Care Quality Commission

Emma Swindells Limited

Park Dental Practice

Inspection Report

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Date of inspection visit: 15 March 2016
Date of publication: 13/06/2016

Overall summary

We carried out an announced comprehensive inspection on 15 March 2016 to ask the practice the following key questions; are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Park Dental Practice is located in a residential suburb and comprises a reception, waiting room and office on the ground floor, and a treatment room, a decontamination room and storage and staff room on the first floor. Parking is available on nearby streets and car parks. The practice is accessible to patients with disabilities and impaired mobility but not to wheelchair users.

The practice provides general dental treatment on a private basis to patients of all ages.

The practice is open Monday, Wednesday, Thursday 9.00am to 5.30pm, Tuesday 9.00am to 5.00pm, and Friday 8.00am to 3.00pm. The practice is closed for lunch between 1.00pm and 2.00pm.

The practice is staffed by one dentist, a receptionist, and three dental nurses, one of whom is a trainee, and another of whom is a dental nurse / receptionist.

The principal 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.

We received feedback from 39 people about the services provided. Every comment was positive about the staff and the service. Patients commented that the practice

Summary of findings

was clean and hygienic and they found the staff welcoming, friendly, and caring. They had trust in the staff and confidence in the dental treatments and said that they were always given clear, detailed and understandable explanations about dental treatment. Several patients commented that the team were efficient and worked well together and that the dentist had high standards of professionalism, put patients at ease and listened carefully. Patients commented that they would highly recommend the practice to anyone.

Our key findings were:

- The practice recorded and analysed significant events and incidents and received and acted on safety alerts.
- Staff had received safeguarding training and were fully familiar with the process to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies, and emergency medicines and equipment were available.
- Premises and equipment were clean, secure and properly maintained.
- Infection control procedures were in place and the practice followed current guidance.
- Patients' needs were assessed and care and treatment were delivered in accordance with current legislation, standards and guidance.
- Patients received explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Staff were supported to deliver effective care, and opportunities for training and learning were available.
- Patients were treated with dignity and respect and their confidentiality was maintained.
- The appointment system met the needs of patients.
- Services were planned and delivered to meet the needs of patients and reasonable adjustments were made to enable patients to receive their care and treatment.
- The practice had a formal system in place for obtaining feedback from patients, and staff were able to feedback informally at any time.
- Staff were supervised, felt involved and worked as a team.
- Governance arrangements were in place for the smooth running of the practice and the practice had a structured plan in place to audit quality and safety.

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

- Review the practice's sharps risk assessment and procedures having due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the practice's procedures and protocol for maintaining accurate, complete and detailed records relating to the employment of staff and ensure the required specified information in respect of all persons employed by the practice is held.
- Review the practice's complaint handling procedures to ensure details are provided in the practice leaflet and on the practice website as to further steps people can take should they be dis-satisfied with the outcome of their complaint.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

There were systems in place for identifying, investigating and learning from events, incidents and complaints and we saw evidence that the systems were working well. Staff were aware of their responsibilities to report incidents. Safety alerts were received by the practice and there was evidence of action taken in response to these alerts.

Staff understood their responsibilities for identifying and reporting potential abuse. Staff were trained in safeguarding and there were policies and procedures in place for them to follow.

We observed that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare.

The practice had a recruitment policy and recruitment procedures in place which were in accordance with current regulations, however we did not see all the required information in relation to one member of the five staff. There was a sufficient number of suitably qualified staff working at the practice. We saw evidence of inductions for staff and of regular reviews and appraisals.

The practice had identified and assessed risks and staff were aware of how to minimise risks, but some risk assessments needed to be reviewed and updated to take account of legislation and current guidance, for example the sharps risk assessment.

We found the equipment used in the practice, including medical emergency and radiography equipment, was well maintained and tested at regular intervals. The practice had the recommended emergency medicines and equipment available, including an automated external defibrillator, (AED). [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. Staff were carrying out regular checks on the medicines and equipment.

There were systems in place to reduce and minimise the risk and spread of infection and the premises and equipment were clean, secure and properly maintained. The practice was cleaned regularly and there was a cleaning schedule in place. Infection prevention and control policies and procedures were in place and staff were following these.

