Complete Healthcare Limited

Oakmead Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 October 2015 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

The Oakmead Dental Care practice is located in the London Borough of Bromley. The premises are situated in a split-level, purpose-built building. There are five treatment rooms, a dedicated decontamination room, a waiting room with reception area, staff room, administrative office, and two toilets.

The practice provides private services to adults and NHS dental services for children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, implants, and oral hygiene. The practice also offers intravenous conscious sedation for some treatments.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), three associate dentists, six dental nurses, a trainee dental nurse, five receptionists, and two hygienists, one of whom also works as the practice manager.

The practice opening hours are on Monday from 8.00am to 7.30pm, Tuesday from 8.00 am to 7.00pm, Wednesday from 8.30am to 8.00pm, Thursday from 10.00am to 8.00pm, Friday from 8.00am to 5.30pm, and Saturday from 9.00am to 1.00pm.

The principal dentist is the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers,

Summary of findings

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

The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

Twelve people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the protocol for sharing and learning from complaints with a view to preventing a recurrence of any problems.

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.

The practice had systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control and medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We found the equipment used in the practice was well maintained and checked for effectiveness.

There were some areas where improvements could be made to safety systems. For example, an automated external defibrillator (AED) for exclusive use by the practice in medical emergencies could be considered. Risk assessments for the safe use of sharps and the need for a Disclosure and Barring Service check in non-clinical staff should also be in place.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. The practice maintained appropriate dental care records and details were updated appropriately. The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Clinical staff worked towards meeting professional standards and completing continuing professional development (CPD) standards set by the General Dental Council (GDC). Staff told us they were well-supported by the principal dentist through informal supervision and ad hoc staff meetings.

Are services caring?

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

We received positive feedback from patients through comment cards. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that patient confidentiality was well maintained. There were plans in place for improving the security of dental care records through the installation of new, lockable filing cabinets.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. Patients were invited to provide feedback via a satisfaction survey and the results of these surveys had been analysed and acted on.

There was a complaints policy which was displayed in the waiting room. Three complaints had been received by the practice in the past year. The practice manager had followed the complaints policy and had carried out relevant investigations and recorded the outcome of these. The practice could take further action to disseminate the outcomes of these investigations among staff with a view to preventing a recurrence of any problems.

Summary of findings

Are services well-led?

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

The practice had clinical governance and risk management protocols in place. These were disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. Feedback from staff and patients was used to monitor and drive improvement in standards of care.

Oakmead Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 22 October 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with five members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. The principal dentist demonstrated how they carried out decontamination procedures of dental instruments.

Twelve people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. Two incidents had been recorded in the past year. There was a policy for staff to follow for the reporting of these events and we saw that this policy had been followed in these cases. Incidents had been appropriately recorded and investigated. Actions taken at the time and any lessons that could be learned to prevent a recurrence were noted and discussed with individual members of staff. For example, there had been an incident involving a needle stick injury in September 2015. The protocol in place for managing such injuries had been followed by the relevant member of staff. We discussed this issue with the member of staff involved and with the practice manager. They told us that the incident would be discussed at a staff meeting in November 2015 to identify any wider learning points to prevent a recurrence. They also noted that a review of the sharps injury protocol was underway to identify up-to-date services for blood testing in the local area.

We noted that it was the practice policy to offer an apology when things went wrong.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). None of the accidents or incidents had required notification under the RIDDOR guidance.

Reliable safety systems and processes (including safeguarding)

The practice manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance and local authority telephone numbers for escalating concerns that might need to be investigated. This information was displayed in the office and decontamination room. There was evidence in staff files showing that staff had been trained in safeguarding children. We also noted that the principal dentist had developed an in-house training resource for practice staff in relation to safeguarding vulnerable adults.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A rubber needle guard was used during the recapping stage at all times and the responsibility for this process rested with each dentist. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to needle stick injuries. However, the practice did not have in place a written protocol describing the rationale behind the reasons why dental local anaesthetic syringes were to be recapped during patient treatment. A written risk assessment and associate risk-reduction protocol would ensure full compliance with the EU Directive on safer sharps (2013).

The practice followed national guidelines on patient safety. For example, we checked how the practice treated the use of instruments which were used during root canal treatment. A dental nurse explained that these instruments were single use only. She explained that root canal treatment was carried out using a rubber dam in line with guidance supplied by the British Endodontic Society. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.]

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. Oxygen and other related items, such as manual breathing aids and portable suction, were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with the emergency oxygen in a location known to all staff. The expiry dates of medicines and equipment were monitored using a check sheet which enabled the staff to replace out-of-date drugs and

equipment promptly. Staff received bi-annual training in using the emergency equipment. The staff we spoke with were all aware of the locations of the emergency equipment.

