there were records of when actions resulting from team meetings were addressed and signed off as closed.

Reliable safety systems and processes (including safeguarding)

The practice manager and principle dentist were the named practice leads for child and adult safeguarding. They were able to describe the types of behaviour a patient might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia. The practice manager said that they were arranging for the whole staff team to receive specific training in dementia in early 2017 in recognition that the practice was situated in an area with a higher than national average incidence of elderly people.

The practice had a safeguarding policy reviewed in the last 12 months. The policy referred to national and local guidance. Information about the local authority contacts for safeguarding concerns was held in a file in the practice manager's office. We discussed how this was accessible to the staff team when the practice manager was not on duty. The practice manager said that they would arrange for copies of local authority contacts to be available also in the staff room.

We spoke with all nine staff on duty and they confirmed they had received training in safeguarding patients (adults and children). Staff were able to illustrate scenarios of when they had identified concerns and raised queries to relevant authorities. Staff training records did not accurately reflect that this training had taken place. The practice manager said that they would review staff training records to ensure that the records were maintained accurately.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice had a current policy on the re-sheathing of needles, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in with the emergency equipment in an area accessible only to staff. This was available for the dental practice to use; the staff were aware of its location and how to use it. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal

Are services safe?

heart rhythm). We noted that the practice only had AED pads suitable for use on adults. The practice manager said they would make arrangements to purchase a set of pads suitable for use with children.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. This equipment was checked for safe use each day the practice was open.

We looked at first aid equipment. We noted that three dressing had passed their expiry dates. The practice manager said they would ensure these were replaced. There were no eye wash supplies in the event of an accidental splashing. We were told that this would be purchased for the decontamination room.

Staff recruitment

The staff structure of the practice consisted of three dentists and two dental hygienists. There was a practice manager, three dental nurses, a trainee dental nurse and two reception staff.

Many of the staff had been in post for a number of years. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

The practice policy stated that Disclosure and Barring Service (DBS) checks for all members of staff would take place prior to employment. We saw evidence that all dentists and hygienists had a DBS check. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, the practice manager said that not all dental nurses or receptionists had been checked and risks assessments as for why checks were not carried out had not been completed. Following the inspection the practice manager wrote to us to state that applications for all staff without DBS checks had been applied for. We looked at a sample of staff files, chosen at random. We looked at three files. Other background checks relating to staff recruitment (such as proof of identity, references, professional registrations, professional immunity insurance and immunisation status had been completed).

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had clearly marked exits and an evacuation plan. There were also fire extinguishers situated at suitable points in the premises. We saw that the annual review for the practice fire risk assessment was overdue. Records did not demonstrate that outstanding actions from the preceding review had been signed off by the practice manager as actioned. The evacuation plan also had not considered the additional needs of sedated patients receiving treatment in the practice. Following the inspection the practice manager wrote to us to confirm that all actions from the preceding fire risk assessment had been signed off as completed and that the risk assessment had been reviewed and amended taking into consideration an evacuation plan where patients in the practice may be under conscious sedation when receiving treatment.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. The practice struggled with available storage space. Some cleaning products were stored in a staff only area but were not locked away. We raised this with the practice manager who said that they would review the suitability of the arrangements when storing of cleaning products.

The practice had a system in place for receiving and responding to 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). Relevant alerts were discussed during staff meetings which facilitated shared learning.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. There was an

Are services safe?

infection control policy, which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The lead infection control nurse carried out bi-annual audits of infection control processes at the practice using a recognised industry assessment tool.

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

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the purpose built decontamination room and dental surgeries. The dental nurse described the process they followed to ensure that the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines.

We looked in the cleaning cupboard. This was outsourced to a cleaning contractor. Environmental cleaning was carried out in accordance with the national colour coding scheme by the cleaning staff employed to work throughout the building. However, we saw the cupboard was disorganised.

