Cairn Brae Dental Practice

Tooting Bec Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Tooting Bec Dental is a dental practice located in the London Borough of Wandsworth. The premises are on the ground floor of a building in a high-street location. There are two treatment rooms, although only one is currently in use. There is also a dedicated decontamination room, X-ray room, reception with waiting area, and a patient toilet.

The practice provides private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, extractions, crowns and bridges as well as specialist services, such as dental implants and conscious sedation.

The staff structure of the practice consists of two principal dentists, an associate implantologist and two trainee dental nurses. The practice was also in the process of recruiting specialists in endodontics and orthodontics at the time of the inspection.

The practice opening hours are from 9.00am to 6.00pm Monday to Friday and from 9.00am to 5.00pm on Saturday.

One of the principal dentists was the registered manager. A registered manager is a person who is registered with the CQC 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.

Summary of findings

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

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

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances. However, although all clinical staff had had some safeguarding training, this was not always to the recommended level.
- Staff knew how to report incidents and forms were available to keep a record of any incident which could be used by the practice for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review availability of equipment for managing 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 staff training to ensure that all of the staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review its audit protocols to ensure infection control audits are undertaken at regular intervals and, where applicable, learning points are documented and shared with relevant staff.
- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review the protocols for obtaining and maintaining accurate, complete and detailed records relating to staff employed for the purpose of carrying on the regulated activities, giving due regard to current legislation and guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography.

We found the equipment used in the practice was generally well maintained and checked for effectiveness. However, some additional items were required for the medical emergencies kit.

There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were working towards meeting all of the training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

However, we noted that records for one member of staff were incomplete as their contract only allowed for them to work at the provider's other location, although they were providing some care at this practice. We also noted that staff providing conscious sedation had some additional training needs, which had not yet been met.

Are services caring?

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

The practice provided clear, written information at the practice, and on its website, which supported people to make decisions about their care and treatment. The dental care records demonstrated that they provided people with explanations about the risks and benefits of different treatments. This supported people to be involved in making their own choices and decisions about their dental care.

We received positive feedback from patients. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Summary of findings

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. The needs of people in the local area had been considered and staff spoke a range of languages. The practice was wheelchair accessible with the treatment rooms situated on the ground floor.

There was a complaints policy in place; we were told no complaints had been received in the past year. Patient feedback, through the use of an annual patient satisfaction survey and suggestions box in the waiting area, was used to improve the quality of the service provided.

Are services well-led?

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

The practice had clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. There were some areas where risk management and audit processes could be improved. This included protocols in relation to the Control of Substances Hazardous to Health 2002 (COSHH) and the carrying out of bi-annual infection control audits.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with each other. They were confident in the abilities of the principal dentists to address any issues as they arose.

Tooting Bec Dental

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 23 March 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

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

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system in place for reporting and learning from incidents. There had not been any significant events related to patients in the past year. There was a written policy which described what types of events might need to be recorded and investigated.

We discussed the investigation of incidents with one of the principal dentists. They told us that they were committed to operating in an open and transparent manner. Patients would be told if they were affected by something that went wrong; they would investigate any such incidents, offer an apology to patients, and inform them of any actions that were taken as a result. Improvements could, however, be made to ensure staff were aware of the Duty of Candour requirements. [Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was an accidents reporting book. No accidents had occurred within the past year.

Reliable safety systems and processes (including safeguarding)

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

The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns was readily available for staff.

There was evidence in the staff records that we checked which showed that staff had received training in safeguarding adults and children, though not all of the clinical staff had been trained to the recommended level. We raised this issue with the principal dentist. They sent us evidence, two days after the inspection, that this training had now been completed.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of sharps injuries. Local anaesthetic was administered using a small, computer-controlled handpiece for delivering local anaesthetic. The dentists used a new needle and tubing for each patient. After use, the dentist disposed of the equipment directly into a sharps bin. We were told that the system prevented the need for resheathing needles during the delivery of local anaesthetics and thus helped minimise the risks to staff associated with the procedure. In some circumstances, where it was not possible to use this device, the dentists used a 'safer sharps' system where a sliding, protective sheath covered the needle between use, and also during disposal of the syringe. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. There was a written protocol for staff to follow in the event that they did experience a needle stick injury.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. Rubber dam should be used when endodontic treatment is being provided. On the occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction. However, additional sizes of some equipment, such as the oropharyngeal airways, were needed, in line with the Resuscitation Council UK guidelines. The principal dentist

told us that such items would now be ordered. (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). ,