The practice did not own 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). However, they had an arrangement with another dental practice very close to Oakmead Dental Care (two doors down on the same street) to use their AED if the need arose. We discussed the use of this AED with the practice manager and principal dentist. We noted that the practice that held the AED did not share the same opening hours as Oakmead Dental Care. Therefore, there were times when Oakmead Dental Care did not have immediate access to an AED. The principal dentist told us they had already considered this issue following attendance at a recent life support training course. They would be purchasing an AED for use at Oakmead Dental Care as soon as practicably possible.

Staff recruitment

The practice staffing consisted of a principal dentist, three associate dentists, six dental nurses, a trainee dental nurse, five receptionists, and two hygienists, one of whom also works as the practice manager.

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that the person being recruited was suitable for the role. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. The majority of the staff had been employed at the practice over a long period of time. Three new members of the reception team had recently been recruited. We checked the recruitment file for the newest member of staff and found that copies of all relevant documents had been kept.

The principal dentist told us that it was their policy to carry out a Disclosure and Barring Service (DBS) check for all clinical staff members prior to employment and periodically thereafter. We checked five staff files and found that a DBS check had been carried out for all clinical staff members. We asked about DBS checks for non-clinical staff members (e.g. reception staff). The principal dentist told us these were not routinely carried out. However, there was no formal risk assessment in place to determine which members of staff would, or would not, need a DBS check. The recruitment policy also did not refer to the carrying out of DBS checks.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted that a review of COSHH substances in use at the practice had not been carried out for over a year.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the principal dentist via email. These were disseminated to staff, where appropriate.

There was a business continuity plan in place. There was an arrangement in place to use another practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts in the local area were displayed in the staff kitchen for prompt access in the event that a maintenance problem occurred at the premises.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The principal dentist had delegated the responsibility for infection control procedures to a lead dental nurse. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The practice had carried out practice-wide infection control audits every six months, with the last audit having been completed in June 2015.

Are services safe?

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment rooms, decontamination room and toilets. Hand-washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

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

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. She demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The drawers of a treatment room were inspected in the presence of the nurse. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The dental nurse described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had also been carried out by an external contractor in August 2014. A number of recommendations were detailed in the report; this included regular testing of the water temperatures of the taps in several rooms in the building. However, this recommendation had not been followed. We discussed this with the principal dentist and practice manager. They assured us that this would be addressed as soon as possible.

The practice used a decontamination room for instrument processing. Protocols were displayed on the wall to remind staff of the processes to be followed at each stage of the decontamination process. The dental nurse demonstrated the process. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing using a separate cleaning sink and rinsing bowl for the initial cleaning process. Items were place in an autoclave (steriliser) following inspection under an illuminated magnifier. When instruments had been sterilized they were pouched and stored appropriately, until required. All pouches were dated with a date of sterilisation and an expiry date. The dental nurse also demonstrated that systems in place to ensure that the autoclaves were working effectively. These included the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

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

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the autoclaves had been serviced and calibrated in October 2015. The practices' X-ray machines had been serviced and calibrated during the period June 2013 and October 2015 in

Are services safe?

accordance with the recommended time intervals for X-ray machine maintenance. Portable appliance testing (PAT) for all electrical appliances had been carried out in February 2015 and was due again in February 2016. A Pressure Vessel Certificate for the two dental compressors and two autoclaves were dated in September 2015 and July 2014 and was in accordance with the Pressure Systems Safety Regulations 2000.

We checked a sample of dental care records which showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients. We also noted that the medicines used in intravenous conscious sedation, (e.g. Midazolam and the reversal agent Flumazenil) were stored appropriately and were in date. The batch number and expiry dates of Midazolam along with the amounts used were recorded during each episode of conscious sedation.

Radiography (X-rays)

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. We also saw evidence that staff had completed radiation training.

A copy of the most recent radiological audit was available for inspection. The practice carried out an audit of quality every three months and there were records dating back to 2013. We also checked the dental care records. The audits and records showed that dental X-rays or computed tomography (CT) scans were justified, reported on and quality assured every time. X-rays and CT scans were taken in line with current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines. We saw patient X-rays of a high quality and these were clearly labelled and mounted.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The staff working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The principal dentist and one of the associate dentists described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

We checked the dental care records for two patients who had undergone intra-venous sedation. We found that patients had important checks prior to sedation; this included a medical history, height, weight and blood pressure. During the sedation procedure, checks were also carried out at regular intervals and a record of these checks was kept. These checks included pulse, blood pressure and the oxygen saturation of the blood. The processes carried out were in line with current good practice guidelines demonstrating that sedation was carried out in a safe and effective way.