Following the inspection the practice manager wrote to us to say that they had met with the cleaning contractor and developed a plan to improve organisation of the cleaning cupboard to ensure minimal risk of cross contamination when storing damp mop heads.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

Dental instruments were cleaned in a washer disinfector. In the event of a failure of the washer disinfector the practice had equipment to suitably manually cleaned instruments. Once inspected as clean under a light magnification device instruments were then placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

The practice carried out checks of the autoclave to assure that it was working effectively. Twice daily checks when the practice was open included the automatic control test and steam penetration test. A log book was used to record the essential daily validation checks of the sterilisation cycles.

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

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out during 2016. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. The practice kept a record of the outcome of these checks on a monthly basis.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been

issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance and was next due in 2017. PAT is the name of a process during which electrical appliances are routinely checked for safety every two years as a minimum.

The expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly. Dental care products requiring refrigeration were stored in a fridge in line with the manufacturer's guidance.

We saw that one medicine that could be stored in a refrigerator, or optionally at room temperature with a shorter use by date, was stored in a refrigerator. Staff told us there was no formal system in place to monitor and record the temperature inside the refrigerator to ensure safe storage. We discussed this with the practice manager and principle dentist. They decided to remove the medicine from the refidgerator and store at room temperature (within the storage guidelines) and record on the medicines packaging a revised use by date for the medicine. The practice manager and principle dentist were advised that should medicines be refrigerated in the future a daily record of the cold storage temperature would need to be maintained and action taken in the event of the medicine being stored outside of the recommended range of cold temperatures.

Practice dental staff assisted by dental nurses were able to offer patients conscious sedation. (These are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The practice had protocols for conscious sedation, giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.' Records showed that dentists who carried out, and dental nursing staff who assisted in conscious sedation, had the appropriate training and skills to carry out the role.

The practice maintained a record of all medicines received into the practice, prescribed for patient use and destroyed/ returned to pharmacy. One medicine was subject to Schedule 3 of the Controlled Drug Schedule and is subject to special secure storage and record keeping requirements. The practice was not storing and recording the medicine fully in line with these requirements. We raised this with the practice manager and principle dentist who took immediate action to source and install the required additional storage facility and to ensure recording of the medicine receipt and use was in a bound numbered page book where pages could not be removed.

Radiography (X-rays)

There was a radiation protection file, which was in the process of being completed at the time of the inspection, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw that the X-ray equipment had been serviced in 2016, within the three yearly recommended maintenance cycle.

We saw evidence that the dentists had completed radiation training in the last 12 months.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists and hygienists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with two dentists and a hygienist and asked them to describe to us how they carried out their assessments. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history when they booked in for their appointment to give to the dentist. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

Patients' dental care records were updated with the proposed treatment after discussing options with the patient. Treatment plans were printed for each patient on request, which included information about the costs involved whether private or NHS. Patients were referred to the practice information leaflet, or website for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of thirteen dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Dentists and the hygienist told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the reception area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the case. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training.

There was a written induction programme for new staff to follow and evidence in the staff files that this had been used at the time of their employment. The induction checklist did not list safeguarding as training to be carried out during the induction period. We spoke with staff and were satisfied that this topic was covered during the induction period. The practice manager told us they would amend the induction checklist to capture the record that new staff awareness of patient safeguarding had been covered.

Many of the staff employed had worked at the practice for a number of years. Staff told us that the management team was supportive and invested in their staff through regular training opportunities to promote clinical excellence at the practice.

Working with other services

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

Staff at the practice explained how they worked with other services, when required. The dentists and hygienist were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for complex orthodontic work.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was

Are services effective?

(for example, treatment is effective)

prepared and sent to the hospital with full details of the dentists' findings and a copy was stored on the practice's records system. We looked at two examples of referral letters. These were comprehensively completed and referrals took place in a timely way to avoid delay to treatment. The receptionist kept an electronic record noting the dates when referrals were made, when the appointment had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at two patient records requiring consent for treatment under conscious sedation and saw consent to treatment was suitably recorded in the patient dental care records in line with conscious sedation guidance.

