Xeon Smiles UK Limited

Oasis Dental Care - Gloucester

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 November 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 this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Oasis dental care practice is situated in a converted domestic premises in an urban area. It has five dental chairs and specifically offers dental implants, a hygienist service and orthodontics. There are five dental consulting rooms, four on the first floor and one on the ground floor, an office, reception area and three waiting areas.

The practice had recently undergone a refurbishment inside however the outside still required attention. Since the refurbishment the practice had offered extended opening hours from 8am to 8pm allowing patients the opportunity to book an appointment at their convenience.

The premises had disabled access via the use of a ramp into the practice and facilites are accessible on the ground floor level.The practice had a car park available at the rear of the building and also on street parking near the practice.

The practice was open: Monday – Thursday 8.00am – 7.45pm, Friday 8.00am – 5.00pm and closed at weekends. Opening times and out of hours number can be found on the website and via the answer phone.

Summary of findings

The practice had four dentists and an orthodontist who were supported by five dental nurses, four dental hygienists two reception staff and a registered manager.

All fees were displayed in information leaflets for patients available in the practice and NHS fees were displayed on the practice website and in the waiting areas of the practice. There were arrangements in place to ensure patients received urgent dental assistance when the practice was closed. These arrangements are displayed in the practice and on a telephone answering service.

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. The registered manager is also one of the three trained dental nurses in the practice.

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 received feedback from three patients. In addition we spoke with four patients on the day of our inspection.

Feedback from patients was positive about the quality of care, the caring nature of all staff and the overall high quality of customer care. They commented staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided.

Our key findings were:

- We observed and were told by staff the practice ethos provided patient centred dental care in a relaxed and friendly environment.
- Leadership was provided by an empowered practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- Premises appeared well maintained inside, but the exterior required attention, and visibly clean. Good cleaning and infection control systems were in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the autoclaves and the X-ray equipment
- There were sufficient numbers of suitably qualified staff who maintained the necessary skills and competence to support the needs of patients.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Infection control procedures were mostly satisfactory but the dental nurses were not flushing the dental water lines between patients as recommended. The practice mostly followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding children and adults and living in vulnerable circumstances.
- There was a process in place for the reporting of untoward incidents that occurred in the practice.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- Dentists used Loupes – these enable the clinician to have a magnified view of the operation site thus enabling greater accuracy of treatment.
- Digital radiographs were used to help explain necessary treatment to patients while in the chair.
- The practice had a comprehensive system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required including early morning and evening appointments.
- Staff received training appropriate to their roles and were supported in their continuing professional development (CPD) by the company.
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.

Summary of findings

- Information from three completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.

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

- Review the dental nurses practice regarding the flushing of dental water lines between patients to ensure it complies with essential standards.
- Review the storage arrangements for cleaning buckets and mops which were stored in the corridor.
- Review providing the dental hygienist with the support of an appropriately trained member of the dental team at all times.

Review the system for monitoring staff training with specific reference to self-employed staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had effective arrangements in place to help ensure the safety of staff and patients. This included for essential areas such as infection control and the management of medical emergencies and dental radiography (X-rays).

We found all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying and investigating patient safety incidents.

There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

The practice carried out and reviewed risk assessments to identify and manage risks.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency. In the event of an incident or accident occurring the practice documented, investigated and learnt from it.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidenced good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs.

The practice kept detailed electronic records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. Records showed that patients were recalled in line with national guidance and screened appropriately for gum disease and oral cancer.

They monitored any changes in the patient's oral health and made referrals as appropriate to other primary and secondary care providers such as for specialist orthodontic treatment or hospital services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition. (DBOH). Comments received via the three CQC comment cards reflected that patients were very satisfied with the assessments, explanations, the quality of dentistry and outcomes they experienced.

Summary of findings

Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan and in line with General Dental Council (GDC) requirements for registrants.

Are services caring?

No action

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

We reviewed three completed CQC comments and received feedback on the day of the inspection from four patients about the care and treatment they received at the practice. The feedback was positive with patients commenting on the excellent service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency.

Patients told us the quality of care was very good. Patients commented upon the friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection and security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

No action

We found 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 how the practice was run. Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information in a language they could understand and had access to telephone interpreter services.

There was level access into the building for patients with limited mobility, or those with prams and pushchairs. There were two waiting areas and five treatment rooms with one on the ground floor enabling a wheelchair or pram to be manoeuvred. We observed the reception desk was compliant with the Equality Act 2010 and had a hearing loop; information and forms were available in large print when required. They had access to a translation service.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

No action

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

The practice assessed risks to patients and staff and carried out a programme of audits as part of a system of continuous improvement and learning. There were clearly defined leadership roles within the practice and staff told us they felt well supported and enjoyed their work.