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

Staff received annual training in using the emergency equipment and basic life support techniques. However, the principal dentist who provided conscious sedation for some patients had not yet completed the higher level (intermediate life support) training as recommended in the guidance document: "Standards for Conscious Sedation in the Provision of Dental Care 2015." The principal dentist confirmed via email, two days after the inspection, that such a training course had now been booked. (Conscious sedation are techniques in which the use of a drug, or drugs, produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

Staff recruitment

The staff structure of the practice consists of two principal dentists, an associate implantologist and two trainee dental nurses. The practice was also in the process of recruiting specialists in endodontics and orthodontics at the time of the inspection.

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We checked the staff records and saw that relevant documents had been obtained, or were in the process of being obtained, prior to employment.

However, we found that the dental nurse who assisted in the carrying out of conscious sedation at the practice only had a contract in place to work at the provider's other practice location. We raised this issue with one of the principal dentists who assured us that relevant records for this member of staff would now be kept at the practice and a new contract would be drawn up to include the work carried out at the second location.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS 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).

Monitoring health & safety and responding to risks

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

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

There was an arrangement in place to direct patients to another local practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts for services in the local area were kept up to date on the provider's computer intranet system in the event that a maintenance problem occurred at the premises.

The practice had carried out a risk assessment with a view to meeting the Control of Substances Hazardous to Health 2002 (COSHH) regulations. However, a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified was incomplete and needed updating. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. One of the principal dentists was the infection control lead. There was an

Are services safe?

infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste.

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

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

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in February 2016. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned prior to inspection under a light magnification device. Items were then placed in an ultrasonic bath. Following this, the instruments were placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclave and ultrasonic bath were working effectively. These included, for example, the automatic control test, steam penetration test, ultrasonic activity ('foil') test and protein residue test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

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

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

The practice had carried out one practice-wide infection control audit in the past two years. HTM 01-05 guidance recommends that infection control audits are due every six

months. We spoke with one of the principal dentists about this issue and they commenced such an audit on the day of the inspection. This successfully identified actions which could further improve performance, such as the purchase of computer keyboard covers, and the correct labelling of sharps bins. These actions were implemented on the day of the inspection.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example portable appliance testing (PAT) for all electrical appliances had been carried out and was due again in March 2017. A Pressure Vessel Certificate for the dental compressor and autoclave had been issued in February 2016, in accordance with the Pressure Systems Safety Regulations 2000. The practices' X-ray machines had been newly installed, serviced and calibrated in December 2013.

The practice was working towards meeting the standards out in the new guidance document: "Standards for Conscious Sedation in the Provision of Dental Care 2015." The practice had carried out an audit of its conscious sedation dental care records and carried out a risk assessment in relation to the use of conscious sedation. The medicines used in intravenous conscious sedation, (e.g. Midazolam and the reversal agent Flumazenil) were stored appropriately and were in date. The batch number and expiry dates of Midazolam along with the amounts used were recorded during each episode of conscious sedation and a log book was kept. We examined the contents of a pre-prepared sedation kit containing relevant items of equipment. We found one out-of-date valve that needed replacing; this was disposed of on the day of the inspection.

The implantologist who worked at the practice had a written agreement in place. This specified the responsibilities and accountabilities of the practice and the professional visiting the practice. We noted that the terms of this agreement allowed the implantologist to bring some of their own equipment to the premises, indicating that it was their responsibility to ensure the safety of this equipment as the lead clinician.

Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set and installation log for the new equipment installed in 2013. There was also a copy of the local rules. However, we noted that the schematic produced by the RPA did not reflect the location of the Orthopantomogram (OPG) – (An OPG (or orthopantomogram) is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these.) The principal dentist called the RPA on the day of the inspection with a view to resolving this issue.

We saw evidence that staff had completed radiography and radiation protection training. Audits on X-ray quality had been undertaken within the past month.

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

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

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

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

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. One of the principal dentists told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. They were aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and dietary advice. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting area and treatment room. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. We also noted that one of the principal dentists had a special interest in smoking cessation and had completed some training with a view to delivering smoking cessation advice.