Health promotion & prevention

The practice placed a high value on the prevention of dental disease and used the services of two dental hygienists who worked under the prescription of the dentists at the practice. The hygienists provided a variety of treatments including simple scaling and polishing of teeth to more complex gum treatments for patients suffering from the more aggressive forms of gum disease. They also provided tailored preventative advice and treatments, where necessary.

The waiting area and dental treatment rooms at the practice contained literature in leaflet form that explained about how to reduce the risk of poor dental health. Included were laminated sheets on how to maintain healthy teeth and gums.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood, and where applicable smoking and alcohol advice was also given. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The sample of dental care records we checked demonstrated that dentists had given oral health advice to patients.

The principal dentist used detailed dietary analysis records to monitor the impact of diet on their patients' dental disease. They used the results to explain how a poor diet coud lead to dental decay.

One of the hygienists ran a 'kid's cleaning club' for 30 minutes once a month on a Saturday morning for children aged 6-12 years. This was provided free of charge for any child. The child did not have to be connected with the practice. Groups of up to 10 children were given free tooth brushes, tooth brushing instruction and dietary advice. The practice also invited members of the public, again not necessarily connected with the practice, to attend mother and baby sessions to discuss tooth eruption dates, teething, tooth brushing and fluoride, weaning and dietary advice.

Staffing

Staff told us they received appropriate professional development and training. We checked six staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the

Are services effective?

(for example, treatment is effective)

General Dental Council. This included responding to emergencies, safeguarding and X-ray training. Staff involved in providing sedation services had attended the required training courses.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. Staff told us they had been engaged in yearly appraisals which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals were made to other dental specialists when required. For example, the practice carried out some implant treatments. However, they did not possess a computed tomography (CT) scanner used for the diagnosis and treatment planning in dental implant cases. The practice used a specialist medical imaging company to provide this service. We were shown the referral form for how the system operated.

The principal dentist also explained the system for managing referrals. As an example, they described how the practice dealt with referrals for patients suffering from wisdom teeth problems. The dentist explained the nature of the problem to their patients using the details contained in the referral letter. The referral letter, and any necessary X-rays, were then given to the patient whose responsibility it was to post the letter to the referral consultant. This applied to all forms of secondary referral. The aim of this approach was to give the patient ownership and a sense of responsibility in the referral process. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure they had received a satisfactory outcome and all necessary post-procedure care.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the principal dentist and an associate dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. The principal dentist used a camera to take photographs of teeth prior, during and at the end of dental treatment. These images were used to document progress as well as being used as a tool for communicating the process to patients. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments.

Staff were aware of the Mental Capacity Act 2005. They could explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from 12 patients. They described a positive view of the service. The practice had also carried a patient survey every three months throughout 2015. The results of the survey indicated a high level of satisfaction with care. Patients commented that the team were friendly, kind and respectful. Patients were happy with the quality of treatment provided. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. They were aware of the importance of protecting patients' privacy and dignity. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored electronically and in a paper format. Computers were password protected and regularly backed up to secure storage; screens at reception were not overlooked which ensured patients' confidential information could not be viewed. We noted that the paper records were stored in filing cabinets behind reception. These were not lockable and therefore dental treatment records were not as secure as they could be. The principal dentist had recognised and addressed this issue. They had arranged for lockable filing cabinets to be installed shortly.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the private and NHS dental charges or fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available.

We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. The principal dentist paid attention to patient involvement when drawing up care plans. They used a system of control phase, holding phase and definitive phase to treatment planning. These corresponded to short, medium and long term treatment objectives. Annotated diagrams were used to support explanations about the treatment objectives, options and costs for each patient. This document was given to each patient and a copy retained in the patients dental care record.

The patient feedback we received via comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. One of the hygienists told us they scheduled additional time for patients depending on their knowledge of the patient's needs, including scheduling additional time for patients who were known to be anxious or nervous. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient. The feedback we received via comments cards and from the practice's satisfaction survey indicated that patients felt they had enough time with clinicians and were not rushed.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours, emergency 'out of hours' contact details and practice policy documents. This information was also explained in the patient information leaflet and policy folder which was available in the waiting area. The practice had a website which reinforced this information. New patients were given a practice brochure which included advice about payment, appointments, and complaints.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. We noted that it was part of the staff induction to discuss issues around equality and diversity with reference to the practice's policy on this topic.