We saw evidence that X-rays were justified, reported on and quality assured, and evidence of auditing of the quality of the X-ray images, which demonstrated the practice was protecting patients and staff from unnecessary exposure to radiation.

Are services effective?

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

Patients received an assessment of their dental needs which included assessing and recording their medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were fully explained and consented to. The practice kept detailed dental records of oral health assessments and treatment carried out, and monitored any changes in the patients' oral health. The practice provided regular oral health advice and guidance to patients and used displays to promote good oral health and healthy lifestyles.

Current guidelines were followed in the delivery of dental care and treatment for patients. The treatment provided for patients was evidence based and focussed on the needs of the individual. Patients were referred to other services where necessary, in a timely manner.

Summary of findings

Qualified staff were registered with their professional body, the General Dental Council, (GDC). Staff received training, development and support appropriate to their roles and learning needs and were supported in meeting the requirements of their professional body. The practice had a detailed, structured training plan in place and there was a strong emphasis on learning and training.

Are services caring?

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

Patients commented that staff were caring, polite, and friendly. They told us that they were treated with respect and that they were happy with the care and treatment given.

Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Patient feedback on CQC comment cards confirmed that staff made them feel relaxed and at ease and the dentist had helped them to overcome their dental fear.

We found that treatment was clearly explained and patients were provided with information regarding their treatment and oral health. Patients were given time to decide before treatment was commenced. Patients commented that the staff were informative and that information given to them about options for treatment was helpful.

Are services responsive to people's needs?

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

Patients had access to appointments to suit their preferences, and emergency appointments were available on the same day. Patients could request appointments by email, telephone or in person. The practice opening hours and out of hours appointment information was provided at the practice entrance, in the patient leaflet and on the practice website. Feedback from patients on CQC comment cards confirmed that it was easy to obtain an appointment to suit their preferences and there were always emergency appointments available.

The practice captured social and lifestyle information on the medical history forms completed by patients which helped the dentist to identify patients' specific needs and helped to direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records. One patient with specific needs commented that staff could not be more helpful.

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. The practice was not accessible to wheelchair users but staff provided information on local practices which were accessible. A waiting room and an accessible toilet were located on the ground floor. The treatment room was on the first floor. Staff had access to interpreter services where patients required these.

The practice had a complaints policy in place which was displayed in the waiting room and outlined in the practice leaflet, and on the website. However further steps which people could take should they be dis-satisfied with the practice's response were not included in the leaflet or on the website.

Are services well-led?

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

The provider had effective systems and processes in place for monitoring and improving services.

Summary of findings

The practice had a management structure in place and some staff had lead roles. Staff we spoke to were aware of their roles and responsibilities within the practice. Staff reported that the manager was approachable and helpful and took account of their views. The culture of the practice encouraged openness and honesty and staff told us they were encouraged to report concerns. Staff reported they were happy in their roles.

There was a range of policies and procedures in place at the practice. Policies were underpinned by protocols and procedures to assist and guide staff in undertaking tasks. Policies, procedures and protocols were regularly reviewed and audited for their effectiveness.

The practice carried out planned audits to identify where quality or safety was being compromised. We saw evidence to show that information from audits, checks and learning from events and incidents were used to monitor and improve the quality and safety of the service.

We saw some evidence to show risks were identified, understood and managed however some of the practice's risk assessments required reviewing and updating to ensure they were in accordance with current legislation and guidance, for example the sharps risk assessment and the business continuity plan.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete, accurate and securely stored. Patient information was handled confidentially.

The practice held staff meetings frequently and these were used to share information to inform and improve future practice as well as to deliver training.

The practice had a formal system to actively seek the views of patients and we saw evidence of improvements to the practice in response to feedback. Staff were able to provide feedback informally at any time.

Park Dental Practice

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.

The inspection took place on 15 March 2016 and was led by a CQC Inspector assisted by a dental specialist adviser.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included details of complaints they had received in the last 12 months, their latest statement of purpose, and details of their staff members including their qualifications and proof of registration with their professional body.