The practice had accessible and visible leadership with structured arrangements for sharing information across the team, including holding practice based staff meetings which were documented for those staff unable to attend. Staff told us they felt well supported and could raise any concerns with the registered manager.

Summary of findings

The practice had systems in place to seek and act upon feedback from patients using the service.	

Oasis Dental Care - Gloucester

Detailed findings

Background to this inspection

This inspection took place on 7 November 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector, a second inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

We informed the NHS England local area team we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection, we spoke with the registered manager, dentists, area business manager for the group, dental nurses, reception staff and reviewed policies, procedures and other documents. We reviewed three comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place for reporting and learning from significant incidents. Accidents would be recorded in an accident / incident book. The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE).

Procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

There had been two accidents/incidents in the last 12 months both relating to sharps injuries to staff. The incident report forms had been completed in full and there was evidence shared learning followed the incidents recorded in practice meeting minutes.

We discussed with three dentists how they would manage a significant incident such as wrong tooth extraction; they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a recurrence. The practice manager knew when and how to notify CQC of incidents which cause harm. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded 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).

The practice manager told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

All the dentists we spoke with confirmed that a latex free rubber dam was used where possible when performing root canal treatments. (A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment). We discussed this with the dentists and practice staff, and were shown the relevant entry in specific dental care records and the equipment in place in the treatment rooms. The dentist described what alternative precautions were taken to protect the patient's airway during the treatment when a rubber dam was not used and showed us the risk assessment written in the dental care record.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). We saw the correct protocol had been followed for a recent sharps injury to a member of staff which ensure their health and well-being and the protection of patients.

Staff files contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The equipment included 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). Oxygen and other related items, such as manual breathing aids, were also available in line with recommended guidelines. We saw a range of medicines to manage more common medical emergencies. The emergency medicines and equipment were stored in a central location, clearly labelled and known to all staff.

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 medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

One of the emergency medicines was stored in a refrigerator. We observed the temperature of the refrigerator was monitored regularly to ensure medicines and dental care products were stored correctly and with the manufacturer's guidelines.

The practice held training sessions each year for the whole team to ensure they maintained their competence in dealing with medical emergencies.

Staff spoken with showed us documentary evidence which demonstrated regular checks were carried out to ensure the equipment and emergency medicines were in date and safe to use. Records showed most staff had completed training in emergency resuscitation and basic life support. The manager told us it was difficult to monitor all self-employed staff completed this training but would take immediate action to ensure they completed the training. Staff spoken with demonstrated they knew how to respond in the event of a medical emergency.

Staff recruitment

The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the practice policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We looked at the recruitment files for four members of staff and found that some information was not consistently recorded or available. For example, one file had no written references and two files had no photographic identification. While the practice manager eventually found most of the recruitment documents requested they were not well organised and easily available in the practice.

The practice manager told us newly employed and agency staff had been taken through an induction process to ensure they were familiarised with the way the practice operated. This was corroborated with documentary evidence which had been signed to demonstrate completion of the process. We were told all newly employed staff met with the practice manager to ensure they felt supported to carry out their role.

The practice had a system in place for monitoring staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and ongoing.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. Records showed that fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly checked.

The practice had an electrical fire alarm but we were told this was not working and the company had not planned to repair or replace it. They had therefore implemented a system of whistles, which the fire authority corroborated met the minimum requirements but was not best practice. Following the inspection visit we received information form the practice manager the company was now going to repair or replace the electrical fire alarm system.

The practice had a risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, the practice had a comprehensive file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, amalgam and latex.

Are services safe?

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

Infection control

There were mostly effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05)' and complied with the requirements of the DOH publication 'Code of Practice' July 2015. These documents and the practice policy and procedures for infection prevention and control were accessible to staff.

There was a dedicated decontamination room in the practice which was used for cleaning, sterilising and packing instruments. There was clear separation of clean and dirty areas in the treatment room and the decontamination room with signage to reinforce this. These arrangements met the HTM01- 05 essential requirements for decontamination in dental practices.

We observed the decontamination process and noted suitable containers were used to transport dirty and clean instruments between the treatment rooms and decontamination room. The practice used an ultrasonic bath for the initial cleaning process, then following inspection with an illuminated magnifier the instruments were then placed into an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, 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 the autoclaves used in the decontamination process were working effectively. We saw the completed data sheets used to record the essential daily validation checks of the ultrasonic bath and autoclaves thus ensuring safe decontamination of the dental instruments.

We observed how waste items were disposed of and stored securely until collection. The practice had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

We looked at the consultation and treatment rooms where patients were examined and treated and observed the rooms and all equipment appeared clean, uncluttered and well-lit with good ventilation.

Staff told us the importance of good hand hygiene was included in their infection control training. A hand washing poster was displayed near the sink to ensure effective decontamination. There were good supplies of protective equipment for patients and staff members. The practice used latex free disposable gloves for the protection of patients and staff.

