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88 High Street Dental Practice

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 25 February 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

88 High Street Dental Practice has one dentist and two qualified dental nurses who are registered with the General Dental Council (GDC). There is also one trainee dental nurse. The practice's opening hours are from 8.45am to 6pm Monday to Friday and from 7.45am to 1pm on Saturday.

88 High Street Dental Practice provides NHS and private treatment for adults and children. The practice is situated in a converted property. There are three dental treatment rooms located on the ground floor. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area on the ground floor.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 31 completed cards. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was good.

Summary of findings

Our key findings were:

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Staff had been trained to deal with medical emergencies.
- The practice kept up to date with current guidelines when considering the care and treatment needs of patients.
- Infection prevention and control systems were in place, and audits were completed on a six monthly basis.
- Options for treatment were identified and explored and patients said they were involved in making decisions about their treatment.
- Patients' confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation
- Health promotion advice was given to patients appropriate to their individual needs such as smoking cessation or dietary advice.
- Some staff from within the practice visited local schools to provide oral health and hygiene advice to children.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the procedures for completing accurate, complete and detailed records. This should include a date of implementation and review on policies, contact details of the local authority responsible for safeguarding investigations on the adult and child safeguarding policies, dates of staff appraisal and satisfaction surveys and methods of identifying staff that have completed tasks such as cleaning schedules. Establish an accessible system for identifying, receiving, recording, handling and responding to verbal complaints made by patients.
- 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 storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the practice's local rules ensuring that correct details are recorded.
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff which enables staff to raise issues or concerns and to receive feedback about their work at the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Systems were in place for recording and reporting significant events and accidents and staff were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There were systems in place to help ensure the safety of staff and patients. These included risk assessments, safeguarding children and adults from abuse and responding to medical emergencies. Staff had received training in safeguarding patients and knew the signs of abuse and who to report them to. There were sufficient numbers of suitably qualified staff working at the practice. Staff received training to enable them to fulfil their job role. Sufficient quantities of equipment to meet patients' needs were in use at the practice and these had been maintained as required. However fridge temperatures where medicines were stored were not monitored. The practice did not have a portable suction device in accordance with the British National Formulary and Resuscitation Council UK Guidelines.

Are services effective?

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

Staff assessed patients' needs and dental care records provided comprehensive information about their current dental needs and past treatment. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. Patients were referred to other services appropriately.

Staff had the skills, knowledge and experience to deliver effective care and treatment and received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

Consent for treatment was obtained before treatment began. Staff were knowledgeable about the principles of the Mental Capacity Act (MCA) 2005 and its relevance when attempting to obtain consent from patients who may not have capacity to provide consent.

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. We collected 31 completed Care Quality Commission patient comment cards and all recorded positive comments. Feedback from patients was that staff were professional and caring. We were told that the quality of care was good.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took those these into account in relation to the practice's opening hours and appointment systems. Patients could access treatment and urgent and emergency care when required. The practice had three ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Summary of findings

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent appointments each day.

There was a procedure in place for responding to patients' complaints The practice's complaints policy was available to patients in the waiting room. We saw that formal written complaints had been acknowledged, investigated and responded to in writing. However there was no documentary evidence to demonstrate that verbal complaints had been addressed to the satisfaction of the complainant.

Are services well-led?

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

Governance arrangements were in place and the practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning. However monitoring systems were not robust. For example the guidance issued by the Resuscitation Council regarding equipment to be used in an emergency was not being adhered to as the practice did not have access to portable suction. The temperature of the fridge used to store a medicine used in a medical emergency was not being monitored to ensure this medicine was being stored at the correct temperature. Some of the information held at the practice was not dated to show dates of implementation or review, for example satisfaction surveys, staff appraisal and some of the practice's policies.

There were arrangements in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend.

88 High Street Dental Practice

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 25 February 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was led by a CQC inspector who had access to remote advice from a specialist advisor.

We informed NHS England area team that we were inspecting the practice, however there were no immediate concerns from them.

During our inspection visit, we reviewed policy documents and staff records. We spoke with ten members of staff, including the management team and six patients. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient treatment records and patient dental health education programme.

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 incident and accident reporting systems in place. There had been no significant events or accidents at the practice within the last 12 months. Reporting forms were available for completion in the event of an accident or significant event and guidance was available detailing the steps to take when recording and reporting significant events. We discussed the reporting of injuries, diseases or dangerous occurrences (RIDDOR). There had been no incidents under RIDDOR regulations. The registered manager had a good awareness of RIDDOR and when to report under these regulations.