Staffing

Staff told us they received appropriate professional development and training. We checked all of the staff records and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, infection control and radiography and radiation protection training. Staff had also completed some safeguarding training, but this was not always to an appropriately high level.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they had been engaged in appraisal and supervision processes which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

Are services effective?

(for example, treatment is effective)

The practice had reviewed the staff training requirement in conscious sedation as set out in The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015. The principal dentist who delivered conscious sedation was now booked to renew their training in June 2016. The dental nurse was also currently attending a relevant training course to renew their skills.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

One of the principal dentists explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complicated extractions. The practice aimed to reduce the need for referrals by engaging new staff who could provide specialist endodontic and orthodontic treatments.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to one of the principal dentists about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

All of the staff we spoke with were aware of the Mental Capacity Act 2005. (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). The principal dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The feedback we received from patients was all positive and referred to the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and the staff told us that the doors were closed at all times when patients were having treatment.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in an electronic format. Records stored on the computer were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice displayed information on its website which gave details of the private dental charges or fees. This information was also displayed in the waiting area.

We spoke with one of the principal dentists and a trainee dental nurse on the day of our inspection. They told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the dental care records that the dentist recorded the information they had provided to patients about their treatment and the options open to them. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and guides to different types of dental treatments. The practice had a website which reinforced this information.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. There was an equality and diversity policy which staff were following.

Staff spoke four different languages, which supported some patients to access the service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired. The practice was wheelchair accessible with access to the treatment room on the ground floor and a disabled toilet.

Access to the service

The practice opening hours are from 9.00am to 6.00pm Monday to Friday and from 9.00am to 5.00pm on Saturday.

We asked one of the trainee dental nurses, who also worked as a receptionist, and one of the principal dentists about access to the service in an emergency or outside of normal opening hours. They told us that patients were directed to call a mobile number, which was clearly displayed on a noticeboard outside the practice. Messages left on the answerphone were directed to one of the principal dentists so that they could call the patient back and determine their level of need. The dentist then either arranged to see the patient, or referred them to another service, depending on the outcome of their telephone assessment.

Staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was held in a patient information leaflet given to new patients and was available, on request, from staff working on the reception desk.

We viewed a copy of the complaints policy and saw that it described how the practice handled formal and informal complaints from patients. There had not been any complaints recorded in the past year.

Patients were also invited to give feedback through a patient satisfaction survey and a suggestions box situated in the reception area. The information received demonstrated that patients were satisfied with their care.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

Records related to patient care and treatments were kept accurately and staff records were generally well maintained.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. We identified few areas such as the COSHH file and emergency equipment, where improvements were required. The principal dentist we spoke with about these issues was responsive to our feedback and confirmed that they would act to remedy these issues.

There were regular staff meetings to discuss key governance issues; 13 meetings had taken place in the past year. We reviewed minutes from meetings held in the past year and noted that topics such as staff training, infection control, record keeping, and patient feedback were discussed.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. The trainee dental nurse told us that they felt comfortable about raising concerns with the principal dentists. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. Staff told us they enjoyed their work. They received regular appraisals which commented on their own performance and elicited their goals for the future.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for conscious sedation protocols, clinical record keeping, and X-ray quality. The practice manager demonstrated how the outcome of these audits had been used to improve the quality of the service. For example, the recent (February 2016) X-ray audit had identified the need to improve the recording of the justification and authorisation in patients' dental care records. One of the principal dentists had designed a new computer template which prompted each dentist to record this information when an X-ray was taken. We observed that this template was now in use.

However, the practice had not carried out a practice-wide infection control audit within the past six months, in line with HTM-01 05 guidance. One of the principal dentists started such an audit on the day of the inspection.

The provider had a clear vision for the practice and one of the principal dentists described plans for improving the practice over the coming year. The aim was to improve the range of services offered through the engagement of dental specialists in endodontics and orthodontics.

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC). However, the majority of staff needed to complete some additional safeguarding training to ensure that they had been trained to an appropriate level. The principal dentist we spoke with sent us evidence via email after the inspection to demonstrate that this training had been completed.

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

The practice gathered feedback from patients through the use of an annual patient satisfaction survey and a suggestions box in the waiting area The majority of feedback had been positive. The practice had responded to feedback, for example, by extending their open hours on a Saturday from midday to 5.00pm.

The trainee dental nurse told us the principal dentists were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.