All of the staff were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). Clinical staff had completed formal training in relation to the MCA in 2015. The dentists could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The 15 comments cards we received and interviews with eight patients on the day, all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms' doors were closed at all times when patients were having treatment. Conversations between patients and the dentists/hygienist could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in a dedicated lockable staff only area. There were also electronic records for X-rays and charting. Computers were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice detailed information about services on the practice website. This gave details of the range of services available, dental charges or fees and payment options (such as membership of private dental schemes). A poster detailing NHS and private treatment costs was displayed in the waiting area.

We spoke with nine staff on duty on the day of our inspection. All of these staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable.

The patient feedback we received on the day of the inspection confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. The dentists and hygienist decided on the length of time needed for their patient's consultation and treatment according to patient need. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to urgent appointments on the day that they needed to be seen. Same day urgent appointments were scheduled for patients registered with the practice. On the day of the inspection we heard one person requesting an urgent appointment. They were seen and assessed by a dentist within one hour of this request.

During our inspection we looked at examples of information available to people. The practice website contained a variety of information, including opening hours and costs. There was also a printed patient information leaflet at the practice.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy for staff to refer to. Staff told us there were no patients registered at the practice speaking English as a second language. The practice was in an area with a higher than national average number of elderly people. We observed staff assisting older people with mobility problems around the building and making arrangements for older patients to travel to and from their appointments. Text/phone reminders for appointments were arranged by reception staff.

The practice was a converted Victorian era house. This presented some challenges for accessibility as it was in an elevated position from the road with stepped access and had narrow corridors. A chair lift had been installed to aid patients accessing the premises from street level. The principle dentist said he would visit patients on a domiciliary basis for an initial assessment if mobility was problematic and then arrange for treatment by referral to secondary care or an alternative accessible unit.

Access to the service

The practice opening hours were Monday to Thursday from 9.00am to 5.30pm and from 9.00am to 4.00pm on Fridays. There was an answer phone message directing patients to emergency contact numbers when the practice closed.

The receptionists told us that patients, who needed to be seen urgently, for example because they were experiencing dental pain, were seen on the same day that they alerted the practice of their concerns. The feedback we received via comment cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been one complaint recorded during 2016 regarding dental work. We looked at the complaint in detail. This was handled in a timely way and attempted to be resolved to the satisfaction of the patient complaining

Patients were also invited to give feedback in person or via a comments box at the practice. Patients could also leave comments through the NHS Choices website. The practice had used patient surveys in the past but there were no current plans to repeat patient surveys. There was not an overall strategy in place for seeking patient views to use as a method for improving services.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a management structure. The governance arrangements for this location were overseen by the practice manager and principle dentist who was responsible for the day to day running of the practice. The practice manager told us about the governance structures and protocols at the practice. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

Regular staff meetings took place at the practice with records maintained of all staff meetings. Minutes from staff meetings were circulated via a staff communication board.

We found that record keeping for some aspects of practice governance had not kept pace with actual action taken. For example, dating and signing off of actions that had been completed for the fire risk assessment and staff training records to accurately reflect training that had taken place. Other records had been completed fully, such as clinical records.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the practice manager and principle dentist. They felt they were listened to and responded to when they did so.

We found staff to be dedicated in their roles and caring towards the patients. We found the dentists provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the practice manager and principle dentist. All staff had received a documented appraisal in the last 12 months.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. There was evidence of repeat audits at appropriate intervals and these reflected standards and improvements were being maintained. For example, radiograph, medical history, infection control and record keeping audits.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through the use of a comments box in the practice and by speaking with staff. The practice manager said that most comments were general opinion about upgrade to the premises, including waiting areas. We have noted in this report that an overall strategy for seeking patients views was underdeveloped. We were told that the practice website was being improved to allow patients to leave comments through a Facebook link.

Staff told us that the management team were open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the management team.