The registered manager confirmed that they received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. We were told that these alerts were discussed with the dentist and any that were specific to the dental practice would be discussed with all staff at a practice meeting. We were not shown any alerts and did not see evidence that they were discussed during practice meetings. There was no log of MHRA alerts and no evidence to demonstrate action taken when these alerts were received.

We discussed duty of candour with the registered manager. We were told that there was no duty of candour policy but meetings were arranged between the registered manager and complainants to discuss details of any complaints received. The registered manager confirmed that duty of candour policy would be developed. Duty of candour relates to specific requirements that providers must follow when things go wrong with care and treatment, including informing patients about the incident, providing truthful information and an apology.

Reliable safety systems and processes (including safeguarding)

We discussed safeguarding with the registered manager. We were told about one incident which had been reported to the police approximately three years ago. There had been no other safeguarding incidents that required investigation by the appropriate authorities. Training records showed that all staff had received vulnerable adults and children safeguarding training in July 2015. A policy was in place to guide staff of the action to take in relation to children and adults who may be the victim of abuse. The policy did not record external contact details for the local authority responsible for investigations. We were told that staff would contact the phone number on the 'child line' poster on display in the waiting area. The practice did not have the contact details of the local authority responsible for investigations. We were told that these contact details would be obtained and included on the safeguarding policies. The principal dentist and registered manager acted as the safeguarding leads. They acted as a point of referral should members of staff encounter a child or adult safeguarding issue. We were told that safeguarding was discussed at practice meetings. We saw minutes of meetings which demonstrated that safeguarding had been discussed and refresher training provided.

We spoke with staff about the prevention of needle stick injuries. They explained that the practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a needle protection device and for disposing of used needles into the sharps bin. There had been one needle stick injury at the practice within the last three years. We observed that this had been reported through the practice incident reporting system and managed in accordance with practice policy. We saw that sharps information was on display in the decontamination room and other locations were sharps bins were located. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps

We asked the registered manager and supervisor how they treated the use of instruments used during root canal treatment. They explained that these instruments were single use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. There was an automated external defibrillator (AED), a portable electronic device that analyses life-threatening irregularities of the heart and is

able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment with all staff receiving update training in February 2016. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. However the practice did not have access to portable suction with appropriate suction catheters and tubing. (Portable suction units are used to clear vomit or secretions from the airway in cases of medical emergency).The emergency medicines and oxygen were all in date and stored in a central location known to all staff. The expiry dates of medicines and equipment were monitored using a monthly check sheet that enabled staff to replace out of date medicines and equipment promptly.

We saw that a first aid kit was available which contained some equipment for use in treating minor injuries. However this was not being monitored to ensure equipment was within its expiry date. The supervisor had completed first aid training although this person only worked at the practice one day per week. We were told that the principal dentist had also completed this training although training records seen did not demonstrate this.

Staff recruitment

We discussed staff recruitment and looked at two staff recruitment files. Staff files that we saw contained pre-employment information such as written references, proof of identity and their curriculum vitae. Information was available regarding the staff member's professional registration and also copies of their training certificates. Robust systems were in place to ensure that appropriate pre-employment checks were undertaken for all staff prior to employment. We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

There were enough staff to support the dentist during patient treatment. We were told that the dentist worked with two dental nurses on all occasions. The practice employed a receptionist and we were told that other staff would also work on the reception as needed to ensure that the reception area was not left unstaffed at any time. The registered manager told us that they were responsible for authorising annual leave which must be booked in advance. Planned and unplanned absences were covered by members of the management team or from dental nurses from a nearby practice which was also owned by the provider.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. A health and safety policy was available and staff had signed to say that they had read and would work in accordance with the policy. The practice carried out a number of risk assessments including radiation, fire safety and health and safety.

We discussed the arrangements in place to maintain fire safety. We saw that fire safety checks were undertaken on a weekly basis as necessary. An external agency provided fire protection equipment servicing. We were told that staff had undertaken fire drills which were completed by the company who serviced and maintained the practice's fire safety equipment.

Infection control

On the day of inspection we saw that the three dental treatment rooms, waiting area, reception and toilet were clean, tidy and clutter free. Environmental cleaning of non-clinical areas was undertaken by a member of domestic staff who worked in accordance with the national colour coding scheme. Dental nurses undertook all cleaning of clinical areas and we saw that staff ticked these records to confirm this had taken place. . Patient feedback from comment cards reported that the practice was always clean and tidy

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had a robust infection control policy that was regularly reviewed; this was on display in the decontamination area, the registered manager was identified as the infection control lead. Staff had signed to say that they had read and would work in accordance with this policy. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and toilet. Hand washing protocols were also displayed appropriately in various areas of the

practice and staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. A review of practice protocols showed that HTM 01 05 (national guidance for infection prevention control in dental practices') Best Practice Requirements for infection control were being met. It was observed that audits of infection control processes carried out in 2015 and 2016 confirmed compliance with HTM 01 05 guidelines.