We reviewed the last detailed legionella risk assessment report from 2014 which was carried out by an external organisation. This had rated the practice as a medium risk practice. The practice manager told us and showed documentary evidence that a further legionella risk assessment been completed in October 2016 but the practice had not yet received the report. They had appropriate processes in place to prevent legionella contamination such as flushing of dental unit water lines at the beginning and end of the day, with an appropriate disinfectant and monthly testing of the hot and cold sentinel taps in the practice as required by the HSE publication ACOP L8. However we were told they did not always flush the dental water lines between patients as recommended. The practice manager told us she would address this issue with staff immediately.

These processes ensured the risks of Legionella bacteria developing in water systems within the premises had been identified and preventive measures taken to minimise risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in all potable water and which if not controlled can put staff and patients at risk of contracting Legionnaires disease which can be fatal.) The records seen were written in pencil not pen as required by professional record keeping standards.

There was a good supply of cleaning equipment which was colour coded and stored in a cupboard however the mops

and buckets were too big and were stored in the corridor which is not good practice. We saw documentary evidence cleaning of the premises followed published National Patient Safety Association (NPSA). The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. The practice manager had a system for monitoring the immunisation status of each member of staff for the safety and protection of patients and staff.

Equipment and medicines

There were systems in place to check all equipment had been serviced. Records seen showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner.

A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use. Electrical wiring certificates were seen and up to date. Other equipment checks were regularly carried out in line with the manufacturer's recommendations.

For example, the three autoclaves had been serviced and calibrated in August 2016. The practice X-ray machines had been serviced and calibrated in 2016. The practice compressor had been inspected in 2015 in accordance with the Pressure Equipment Regulations 1999. A gas safety certificate had been issues in August 2016. All these certificates demonstrated the practice maintained their equipment appropriately.

We were shown the practice stored prescription pads in a secure cabinet to prevent inappropriate use due to theft. The practice also had a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing. We observed the practice was dispensing antibiotic and pain relief medicines to patients in a way which did not comply with the Human Medicines Act 2012.

While some records were kept of medicines entering and leaving the premises there was not a full audit trail to ensure these prescription only medicines were appropriately stored and handled in accordance with the Act. The practice manager told us they would take immediate action to address the shortfalls in the management and dispensing of these medicines. Following the site visit we received written confirmation of action taken.

We observed the practice had equipment to deal with minor first aid problems such as minor eye issues which was in date and ready for use. We were shown they also had body fluid and mercury spillage kits to use should the need arise.

Radiography (X-rays)

We were shown 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 and the necessary documentation pertaining to the maintenance of the X-ray equipment.

Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown a radiological audit for each dentist had been carried out in 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. These findings demonstrated the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. X-rays were digital and images were stored within the patient's dental care record.

We saw training records showed staff, where appropriate, had received training in core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence 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 then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained in language the patient could understand.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products.

The patient 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.

The practice kept detailed electronic records of the care given to patients. Dental care records seen demonstrated the findings of the assessment and details of the treatment carried out were recorded. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The waiting rooms and reception area at the practice contained leaflets that explained the services offered at the practice. These included information about how to carry out effective dental hygiene and how to reduce the risk of poor dental health. There was also information about making patients aware of the early detection of oral cancer. The practice also sold a wide range of dental hygiene products to maintain healthy teeth and gums. These were available in the reception area. The practice web site also provided information and advice to patients about how to maintain healthy teeth and gums.

The practice had appointed four dental hygienists to work alongside the dentists to deliver preventive dental care. 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 dietary, smoking and alcohol advice was given to them where appropriate. The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

The dentists explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. This was in line with the Department of Health guidelines about prevention of dental decay, known as 'Delivering Better Oral Health'. (Delivering Better Oral Health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England).

The practice provided health promotion information to support patients in looking after their general health using leaflets, posters and other patient information media. Patients reported they felt well informed about their dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

Are services effective?

(for example, treatment is effective)

The practice had four dentists and an orthodontist who were supported by five dental nurses, four dental hygienists two reception staff and a registered manager who is also a registered dental nurse.

The dental hygienists did not always work with chairside support. We pointed this out to the practice manager and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team' specifically standard 6.2.2 working with other members of the dental team. The practice manager told us that whenever possible chairside support was provided but currently staffing levels did not enable this.

The practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The practice manager kept some records of training completed by staff however we observed there was no comprehensive record with details of all staff training collated to enable effective monitoring, and to ensure staff maintained their skills and knowledge for the safety and well-being of patients.

Mandatory training included basic life support and infection prevention and control and all staff except two of the self-employed staff had undertaken this training. We observed the hygienists' had not completed basic life support training in the last 12 months and there were no plans for them to attend training. New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Dental nurses received day to day supervision from the dentists and support from the practice manager.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs.