The practice manager told us the local population was mainly English speaking, although they were aware that it was possible to organise a telephone translation service, if required. They were able to provide large print, written information for people who were hard of hearing or visually impaired. The majority of the practice was wheelchair accessible with all of the treatment rooms on the ground floor with level access from the street. There was also a disabled toilet.

Access to the service

The practice opening hours were on Monday from 8.00am to 7.30pm, Tuesday from 8.00 am to 7.00pm, Wednesday from 8.30am to 8.00pm, Thursday from 10.00am to 8.00pm, Friday from 8.00am to 5.30pm, and Saturday from 9.00am to 1.00pm. Appointments could be made in person,

by telephone, or via the practice website.

The practice manager told us that the dentists always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case. The appointment schedules showed that patients were given adequate time slots for appointments of varying complexity of treatment.

Reception staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could generally get an appointment when they needed one. However, the practice had noted some feedback in the analysis of their satisfaction survey which indicated that not all patients were happy with the waiting time for appointments. We noted that action had been taken to adjust and restructure the appointments system.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a complaints policy which described how the practice handled formal and informal complaints from patients. There had been three complaints recorded in the past year; two were verbal complaints and one received via a social media source. These complaints had been responded to in line with the practice policy. A record was kept of what had occurred and actions taken at the time to address the problem. For example, some patients had been offered a refund for treatments they were dissatisfied with, or offered additional appointments, free of charge, with the clinician of their choice. Patients had received a written or verbal response following the investigation of any complaint. We noted some examples where the records showed that an apology had been offered.

We asked the practice manager how staff were informed about the outcomes of complaints with a view to sharing

Are services responsive to people's needs?

(for example, to feedback?)

learning points and preventing a recurrence. They told us the complaints were discussed on a one-to-one basis with individual members of staff, but were not routinely discussed as a group, for example, during staff meetings.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. The principal dentist had implemented suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them.

There were the arrangements for identifying, recording and managing risks through the use of risk assessment processes. However, not all risk-reduction strategies had been followed up. For example, the recommendations to check water temperatures at monthly and six-monthly intervals had not been carried out following a Legionella risk assessment. We also noted that the COSHH file had not been regularly reviewed and updated.

There were monthly staff meetings to discuss key governance issues. For example, we saw minutes from meetings where issues such as staffing levels, holiday cover, recall intervals and changes to computer software had been discussed. This facilitated an environment where improvement and continuous learning were supported. However, we also noted that the outcomes of incidents and complaints were not routinely discussed at staff meetings.

Leadership, openness and transparency

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

We found staff to be hard working, caring towards the patients and committed to the work they did. We found the principal dentist, who also acted as the Registered Manager, provided effective clinical leadership to the whole dental team. To foster a sense of ownership and accountability within the staff members, the principal dentist delegated certain responsibilities in the practice to other members of the dental team. This included staff members taking the lead in infection control and the management of the levels of stock of materials and equipment used in the practice.

Staff told us they enjoyed their work and were supported by the principal dentist. They received regular appraisals which commented on their own performance and elicited their goals for the future.

Learning and improvement

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice had a programme of clinical audit and risk assessments in place. These included audits for infection control, clinical record keeping, and X-ray quality. The audits showed a generally high standard of work. Areas for improvement were identified through the auditing programme. For example, an audit of the clinical recording keeping was carried out every three months with the most recent having taken place in September 2015. Earlier audits had identified good levels of record keeping, although some problems were identified around the recording of discussions concerning tobacco and alcohol. We discussed this with the principal dentist who told us they had acted to resolve this issue by introducing a new patient assessment recording tool which covered these topics. The three-monthly auditing programme would then be used to monitor for improvements.

The principal dentist had a clear vision for the practice and a written business development plan for the coming year. This covered governance issues, such as the restructuring of the line management roles, as well as improvements to the fabric of the premises. For example, there were plans to develop a second decontamination room and replace filing cabinets in the reception area. The principal dentist also told us about longer-term plans, such as extending the range of services available and replacing X-ray equipment.

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

The practice gathered feedback from patients through the use of a suggestions box in the waiting area, patient satisfaction survey and through the 'Friends and Family Test'. The majority of feedback was positive about the quality of care received. The practice manager had carried out an analysis of the feedback received in the acted on the results. For example, changes had been made to the types

Are services well-led?

of chairs in use in the waiting area in response to feedback. One of the dentists had also restructured their appointments system following feedback about waiting times.

Staff told us that the principal dentist and practice manager were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.