We also reviewed information we held about the practice. During the inspection we spoke to the dentist, dental nurses and receptionists. We reviewed policies, procedures and other documents and observed procedures. We reviewed 38 CQC comment cards that we had sent 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.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had procedures in place to report, analyse and learn from significant events and incidents. The policy was displayed in the staff room and staff we spoke to had a good understanding of what constitutes a significant event in a dental practice. We saw that events were reported and analysed in order to learn from them and improvements were put in place to prevent re-occurrence. The dentist discussed an example with us and we saw that the event had been recorded and analysed, following which actions had been put in place. We saw that the actions included a review and update of training, policies and procedures and a discussion at a staff meeting. All actions had been carried out and improvements put in place.

Staff had an understanding of the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 and were aware of how and when to report. The practice had procedures in place to record and investigate accidents.

Staff had an understanding of their responsibilities under the Duty of Candour. Duty of Candour means people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency and Department of Health. These alerts identify problems or concerns relating to a medicine or piece of medical or dental equipment, or detail protocols to follow, for example, in the event of an outbreak of pandemic influenza. Staff were able to discuss examples of these and we saw evidence of action taken.

Reliable safety systems and processes (including safeguarding)

We saw evidence that the practice had systems, processes and practices in place to keep people safe from abuse.

The practice had a policy for safeguarding children and vulnerable adults which included local safeguarding authority's contact details for reporting concerns and suspected abuse. Contact details and process flowcharts for both child protection and adult safeguarding were displayed for ease of access. The provider had a lead role responsibility for safeguarding. Staff we spoke to clearly understood the policy and procedures. Staff were trained to the appropriate level in safeguarding and were aware of how to identify abuse and follow up on concerns. The dentist was routinely assisted by a dental nurse.

Staff discussed a safeguarding example with us in relation to an adult patient. Staff had recognised that the patient was vulnerable and referred the patient to the local safeguarding team. We saw evidence of good team communication and actions were followed up and learning implemented.

The practice had a whistleblowing policy in place and staff were encouraged to bring safety issues and concerns to the attention of the provider. Staff we spoke to were confident about raising concerns. We found that the policy did not provide details of external contacts for whistleblowing concerns in line with current guidance.

We observed that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records were stored securely. Records contained a medical history which was completed or updated by the patient and reviewed by the dentist prior to the commencement of dental treatment and at regular intervals of care. The clinical records we saw were all well structured and contained sufficient detail to demonstrate what treatment had been prescribed and completed, what was due to be carried out next and details of alternatives.

We saw evidence of how the practice followed and implemented recognised dental treatment guidance and current practice to keep patients safe. For example, the dentist told us that a dental dam was routinely used in all root canal treatments. This was documented in the dental records we reviewed where root canal treatment had been undertaken. A dental dam is a thin, rectangular sheet used in dentistry to isolate the operative site from the rest of the mouth.

Medical emergencies

The provider had procedures in place for staff to follow in the event of a medical emergency. All staff had received basic life support training as a team and this was updated annually. We saw certificated evidence of this. Staff we spoke to were able to describe how they would deal with medical emergencies.

Are services safe?

The practice had emergency medicines and equipment available in accordance with the Resuscitation Council UK, British National Formulary guidelines and the General Dental Council standards for the dental team. Staff had access to an automated external defibrillator (AED) on the premises, [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. We saw records to show that the medicines and equipment were checked regularly. All medicines were within their expiry date.

The practice stored emergency medicines and equipment centrally in the practice and staff were able to tell us where they were located.

Staff recruitment

The practice had a recruitment policy in place, which reflected the requirements of current legislation. The practice maintained recruitment records for each member of staff. We reviewed a sample of these records and saw most of the prescribed information was present, for example, evidence of qualifications, evidence of registration with their professional body, the General Dental Council, where required, evidence of indemnity cover and evidence that Disclosure and Barring checks had been carried out. We were assured by the provider that recruitment information would be obtained and retained for any short term or locum members of staff should they be required.

We were not shown any recruitment information for one member of staff. The provider assured us this was available but we did not see any evidence of this.