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

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) they described the method they used which was in line with current HTM 01 05 guidelines. Annual testing of water was undertaken by an appropriate contractor. Records seen demonstrated that there were no legionella bacteria in water samples taken at the practice.

The practice had a separate decontamination room for instrument processing. This consisted of a separate dirty and clean room with a wall hatch enabling instruments to be passed from the dirty to the clean room. Each room was organised, clean, tidy and clutter free. Dedicated hand washing facilities were available in each room. A dental nurse and trainee dental nurse demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing and an ultra-sonic cleaning bath for the initial cleaning process, following inspection with an illuminated magnifier they were placed in an autoclave (a device for sterilising dental and medical instruments). When instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the various daily and weekly checks. We were shown the records of these tests; they were always complete and up to date. The weekly protein residue test as part of the validation of the ultra-sonic cleaning bath was carried out the results of which were recorded in an appropriate log book.

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

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced in May 2015 and February 2016. Compressor vessel checks were completed in February 2016 and the practices' X-ray machines had been serviced and calibrated as specified under current national regulations. One of the X-ray machines was out of commission on the day of the inspection as a part which had broken was on order. Portable appliance testing (PAT) had been carried out in February 2016.The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a secure cabinet to prevent loss due to theft. Records were kept to demonstrate prescription pad usage.

We saw that one emergency medicine was being stored in the fridge; however staff were not carrying out fridge temperature checks to ensure that this medication was stored at the appropriate temperature. This medicine could be stored outside the fridge but would have a reduced shelf life and the expiry date would therefore need to be amended. The registered manager confirmed that fridge temperatures would be monitored on a daily basis and records kept to demonstrate this.

Radiography (X-rays)

The registered manager told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the treatment room for all staff to reference if

Are services safe?

needed. However, we saw that the details on one set of local rules required updating as the dentist acting as the radiation protection supervisor no longer worked at the practice. Documentation was not kept in a separate radiation protection file but was located amongst other documentation. We saw copies of the critical examination packs for each of the two X-ray sets along with the three yearly maintenance logs. The maintenance logs were within the current recommended interval of three years.

A copy of the most recent radiological audit was available for inspection this demonstrated that a very high percentage of radiographs were of a high standard of quality. Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. The X-rays we observed were of a high quality. We saw that signs were in place on doors conforming to legal requirements to inform patients that X-ray machines were located in the room. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with the dentist about how they carried out oral health assessments for routine care. We were told that a routine examination included an assessment of soft tissue lining the mouth, gums and any sign of mouth cancer. We looked at dental care records which demonstrated that this took place. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The practice also referred to National Institute for Health and Care Excellence guidelines to determine how frequently to recall patients and regarding removal of lower wisdom teeth.

The practice kept up to date electronic dental care records. They contained information about the patient's current dental needs and past treatment. Dental care records we saw showed that details of the condition of patient's gums using the basic periodontal examination (BPE) was recorded. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. The registered manager told us that medical history records were updated by each patient every time they attended for a routine check-up and details were entered on their dental care record. We were told that spot checks were undertaken by the registered manager to ensure that medical history records were kept up to date.

The dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. Dental care records confirmed this as well as recording details of the proposed treatment and alternative options which had been discussed with the patient. Patients were given a written treatment plan with clear estimate of costs to take away and sign before treatment commenced.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). For example, two dental nurses had visited two local nurseries and provided oral hygiene instruction and advice on healthy eating. They provided children with a dental pack that included an egg timer to demonstrate how long children should brush their teeth, toothbrushes and toothpaste. During appointments the dentist and dental nurse explained tooth brushing and interdental cleaning techniques to patients in a way they understood and dietary, smoking and alcohol advice was given to them. Dental care records seen corroborated this. Where required, toothpastes containing high fluoride were prescribed.

Staffing

The practice employed one dentist, three dental nurses (two qualified with the General Dental Council (GDC) and a trainee) a receptionist and a cleaner. The registered manager and a supervisor worked at the practice for one day per week on alternate days so that management support was provided at the practice for some days each week. We were told that telephone support was always available and the registered manager/supervisor would work at the practice on other days if required to support staff.

We discussed induction and training with the registered manager. We were told that new staff had a period of induction to familiarise themselves with the way the practice ran. The registered manager and senior dental nurse provided the induction training; records were available to demonstrate this.

