Victoria Street Dental Practice Ltd

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Inspection Report

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Date of inspection visit: 9 March 2016
Date of publication: 27/05/2016

Overall summary

We carried out an announced comprehensive inspection on 9 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

Victoria Street Dental Practice Ltd is located close to the centre of Crewe and comprises a reception and waiting room on the ground floor, a first floor waiting room, four treatment rooms, one of which is situated on the ground floor, a decontamination room, offices, storage and staff rooms. Parking is available on nearby streets. The practice is accessible to patients with disabilities, impaired mobility, wheelchair users and prams via one of the front entrances.

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

The practice is open Monday to Friday 9.00am to 5.00pm.

The practice is staffed by six dentists, a practice manager, a clinical dental technician, a dental hygienist, a receptionist, and seven dental nurses, one of whom is a trainee, and another of whom is a dental nurse / receptionist.

One of the principal dentists and the Clinical Manager are the registered managers. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 32 people on CQC comment cards about the services provided. Every comment was very positive about the staff and the service. Patients commented that the practice 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 dentists put patients at ease and listened carefully.

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 knew 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 took into account patient feedback but no formal system for obtaining feedback from patients, staff or stakeholders was in place.
- 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 having due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the practice's fire risk assessment to ensure it is in accordance with legislation and current guidelines.
- Review the systems in place for obtaining, analysing and acting on feedback from patients, staff and stakeholders about the quality of care provided.

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 incidents and complaints. 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. There was a sufficient number of suitably qualified staff working at the practice. We saw evidence of inductions for staff and 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. The practice had arrangements in place to ensure continuing care for patients during holidays and service disruptions.

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.

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 at ease.

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 and choice of dentists, to suit their preferences, and emergency appointments were available on the same day. Patients could request appointments by telephone or in person. The practice opening hours and out of hours appointment information was provided on the answerphone and in the patient leaflet. Some evidence of delay to appointments was seen but the practice was addressing this.

The practice captured social and lifestyle information on the medical history forms completed by patients which helped the dentists to identify patients' specific needs and helped them 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.

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. A waiting room, treatment room and an accessible toilet were located on the ground 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.

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.

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 managers were 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.

Summary of findings

The practice carried out planned and random audits to identify where quality or safety was being compromised. Managers additionally carried out spot checks. We saw evidence to show that information from audits and checks was used to monitor and improve the quality and safety of the service, for example, as a result of infection control audits the practice was working towards best practice for decontamination in line with the Department of Health's guidance, Health Technical Memorandum 01- 05 Decontamination in primary care dental practices.

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.

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.

The practice did not have an ongoing formal system to actively seek the views of patients, staff and stakeholders but the practice used the NHS Friends and Family Test and a suggestion box to seek patient feedback.

Victoria Street Dental Practice Ltd

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 9 March 2016 and was led by a CQC inspector who had access to remote advice from a specialist advisor.

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, the 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 dentists and dental nurses. We reviewed policies, procedures and other documents and observed procedures. We reviewed 32 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. There had been no reported significant events in the last 12 months. The managers told us they had recently considered what constitutes a significant event in relation to a dental practice. We discussed examples of events and incidents which could occur in a dental practice. We were satisfied that should such an event occur it would be reported and analysed in order to learn from it and improvements would be put in place to prevent re-occurrence.

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, and we saw examples of these in the accident book.

Staff had an understanding of their responsibilities under the Duty of Candour. Duty of Candour means relevant people are told when a notifiable safety incident occurs and in accordance with the statutory duty are given an apology and informed of any actions taken as a result. The provider knew when and how to notify CQC of incidents which could cause harm.

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 whistleblowing policy in place and staff were encouraged to bring safety issues and concerns to the attention of the managers.

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. Staff we spoke to understood the policy.

Staff were trained to the appropriate level in safeguarding and were aware of how to identify abuse and follow up on concerns. The practice directors had lead role responsibilities for safeguarding and we noted that they were trained to a higher level in safeguarding. The clinicians were assisted at all times by a dental nurse.

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 clinician 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 recognised guidance and current practice to keep patients safe, for example, we checked whether dentists used dental dam routinely to protect the patient's airway during root canal treatment, and we established the practice's policy and protocols for the use of endodontic equipment.

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. Two of the staff were trained to provide first aid.

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 weekly. 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.

Are services safe?

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 all 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.

The practice had an 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 infection control, safeguarding and information security. 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. 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.

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 not storing cleaning chemicals safely as they were positioned on a high shelf in the cleaning cupboard and access to them was difficult. The practice intended to address this immediately.

We saw evidence that the practice had carried out a sharps risk assessment. The practice had not implemented a safer sharps system to mitigate the risks associated with the use of sharps. The practice had a sharps policy in place detailing arrangements for the dismantling and disposal of sharps and the procedure to follow in the event of a sharps injury. The policy and procedures were displayed in the treatment rooms. The policy specified that only the dentists disposed of used needles and sharps and staff confirmed they adhered to this. Staff were fully familiar with the policy and able to describe the action they would take should they sustain an injury. We saw recorded evidence of one sharps injury to a member of staff. Action taken was in line with the policy and recognised guidance. We observed that sharps bins were suitably located in the clinical areas.