The practice had a comprehensive induction programme in place. Clinical and non clinical staff confirmed to us that they had received an induction when they started work at the practice.

Responsibilities were shared between staff, for example there were lead roles for safeguarding and policy reviews. The clinical staff we spoke to were aware of their own competencies and skills.

Monitoring health and safety and responding to risks

The practice had an overarching health and safety policy in place, underpinned by several specific policies and risk specific assessments to identify, assess, and manage risks.

A range of other policies, procedures, protocols and risk assessments were in place to inform and guide staff in the performance of their duties and to manage risks at the practice, for example, consent, confidentiality and waste. The risk assessments detailed arrangements to identify, record and manage risks with a view to keeping staff and patients safe. Policies, procedures and risk assessments were regularly and consistently reviewed and staff were required to sign the policies indicating they had read them. All were easily accessible to staff and staff we spoke to were familiar with the contents.

We saw evidence of a Control of Substances Hazardous to Health Regulations 2002, (COSHH), risk assessment. The practice had procedures in place to assess the risks from substances in accordance with COSHH, and maintained a file containing details of products in use at the practice, for example, chemicals used for dental treatment. The practice retained the manufacturers' data sheets to inform staff what action to take in the event of a chemical spillage, accidental swallowing or contact with the skin. Measures were identified to reduce risks, for example, the use of personal protective equipment for staff and patients, and secure storage of chemicals. We observed the practice was storing cleaning chemicals and materials safely and appropriate signage was present.

We saw evidence that the practice had carried out a sharps risk assessment, but the practice had not implemented measures to reduce the risks associated with the use of sharps, for example, a safer sharps system to dispose of used needles was not available, and there was limited evidence to demonstrate the effectiveness of staff vaccinations. We saw documented evidence demonstrating that four of the five staff had received a vaccination to protect them against the Hepatitis B virus, and evidence relating to the effectiveness of this vaccination for one of the five staff but no evidence of effectiveness or risk assessments for the remaining staff, some of whom undertook clinical procedures. People who are likely to come into contact with blood products and are at increased risk of injuries from sharp instruments should receive this vaccination to minimise the risks of acquiring blood borne infections.

The practice had a policy and a procedure for dealing with sharps injuries. The policy detailed the procedure to follow in the event of a sharps injury but did not detail arrangements for the dismantling and disposal of sharps.

Are services safe?

Staff were familiar with the procedure and able to describe the action they would take should they sustain an injury. We observed that sharps bins were suitably located in the clinical areas for disposal of used sharps.

We saw evidence of a fire safety report from an external fire safety agency and a recent fire risk assessment carried out by the practice which identified a number of actions for the practice to carry out. We saw that the provider had completed all these actions. The practice planned to contract an external fire safety agency to carry out a new risk assessment. The practice had introduced arrangements to manage and mitigate the risks associated with fire, for example, safety signage was displayed, fire-fighting equipment was available and fire drills were carried out.

We saw evidence to demonstrate that the provider anticipated potential risks to the service and planned for these. The practice had a business continuity plan in place in order to minimise the risks associated with, and to be able to respond to and manage, disruptions and developments, such as the failure of utilities, unplanned absences or building damage. However this was a generic assessment and did not reflect all the specific circumstances at the practice. Staff provided cover for each other during absences.

Infection control

The practice was visibly clean, tidy and uncluttered. The practice had an overarching infection control policy in place underpinned by policies and procedures which detailed decontamination and cleaning tasks. Procedures were clearly displayed in appropriate areas such as the decontamination room and treatment room for staff to refer to.

The practice undertook infection control audits regularly and we saw evidence of these. We saw the most recent infection control audit from October 2015. Actions were clearly identified where required and we saw evidence that these had been carried out. We spoke to clinical and non-clinical staff and all were knowledgeable of the procedures and familiar with recognised guidance on infection control.

We observed that there were adequate hand washing facilities available in the treatment room, the decontamination room, and in the toilet facilities. Hand washing protocols were displayed appropriately near hand washing sinks.