The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation infection control, child protection and adult safeguarding, and other specific dental topics. Records showed professional registration with the GDC was up to date for all relevant staff. The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians.

We were told that staff appraisal took place on a six monthly basis. We also saw six monthly personal development plans which had been completed by staff. One personal development plan seen had not been dated.

Are services effective?

(for example, treatment is effective)

Neither the appraisal nor personal development forms had any comments recorded by the appraiser. All information was recorded by the appraisee prior to the appraisal meeting. There was therefore no documented feedback to staff regarding discussions held at the appraisal meeting. We were told that although systems were in place improvements were being considered to further develop the appraisal process.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example referrals were made to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. A log of referrals was kept and patients were able to have a copy of the referral letter. When the patient had received their treatment, they would be discharged back to the practice for further follow-up and monitoring. We were told that there were no patients' complaints relating to referrals to specialised services.

Consent to care and treatment

Dental care records demonstrated that individual treatment options, risks, benefits and costs were discussed with each patient and documented in a written treatment plan. We were told that patients were given time to consider their treatment and consent to treatment was always obtained. We discussed how consent would be obtained from a patient who suffered any mental impairment. We were told that if there was any doubt about the patient's ability to understand or consent to the treatment, the treatment would be postponed. Relatives and carers would be involved if appropriate to ensure that the best interests of the patient were considered as part of the process.

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. We spoke with staff and found they had a good understanding of the Mental Capacity Act 2005 (MCA) and its relevance in obtaining consent. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. We saw that a consent policy was available in the staff handbook which recorded information regarding the mental capacity act. Staff had undertaken an E-learning course regarding mental capacity.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable cabinets. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure.

Thirty one patients provided positive feedback about the practice on comment cards which were completed prior to our inspection. Patients commented that staff had a good attitude, were friendly helpful and caring. On the day of our visit we witnessed patients being treated with dignity and respect by the member of reception staff who was seen communicating with patients in a locally spoken ethnic language. We were told that staff could speak four languages other than English which were widely spoken within the local community.

The treatment room was situated off the waiting area. We saw that doors were closed at all, times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms this protected patient's privacy. We were told that patients would be able to have a confidential discussion with staff in one of the unused treatment rooms if required.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients were provided with a written treatment plan before treatment started. This included details of any costs. NHS and private costs were clearly displayed in the reception area. Dental care records we reviewed demonstrated that clinicians recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS and private treatment. NHS and private treatment costs were clearly displayed in the waiting area. The practice's website described the range of services offered to patients which included general dentistry, orthodontics and dental implants.

We discussed appointment times and scheduling of appointments. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. The practice was open on Saturday mornings which offered flexibility of appointment times to people who might have commitments during the normal working week. We were told that emergency appointment slots were left available each day for patients who were in dental pain. When these appointments were filled patients were invited to sit and wait to see the dentist.

The majority of feedback confirmed that patients were rarely kept waiting beyond their appointment time, although one comment card reported that they often had an extended wait to see the dentist.

Tackling inequity and promoting equality

The practice was located on the first, second and third floor of a converted building on a busy street, there was no car park and patients would use the nearby pay and display car park if required. There were three treatment rooms and two toilets for patients use; all on the ground floor. One of the toilets had been adapted to meet the needs of disabled patients. Entrance to the dental practice was suitable for patients with mobility difficulties or wheelchair users.

The practice recognised the needs of different groups in the planning of its services. We were told that the majority of patients registered at the practice did not have English as their first language but there had not been the need for use of a translation service in the past. The receptionist spoke four languages including Punjabi and Hindi and the dentist and dental nurses also spoke various languages. On the day of inspection we observed staff conversing with patients in a locally spoken ethnic language. We were told that the practice's computer system was able to translate any of their documentation into various languages. For example the complaints policy or practice leaflet. This would help patients have access to information in a format that they were able to understand.

Access to the service

The practice was open from 8.45am to 6pm on Monday to Friday (closed between 1pm to 2pm) and 7.30am to 1pm on Saturday. When the practice was closed patients were directed to call NHS 111. Appointments were booked by telephoning the practice or in person by attending the practice. Staff told us that patients were usually able to get an appointment within a day or two of their phone request. However emergency appointments were available on the same day that patients telephoned the practice.

A text reminder service was available for patients; this helped to reduce the number of patients who did not attend their appointment. However we were told that there was a high number of patients who did not attend their appointments on a daily basis. These appointments were usually filled by patients who attended the practice for an emergency appointment due to dental pain.

The practice displayed its opening hours on the premises, on the practice leaflet and on the practice website. Appointment times differed and information therefore required updating to record the correct details.