Working with other services

The practice worked with other professionals where this was in the best interest of the patient. Dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Dental care records contained details of the referrals made and the outcome of the specialist advice.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and their responsibilities to ensure patients had enough information and the capacity to consent to dental treatment. Staff explained how they would consider the best interests of the patient and involve family members or other healthcare professionals responsible for their care to ensure their needs were met. Staff had undertaken specific MCA training and demonstrated a good working knowledge of its application in practice. All staff understood consent could be withdrawn by a patient at any time.

The staff we spoke with were also aware of and understood the use of the Gillick competency test in relation to young persons (under the age of 16 years). The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We reviewed dental care records to corroborate our information. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Consent to treatment was recorded. Feedback in CQC comment cards and from people spoken with during the inspection, confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We obtained the views of three patients prior to the day of our visit and four patients on the day of our visit. These showed a positive view of the service the practice 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. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

Treatment rooms were situated away from the main waiting areas and we saw that doors were always closed when patients were with dentists. All treatment room doors remained closed during consultations. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored securely.

The practice manager told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS costs was displayed in the waiting area. The practice website also gave details of the cost of treatment and entitlements under NHS regulations.

The three dentists we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

This included information recorded on the standard NHS treatment planning forms for dentistry where applicable and in private treatment plans. Patients were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected. Staff described to us how they involved patient's relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Dental care records we looked at corroborated this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet and on their website.

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

During our inspection, we looked at examples of information available to patients. We saw the practice waiting areas displayed a variety of information which included opening hours, emergency 'out of hours' contact details and how to make a complaint.

We observed the appointment diaries were not overbooked and this provided capacity each day for patients with dental pain to be seen. Feedback from patients corroborated that they were able to get an appointment within 24 hours if they had a dental emergency.

The dentist decided how long a patient's appointment needed to be and considered any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place and provided training to support staff in understanding and meeting the needs of patients.

They had completed a Disability and Discrimination Act (DDA) assessment and made adjustments, for example to accommodate patients with limited mobility. There was wheelchair access to the downstairs waiting area and to facilities on the ground floor. Information was in English but translation services could be utilised if necessary via access to a language line.

Access to the service

The practice displayed its opening hours on the website, in the waiting room and in leaflets. It is open: Monday – Thursday 8.00am – 7.45pm, Friday 8.00am – 5.00pm and closed at weekends. Opening times and the out of hour's number could be found on the website and via the answer phone.

The three CQC comment cards seen, and four people spoken with, reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the registered manager they ensured these were responded to appropriately and in a timely manner.

The practice had received six written complaints in the last 12 months, two clinical and four non clinically related complaints. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response and sought to address the concerns promptly and efficiently to effect a satisfactory outcome for the patient. The registered manager told us, and we saw this corroborated in practice meeting minutes, complaints were discussed amongst the team and any learning identified was implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks, for example infection control and substances hazardous to health. Staff we spoke with were aware of their roles and responsibilities within the practice.

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided.

We saw risk assessments and the control measures in place to manage those risks for example, use of equipment and infection control. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

There were relevant policies and procedures in place to govern activity. There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, record keeping, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service.

There were regular practice meetings to discuss practice arrangements and audit results as well as providing time for educational activity. We saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed.

Leadership, openness and transparency

We saw from minutes of staff meetings, they were at regular intervals and staff told us how much they benefited from these meetings. The practice had a statement of purpose that described their vision, values and objectives.

Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty. Staff felt confident they could raise issues or concerns at any time with the registered manager who would listen to them.

We observed and staff told us the practice was a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff felt well supported by the registered manager and principal dentist and worked as a team toward the common goal of delivering high quality care and treatment.

The service was aware of and complied with the requirements of the Duty of Candour. The registered manager encouraged a culture of openness and honesty. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

We saw there was a comprehensive system to monitor and continually improve the quality of the service; including through a programme of clinical and non-clinical audits. These included for example, audits of record keeping, radiographs and the cleanliness of the environment. Where areas for improvement had been identified in the audits, action had been taken.

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

The practice had systems in place to seek and act upon feedback from patients using the service. The practice gathered feedback from patients through the NHS Friends and Family Test (FFT), NHS Choices, compliments and complaints.

Are services well-led?

Results of the most recent Family and Friends Test (FFT) indicated patients who completed the survey were happy with the quality of care provided by the practice and patients were likely to recommend the practice to family and friends.

There were four feedback comments made on the NHS Choices website since November 2015.Two were negative, one about staff and one about the company. Two were positive about the way they had been put at ease, and how they had been treated with understanding as they were nervous patients.

The practice regularly asked for patient feedback at the end of treatment and the results seen corroborated the comments received on the CQC comment cards.