We observed the decontamination process and found it to be in accordance with the Department of Health's guidance, Health Technical Memorandum 01- 05 Decontamination in primary care dental practices, (HTM 01-05). The practice had a dedicated decontamination room which was not accessible to patients. The decontamination room and treatment room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff used sealed boxes to transfer used instruments from the treatment room to the decontamination room. Staff followed a process of cleaning, inspecting, sterilising, packaging and storing of instruments to minimise the risk of infection. Packaged instruments were dated with an expiry date in accordance with HTM 01-05 guidance. Staff wore appropriate personal protective equipment during the decontamination process.

We observed that instruments were stored in drawers in the treatment room. We looked at the packaged instruments in the treatment room and found that packages were sealed and marked with an expiry date which was within the recommendations of the Department of Health.

Staff showed us the systems in place to ensure the decontamination process was tested and decontamination equipment was checked, tested and maintained in accordance with the manufacturer's instructions and HTM 01-05, and we saw records of these checks and tests.

Staff changing facilities were available and staff were aware of the uniform policy. Staff were well presented and wore uniforms inside the practice only.

The practice had had a recent Legionella risk assessment carried out to determine if there were any risks associated with the premises. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). Actions were identified in the assessment and these had been carried out. We saw records of checks and testing, for example, on water outlet temperatures, which

assists in monitoring the risk from Legionella. The dental water lines and suction unit were cleaned and disinfected daily, in accordance with guidance to prevent the growth and spread of Legionella bacteria.

The treatment room had sufficient supplies of personal protective equipment for staff and patient use.

The practice had an environmental cleaning policy and procedures. Cleaning was the responsibility of the dental nurses. The practice had a cleaning schedule in place identifying tasks to be completed, and used a colour coding system to assist with cleaning risk identification in accordance with National specifications for cleanliness : primary medical and dental practices, issued by the National Patient Safety Agency.

The segregation, storage and disposal of dental waste was in accordance with current guidelines laid down by the Department of Health in the Health Technical Memorandum 07-01 Safe management of healthcare waste. We observed that clinical waste awaiting collection was stored securely. The practice had arrangements for all types of dental waste to be removed from the premises by a contractor.

Equipment and medicines

We saw evidence that the provider had systems, processes and practices in place to protect people from the unsafe use of equipment, materials and medicines.

Staff showed us contracts for the maintenance of equipment, and recent test certificates for the X-ray equipment and the air compressor. We did not see documented evidence of testing for the autoclave but we were assured this had been carried out in July 2015.

The practice had a recent current portable appliance test certificate, (PAT). PAT is the name of a process under which electrical appliances are routinely checked for safety.

We saw evidence to show that the premises was secure and properly maintained in accordance with current legislation and guidance.

We saw evidence that the practice had appropriate arrangements for managing prescriptions. Private prescriptions were printed out where required following assessment of the patient and details were recorded in the dental care records.

The practice monitored the storage conditions and expiry dates of dental materials.

Radiography (X-rays)

The practice maintained a radiation protection file which contained the required information.

The provider had appointed a Radiation Protection Advisor and a Radiation Protection Supervisor.

We saw evidence that the Health and Safety Executive had been notified of the use of X- ray equipment on the premises.

We saw a critical examination pack for the X-ray machine. Routine testing and servicing of the X-ray machine had been carried out in accordance with the current recommended maximum interval of three years.

We observed that local rules were displayed in areas where X-rays were carried out. These included specific working instructions for staff using the X-ray equipment.

We saw evidence of regular auditing of the quality of the X-ray images which demonstrated the practice was acting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and patients and staff were protected from unnecessary exposure to radiation.

Dental care records confirmed that X-rays were justified, reported on and quality assured in accordance with IR(ME)R, current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines.

We saw evidence of recent radiology training for relevant staff in accordance with IR(ME)R requirements.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist carried out consultations, assessments and treatment in line with current National Institute for Health and Care Excellence guidelines, Faculty of General Dental Practice, (FGDP), guidelines, the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' and General Dental Council guidelines.