Concerns & complaints

The practice had received two written complaints within the last 12 months. We saw that details of these complaints along with any correspondence to and from the complainant which was kept in a complaint file. The supervisor was the complaints' lead at the practice. Staff were aware that any complaints received would be immediately forwarded to this person. We were told that patients were always offered a meeting with the registered manager and the dentist. Letters were sent to patients informing them of the outcome of any investigation. This includes those patients who had met with the registered manager and those who had declined this meeting. We were told that verbal complaints were acted upon immediately and these were not recorded in the complaint log. There was no written evidence to demonstrate the number of verbal complaints received or any action taken regarding these.

Are services responsive to people's needs?

(for example, to feedback?)

The practice's complaint policy was on display in the waiting area. This gave the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example the General Dental Council and the Parliamentary and Health Service Ombudsman). We were told that although the policy was only on display in English, this could be printed off in other languages if requested and verbal information could be given by the receptionist who was able to speak other locally spoken languages.

We were told that complaints were discussed at practice meetings as and when they were received if this was appropriate.

Are services well-led?

Our findings

Governance arrangements

The registered manager and the dentist were responsible for the day-to-day running of the practice. We saw a number of policies and procedures in place to govern the practice and we saw these covered a wide range of topics. For example, infection control and health and safety. Policies and processes were regularly review by the registered manager, however some did not have a date of implementation. Relevant policies were also available to staff in an employee handbook which all staff were given a copy. Staff were aware of where policies were held.

Governance arrangements in place also ensured risks were identified, understood and managed appropriately. For example, risk management processes regarding fire safety and infection control were in place to ensure the safety of patients and staff members. However monitoring arrangements in place were not always sufficient, for example a portable suction device with appropriate suction catheters and tubing was not available as part of the equipment to be used in an emergency situation in line with the national guidance issued by the Resuscitation Council. Fridge temperature monitoring records were not available regarding the emergency medicine that was being stored in the fridge and the local rules regarding the X-ray equipment recorded the name of a radiation protection supervisor who no longer worked at the practice.

Monitoring systems to ensure that accurate, complete and detailed records were kept were not robust. Not all policies recorded a date of implementation and satisfaction surveys and staff appraisals also did not record dates. The contact details of the local authority responsible for safeguarding investigations was not recorded on the adult and child safeguarding policies.

Leadership, openness and transparency

The culture of the practice was open and supportive. The registered manager and a supervisor worked at the practice for at least one day per week or more often if required. We were told that these management staff were always contactable by phone for help and advice. During our discussions it was evident that these staff demonstrated a firm understanding of the principles of clinical governance in dentistry.

Formal practice meetings were held on a monthly basis and clinical staff meetings on a three monthly basis. We saw that meetings discussed issues of concern, audits, complaints and training required amongst other topics of discussion.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern.

Learning and improvement

We saw evidence of systems to identify staff learning needs. For example six monthly personal development plans and appraisals. We were told that open discussions were held during appraisal meetings regarding learning needs and concerns, however documentation seen did not demonstrate this. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Training undertaken included annual updates regarding basic life support. Staff kept their own CPD logs which were reviewed as part of the appraisal process by the registered manager. This helped to ensure that staff were up to date with training and support was provided if required.

The practice had carried out clinical and non-clinical audits in areas such as infection control, X-rays, record keeping, waste and waiting times. There was evidence of repeat audits. For example infection control audits were undertaken every six months and X-ray audits were carried out in accordance with current guidelines. However not all audits were dated and information recorded in two audits was not easy to identify the results. The registered manager discussed the need for introducing a method of clarifying what the responses represented.

The practice were a member of the BDA Good Practice Scheme (a framework for continuous improvement run by the British Dental Association).

Regular staff meetings were held where learning was disseminated, for example, on safeguarding vulnerable adults and children. We saw that practice meetings took place every month and clinical staff meetings every three months. Meetings were usually minuted and available to all staff for review if required.

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

Are services well-led?

The practice had systems in place to seek and act on feedback from patients. Changes made as a result of this feedback included providing a television in the waiting room. We saw that the NHS Friends and Family Test was available for patients to complete. The friends and family test is a national programme to allow patients to provide feedback on the services provided.

The practice undertook its own patient survey. Satisfaction surveys were handed out to patients on a continuous basis and the results collated and reviewed every three months. We looked at some surveys which we were told had recently been completed. There was no date of issue or completion on the surveys seen. Satisfaction surveys that we saw recorded positive comments. There was also a suggestion box in the waiting area. The registered manager told us that the results of satisfaction surveys were discussed at practice meetings. Practice meeting minutes that we saw corroborated this.