We were told by the practice that a fire risk assessment had been carried out but we did not see documented evidence of this. The practice planned to contract an external fire safety agency to carry out a new assessment. The practice had introduced arrangements to manage and mitigate the risks associated with fire, for example, some of the staff had received training in fire marshalling, safety signage was displayed, fire-fighting equipment was available and fire drills were regularly carried out.

The practice had two unsupervised waiting rooms which were in separate parts of the building from reception. Staff told us there were always staff in the vicinity of the waiting rooms. Computers in treatment rooms nearby had a means of rapidly alerting other staff where necessary.

We saw evidence to demonstrate that the provider anticipated and planned for potential risks to the service. 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. Staff were able to discuss examples of disruptions. The practice maintained a master list of contact details for service engineers, contractors and staff in the event of disruptions. The provider had two other dental practices and continuing care for patients could be provided at these practices during service disruption. Staff provided cover for

each other during absences and were able to provide cover at any of the provider's practices when required. The practice manager was additionally a qualified dental nurse and able to provide cover for unexpected 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 rooms for staff to refer to.

Two of the staff had lead roles for infection control and decontamination. The practice undertook infection control audits regularly and we saw evidence of these. Actions were identified in them where required. Random checks were carried out by managers on all aspects of decontamination.

We observed that there were adequate hand washing facilities available in each of the treatment rooms, 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 rooms 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 rooms 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 and were protected from splatter by splash screens during cleaning of the instruments.

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

Staff showed us the systems in place to ensure the decontamination equipment was tested and maintained in accordance with the manufacturer's instructions and HTM 01-05, and we saw records of these 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 rooms had sufficient supplies of personal protective equipment for staff and patient use.

The practice had a policy and a procedure for dealing with sharps injuries. We saw documented evidence demonstrating that staff had received a vaccination to protect them against the Hepatitis B virus. People who are likely to come into contact with blood products and are at increased risk of injuries from sharp instruments should receive these vaccinations to minimise the risks of acquiring blood borne infections. We also saw evidence relating to the effectiveness of this vaccination and risk assessments for staff who undertook clinical duties in whom the vaccination was ineffective.

The practice employed a cleaner who was responsible for cleaning all areas of the practice except clinical areas, which were the responsibility of the dental nurses. The practice had a cleaning policy and 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 :

Are services safe?

primary medical and dental practices, issued by the National Patient Safety Agency. We observed that the cleaning equipment was stored appropriately and in accordance with current guidance.

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 decontamination equipment, X-ray equipment and the air compressor. The practice maintained a master list for all equipment service and test dates.

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 records to demonstrate that fire detection and fire-fighting equipment such as fire alarms and extinguishers, were regularly checked by staff. The provider told us this equipment was regularly maintained by an external contractor.

We saw evidence 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. Staff carried out checks on deliveries of NHS prescription pads and pads were stored securely in accordance with current guidance. Private prescriptions were printed out where required following assessment of the patient. Dentists maintained a prescription log to ensure all prescriptions were accounted for, including void prescriptions.

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 critical examination packs for each X-ray machine. Routine testing and servicing of the X-ray machines 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 dentists 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. Dentists 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 dentists 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. Dentists 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 dentists 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. A number of oral hygiene products were available for sale in reception.

The practice prioritised the promotion of healthy lifestyles and good oral hygiene and had produced a range of information and advice which was displayed in reception and the waiting room. These displays reflected the practice's own initiatives, for example on sugar reduction, and national initiatives, for example, National No Smoking Day. The practice also provided healthy lifestyle advice to local schoolchildren.

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,

Are services effective?

(for example, treatment is effective)

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.

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

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, and said that they had protected time in which to read policies and undertake training.

The provider used the skill mix of staff in a variety of clinical roles, for example, dentists, a dental hygienist and a clinical dental technician, to deliver care in the best possible way for the patient.

Some staff had enhanced skills for example one of the dental nurses had a qualification in radiology, and another was trained in sedation.

The practice carried out staff appraisals annually during which training needs were identified, for example, two staff had expressed an interest in undertaking oral health education training. We reviewed the appraisal records and noted these were a two way process with actions clearly identified.

Working with other services

The practice had effective arrangements in place for internal referrals to the hygienist and the Clinical Dental Technician, and for external referrals. The practice referred patients to a variety of secondary care and specialist options where necessary, for example for orthodontic treatment. Clinicians were 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.

Consent to care and treatment

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

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 dentists 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 dentists described how they obtained verbal consent at each subsequent treatment appointment. We saw evidence confirming this in the dental care records.

NHS and private fee lists were displayed in the reception area and information on dental treatments was available in reception and in the waiting room to assist patients with treatment choices.