The dentist described to us how examinations and assessments were carried out. Patients completed a medical history questionnaire which included detailing health conditions, medicines being taken and allergies, as well as details of their dental and social history. The dentist then carried out a detailed examination. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the examination the diagnosis was discussed with the patient and treatment options and costs explained in detail. Patients confirmed in CQC comment cards that examinations were thorough and treatment options were discussed with them. Follow-up appointments were scheduled to individual requirements.

Details of the treatments carried out were documented and specific details of medicines used in the dental treatment were recorded. This would enable a specific batch of medicine to be traced to the patient in the event of a safety recall or alert in relation to a medicine.

We checked dental care records to confirm what was described to us and found that the records were complete, clear and contained sufficient detail about each patient's dental treatment. The dental care records adhered to the FGDP guidance. We saw patients' signed treatment plans containing details of treatment and associated costs. The dentist confirmed to us that appointment lengths could be adjusted to allow more time, for example, when treating an anxious patient.

We saw evidence that the dentist used current National Institute for Health and Care Excellence Dental checks: intervals between oral health reviews, guidelines to assess each patient's risks and needs and to determine how frequently to recall them.

Health promotion and prevention

The practice adhered closely to guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is used by dental teams for the prevention of dental disease in primary and secondary care settings. Tailored preventive dental advice and information was given to the patient in order to improve oral health outcomes for them. This included dietary advice and advice on general dental hygiene procedures. Where appropriate fluoride treatments were prescribed. Adults and children attending the practice were advised during their consultation of steps to take to maintain good oral health. Tooth brushing techniques were explained to them in a way they understood. The sample of dental care records we observed confirmed this. Information in leaflet form was also available in the waiting room in relation to improving oral health and lifestyles, for example, smoking cessation.

Staffing

We saw evidence to show that staff had the skills, knowledge and experience to deliver effective care and treatment.

All qualified dental care professionals are required to be registered with the General Dental Council, (GDC), in order to practice dentistry. To be included on the register dental care professionals must be appropriately qualified and meet the GDC requirements relating to continuing professional development, (CPD). We saw evidence that the qualified dental care professionals were registered with the GDC.

The GDC highly recommends certain core subjects for CPD, such as cardio pulmonary resuscitation, (CPR), safeguarding, infection control and radiology. We reviewed staff CPD records and saw documented evidence of CPR, safeguarding, infection control, radiology, where required, and a wide range of other subjects for all staff demonstrating that they were meeting the requirements of their professional registration. Staff commented that the practice had a strong focus on training and learning.

New staff and trainees undertook a programme of training and supervision before being allowed to carry out any duties at the practice unsupervised.

Are services effective?

(for example, treatment is effective)

The practice had an overall structured training plan which included details and dates of all training scheduled for the year. We saw the plan covered, for example, health and safety, consent and the use of personal development plans. The training plan was clearly displayed in the staff room.

The practice used a variety of means to deliver training to staff, for example, online training, manufacturer's seminars and videos, postgraduate deanery courses, 'lunch and learn' sessions and staff meetings. Staff we spoke to gave examples of training delivered at staff meetings, for example in relation to infection control, equality and diversity and information confidentiality.

The practice carried out staff appraisals regularly during which training needs were identified. We reviewed the appraisal records and noted these were a two way process with actions clearly identified. Staff confirmed appraisals were used to identify training needs.

Working with other services

The practice had effective arrangements in place for referrals. The dentist referred patients to a variety of secondary care and specialist options where necessary, for example for orthodontic treatment. The dentist was aware of their own competencies and knew when to refer patients requiring treatment outwith their competencies. Urgent referrals were made in line with current guidelines. Information was shared appropriately when patients were referred to other health care providers. We saw evidence that referrals were logged and tracked.

Consent to care and treatment

The dentist described how they obtained valid informed consent from patients by explaining their findings to them and keeping records of the discussions. Patients were given a treatment plan after consultations and assessments, and prior to commencing dental treatment.

The patient's dental care records were updated with the proposed treatment once this was finalised and agreed with the patient. The signed treatment plan and consent form were retained in the patients' dental care records. The form and discussions with the dentist made it clear that a patient could withdraw consent at any time and that they had received an explanation of the type of treatment, including the alternative options, risks, benefits and costs. The dentist described how they obtained verbal consent at each subsequent treatment appointment. We saw evidence confirming this in the dental care records.

Treatment costs were displayed in the reception area, in the practice leaflet and on the practice website, and information on dental treatments was available in the waiting room and on the practice website to assist patients with treatment choices.

The dentist explained that they would not normally provide treatment to patients on their first appointment unless they were in pain or their presenting condition dictated otherwise. The dentist told us they allowed patients time to think about the treatment options presented to them.

The dentists told us they would generally only see children under 16 who were accompanied by a parent or guardian to ensure consent was obtained before treatment was undertaken. The dentist demonstrated an understanding of Gillick competency. (Gillick competency is a term used in medical law to decide whether a child of 16 years or under is able to consent to their own treatment).

The Mental Capacity Act 2005, (MCA), provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Staff we spoke to had an awareness of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback given by patients on CQC comment cards demonstrated that patients felt they were always treated with kindness and respect, and staff were friendly, caring and helpful. The practice had a separate room available should patients wish to speak in private. The treatment room was situated away from the main waiting area and we saw that the door was closed at all times when patients were with the dentist. Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Several patients confirmed in CQC comment cards that the dentist had made them feel at ease and helped them to overcome their dental fear. The dentist explained that children attending for treatment could choose the colour of lights in the treatment room to make the environment more welcoming to them.

Involvement in decisions about care and treatment

The dentist discussed treatment options with patients and allowed time for patients to decide before treatment was commenced. We saw this documented in the dental care records. CQC comment cards we reviewed told us care and treatments were always explained in a language patients could understand. Patients commented that they were listened to. Patients confirmed that treatment options, risks and benefits were discussed with them and that they were provided with helpful information to assist them in making an informed choice.

Patients commented that the staff were open, honest and informative, and that they had confidence in the dental treatments. Patients commented on the high professionalism and level of skill the dentist had.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw evidence that services were planned and delivered to meet the needs of people.

The practice premises was well maintained and provided a comfortable environment.

The practice tailored appointment lengths to patients' individual needs and patients could choose from morning or afternoon appointments. Patient feedback on CQC comment cards confirmed that appointments were available to suit their lifestyles and it was always easy to obtain an appointment.

The practice captured social and lifestyle information on the medical history forms completed by patients. This enabled the dentist to identify any specific needs of patients and direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records which helped them treat patients individually.

Staff told us that patients were always able to provide verbal feedback which was captured by the practice. The provider had a formal, documented system in place to gather the views of patients and dates for patient surveys were identified in the practice master schedule. Feedback from patients was obtained six monthly.

Tackling inequity and promoting equality

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. The practice was located in a converted residential property. Parking was available on nearby streets and car parks. The entrance to the practice was accessible to people with disabilities and impaired mobility but not to wheelchair users, but information was available to patients on local practices which were accessible. A handrail was installed at the entrance to the practice. The waiting room, reception and toilet were situated on the ground floor and the treatment room was on the first floor accessed by a flight of stairs.

Staff told us they offered interpretation services to patients whose first language was not English and to patients with impaired hearing.

The practice made provision for patients to arrange appointments by email, telephone or in person. Where patients failed to attend their dental appointments staff contacted them to re-arrange appointments where possible and to establish if the practice could assist by providing adjustments to enable patients to receive their treatment.

Patients could choose to receive appointment reminders. The receptionists we spoke to explained to us the protocol for appointment reminders. They were fully aware of the protocol for email and telephone reminders and of confidentiality requirements. Patients who did not wish to receive appointment reminders were clearly identified in their dental care records.

Access to the service

We saw evidence that patients could access treatment and care in a timely way.

The practice opening hours and out of hours appointment information were displayed at the entrance to the practice, provided in the practice leaflet and displayed on the practice website. Emergency appointments were available daily and patients confirmed on CQC comment cards that they were always able to obtain an emergency appointment.

Concerns and complaints

The practice had a complaints policy and procedure which was available in the waiting room, outlined in the practice leaflet and displayed on the practice's website. However the leaflet and website did not provide details of further steps people could take should they be dis-satisfied with the practice's response to their complaint. The practice had not received any complaints in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

The provider had governance arrangements in place to ensure the smooth running of the practice.