The dentists 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. Dentists 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 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. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were with the clinicians. 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 at ease. Patients commented that staff were always available to discuss problems should any arise.

Involvement in decisions about care and treatment

The dentists 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.

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 spacious, 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. Patients could request appointments by telephone or in person. Patients were able to express a preference for which dentist they attended.

The practice captured social and lifestyle information on the medical history forms completed by patients. This enabled the dentists 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 but this was not captured by the practice. The provider did not have a formal, documented system in place to gather the views of patients, however the practice made the NHS Friends and Family Test available to patients.

The provider used staff skills in a variety of clinical roles, to deliver care in the best possible way for the patient, for example, a clinical dental technician, (CDT), and a dental hygienist were employed. The provider explained the specific expertise of CDTs in making dentures, and had employed a CDT for the dentists to refer patients to should patients wish. The CDT also saw internally referred patients to resolve denture problems. Patient feedback had been very positive and patients had commented verbally that the dentures were of excellent quality and they were able to obtain appointments sooner. Dentists reported that this had freed more appointment time in which to see patients.

The NHS Dental Services patient survey, provided the following information:-

- 100.0% of patients of the practice were satisfied with the dentistry they had received compared with 93.8% for England, nationally.

The NHS Dental Services patient survey is carried out by the NHS to monitor the quality and integrity of NHS dental services.

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. There were two front entrances to the practice, one of which was fully accessible to people with disabilities, impaired mobility, and wheelchair users, and led to a ground floor waiting room, a treatment room and an accessible toilet facility.

The practice did not have a website at the time of the inspection but planned to have one in the near future.

Staff told us they offered interpretation services to patients whose first language was not English and to patients with impaired hearing. The practice was situated in an area with a high percentage of Polish speakers and provided information for patients in Polish.

The practice made provision for patients to arrange appointments by 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.

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 and provided in the practice leaflet and on the answerphone. Emergency appointments were available daily and patients confirmed on CQC comment cards that they were always able to obtain an emergency appointment. Patients commented on CQC cards that waiting times and delays were sometimes long. The managers told us the practice was currently trying to improve this.

Are services responsive to people's needs?

(for example, to feedback?)

The NHS Dental Services patient survey, provided the following information:-

- 83.3% of patients of the practice were satisfied with the time they had to wait for an appointment compared with 90.0% for England, nationally.

Concerns and complaints

The practice had a complaints policy and procedure which was displayed in the waiting room and outlined in the practice leaflet. We saw that the complaints received by the practice in the last 12 months had been thoroughly investigated and issues arising from them had been used to inform future practice and improve the quality of care. Patients had been given an explanation and an apology and informed of action taken.

Are services well-led?

Our findings

Governance arrangements

The practice 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. Staff reported that the managers were approachable and helpful and we observed this during the inspection.

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 provider was a member of the British Dental Association, (BDA), and was able to use the services of the BDA for advice and guidance on issues relating to dental practice.

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 recruitment process and the analyses of events incidents, complaints. 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 and random, clinical and non clinical audits, for example, record cards, infection control, X-rays, environmental cleaning, decontamination, hand hygiene and staff meetings. Practice managers additionally carried out spot checks to monitor quality and safety.

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.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete, accurate and securely stored. All computers were password protected and the computer was backed up daily. One of the Registered Managers was the practice's Caldicott Guardian. (A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing).

Leadership, openness and transparency

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

The practice held staff meetings frequently and these were used to share information to inform and improve future practice. We saw recorded minutes of these meetings, and items discussed included, for example, infection control, staffing issues, contract activity, practice maintenance, incidents and training updates. Dates were scheduled in advance to maximise staff attendance and staff unable to attend were updated individually.

Staff we spoke to told us that they communicated on a daily basis to share information and learning, for example, discussing safety alerts.

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 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, as a result of infection control audits the practice

Are services well-led?

was working towards best practice for decontamination in line with the Department of Health's guidance, Health Technical Memorandum 01- 05 Decontamination in primary care dental practices.

The managers explained the practice's audit protocol. If an unsatisfactory result was obtained in an audit, action was taken immediately and re-auditing scheduled in line with the planned programme.

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

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

The practice did not have an ongoing formal system to actively seek the views of patients, staff and stakeholders but the practice used the NHS Friends and Family Test, (FFT), and a suggestion box to seek patient feedback. Some results and comments from the FFT and the NHS Dental Services patient survey were displayed in reception, for example, comments were made in the NHS survey that the practice should try to reduce waiting times. In response to this the managers told us they were looking at how to improve this.

Managers told us that the practice had an open door policy and staff were always able to make suggestions for improvements. The managers were considering a change in the format of staff meetings to maximise staff participation and intended to seek the views of staff in planning this.

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 managers took account of their views. Staff commented that they were well supported by managers and colleagues and always able to seek clarification and assistance if they were unsure of any of their duties.