The practice had a management structure in place and some staff had lead roles. Staff we spoke to were aware of their roles and responsibilities within the practice but not entirely clear on lead roles. Staff reported that the manager was approachable.

There was a range of policies and procedures in place at the practice which were accessible to staff. These included, for example, health and safety, safeguarding children and adults, and infection control. Staff we spoke to were familiar with their content. Policies were underpinned by protocols and procedures to assist and guide staff in undertaking tasks. Policies, procedures and protocols were regularly reviewed and audited for their effectiveness.

The practice had produced a reference manual containing a range of information collated from a variety of sources, for example the Health and Safety Executive and the Department of Health. We saw the manual contained information on equality and diversity, information on conditions for employees and information on the Mental Capacity Act. Staff commented this was a useful reference.

We saw evidence to demonstrate that the provider had effective governance arrangements in place for monitoring and improving the services provided for patients and regularly considered quality and performance. There were established systems and processes in place which were operating effectively, for example, the analyses of events and incidents and safeguarding. The provider had established a recruitment process but we was not closely adhering to it. Staff we spoke to confirmed they were regularly updated with changes to guidance and legislation and received support to meet their professional standards.

The provider had an approach to assist with identifying where quality or safety was being compromised, for example, via the implementation of a comprehensive audit programme. The practice carried out a range of planned clinical audits, for example, record cards, infection control, X-rays, antibiotic prescribing. The dentist had carried out a longevity audit on amalgam fillings provided in order to monitor the effectiveness of this treatment. The provider also used the events and incidents analyses to identify where quality and safety was being compromised and implemented learning from these.

We saw evidence to show risks were identified, understood and managed however the sharps risk assessment required reviewing and updating to ensure it was in accordance with current legislation and guidance, and the business continuity plan required to be amended to reflect the specific cicrumstances in the practice.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete, accurate and securely stored. We saw that computers were password protected and information was backed up on a daily basis.

A master schedule was displayed in the staff room and this included, for example, dates for updating policies, carrying out audits and patient surveys.

Leadership, openness and transparency

The leadership and culture of the practice encouraged openness and honesty. Staff told us they could speak with the dentist or colleagues if they had any concerns and felt their concerns would be listened to and appropriate action taken.

The practice held monthly staff meetings and these were used to share information to inform and improve future practice. Meetings were scheduled well in advance to maximise staff attendance and staff unable to attend were updated individually. Staff who attended in their own time were credited with time worked. There was a formal agenda and several items were regularly included for example infection control. Staff meetings were also used to deliver training.

We saw recorded minutes of these meetings, and items discussed included, for example, clinical issues such as infection control, staffing issues, contract activity, practice maintenance, incidents and training updates.

Learning and improvement

We saw evidence that the practice's quality assurance system was used to encourage continuous improvement.

The practice had a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography. We saw evidence to demonstrate

Are services well-led?

that the auditing processes were functioning well as actions were identified and followed up, and re-auditing was carried out to monitor continuous improvement. We saw evidence to show that information from audits was used to improve the quality and safety of the service, for example, improvements to infection control.

The practice collated information about the quality of care and treatment from patient surveys. Patients were also encouraged to leave feedback any time and this was captured by the practice. People were also able to leave feedback on the practice's website.

Staff we spoke to told us that as they were a small practice they communicated on a daily basis to share information and learning, for example, about events and alerts.

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

We saw evidence to show that the practice involves and engages people who use the service and staff.

The practice had an ongoing formal system to actively seek the views of patients and carried out six monthly surveys. In response to verbal feedback and feedback from the surveys the provider had installed a handrail at the entrance to the practice and had also made early morning appointments available one day per week.

The provider told us that the practice had an open door policy and staff were always able to make suggestions for improvements.

Staff told us that they were encouraged to report any concerns and that they were happy to raise concerns.

Staff reported they were happy in their roles, and the provider took account of their views. Staff commented that they were well supported by manager and colleagues and always able to seek clarification and assistance if they were unsure of any of their duties. Staff reorted they worked well as a team.