Cromwell Place Dental Practice

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Inspection Report

Slepe House
Cromwell Place
St Ives
Cambridgeshire
PE27 5JB
Tel:01480 462563
Website: www.cromwellplacedental.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 16 May 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

Cromwell Place Dental Practice is situated in the market town of St Ives. The service provides a range of dental services to NHS and private patients of all ages and has been under new ownership for approximately one year. The practice has its own small car park and is situated close to public car parks. The practice has four dental treatment rooms, a decontamination room, a reception area and waiting area. Three treatment rooms with an additional small waiting area are on the first floor of the property and may not be accessible to patients with limited mobility.

The practice opens weekdays from 8.45am until 5pm and provided some treatment for private patients on a Saturday according to need. Two dental partners run the practice with assistance from five associate dentists (two of whom provide only specialist services) and two dental hygienists. They are supported by a practice manager, five dental nurses (one of whom is a trainee) and two receptionist/administrators.

Summary of findings

One of the partners 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.

We received feedback from 35 patients either in person or on CQC comments cards from patients who had visited the practice in the two weeks before our inspection. The cards were all positive and commented about the caring and helpful attitude of the staff. Patients told us they were happy with the care and treatment they had received and that staff were very reassuring.

Our key findings were:

- Staff had been trained to handle emergencies. Access to appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared very clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- An accident and incident reporting system was in place, had been followed but still required strengthening so that all incidents and accidents could be reviewed and learning identified and shared.
- Patients told us they were able to get an appointment when they needed one and the staff were kind and helpful.
- Governance arrangements were in place for the smooth running of the practice although these systems were still being embedded by the team and some improvements were still needed to strengthen the audit process and monitor the completion of staff training.
- Information from 33 completed Care Quality Commission (CQC) comment cards gave us a positive picture of a friendly, caring, professional and high quality service.
- A complaints process was in place and was followed in a timely way. Patients received an apology if they had a poor experience.
- Staff felt valued and enjoyed working at the practice.

You can see full details of the regulations not being met at the end of this report.

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

- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005, Gillick competencies and the reporting of injuries diseases and dangerous occurrences regulations (RIDDOR) and ensure all staff are aware of their responsibilities.
- Review the requirements for general environmental risk assessments so that identified risks are safely managed for the safe protection of staff, patients and visitors to the practice.
- Review the practice's recruitment policy and procedures to ensure there is a clear guide on the staff who require Disclosure and Barring Service checks. Review procedures followed for maintaining accurate, complete and detailed records relating to the employment of staff.
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development and there is a system in place to monitor the completion of training.
- Review the practice's audit protocols for radiography and infection control. Check that all audits have documented learning points and the resulting improvements can be demonstrated.
- Review the options to enhance communication with patients who have hearing difficulties and consider the introduction of a hearing loop.
- Review the arrangements to monitor the ultrasonic washers to seek assurance that a robust decontamination process is completed.

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 robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). The practice had not signed up to receive emails about patient safety alerts and agreed to do this. We found that all the equipment used in the dental practice was well maintained. However, the arrangements to monitor the effectiveness of the ultrasonic washers required a review.

The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents although the process for doing this was not yet embedded. Some risk assessments such as legionella and fire had been completed although other general environmental risk assessments required development. Staff needed to familiarise themselves with the requirements for the reporting of injuries diseases and dangerous occurrences regulations (RIDDOR). 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.

Are services effective?

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

The practice provided evidence based dental care that 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. Explanations were given to patients in a way they understood. Risks, benefits, options and costs were explained. Patients were referred to other services in a timely manner and staff followed appropriate guidelines for obtaining patient consent. Some audits were taking place although further development was needed to radiography and infection control to maximise learning and improvement.

The staff received professional training and development appropriate to their roles and learning needs and an appraisal process was in place. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

Staff treated patients with dignity and respect and ensured their privacy was maintained. Patient information and data was handled confidentially. Patients told us that staff were very considerate, listened to their needs and put them at ease. Treatment was clearly explained and they were provided with treatment plans and costs. Patients were given time to consider their treatment options and felt involved in their care and treatment.

Are services responsive to people's needs?

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

Appointment times met the needs of patients and waiting times were kept to a minimum. Information about emergency treatment was made available to patients. A practice leaflet was available in reception to explain to patients about the services provided. The practice had two ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs. Patients who had difficulty

Summary of findings

understanding care and treatment options were supported, although not all staff had received Mental Capacity Act 2005 training, or training in the Gillick principles. The practice did not have a hearing loop system available for patients with hearing difficulties. A complaints policy was in place to deal with complaints in an open and transparent way and the practice apologised to patients when things went wrong.

Are services well-led?

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

The dental partners, practice manager and other staff had an open approach to their work and shared a commitment to continually improving the service they provided. Since taking on the ownership of the service, the partners had developed clinical governance and risk management structures that were still being embedded. A system for monitoring the completion of staff training required development and the audit programme and system for acting on any audit results should be reviewed. The appointment of a practice manager in recent months aimed to support the partners in establishing the governance process and leadership roles were clear. Staff told us that they felt well supported by the management team and could raise any concerns with them. All the staff we met said that they enjoyed working at the practice. Patient and staff feedback was monitored and action was taken where relevant to do so.

Cromwell Place Dental Practice

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.

This inspection took place on 16 May and was led by a CQC Inspector who was supported by a specialist advisor. Before the inspection, we asked the practice to send us some information for review which included a summary of complaints received and general practice information.

During the inspection we spoke with two dentists, two dental nurses, the practice manager and reception staff. We reviewed policies, procedures and other documents. We also obtained the views of two patients on the day of the inspection and received comment cards that we had provided for patients to complete during the two weeks leading up to the inspection.

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 manager had an awareness of RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) but was not clear on the detail of what was a reportable incident. The practice had implemented an incident reporting system for staff to follow when something went wrong. This required some improvement as there was no policy in place to help staff recognise an incident or significant event, or to support a process for investigation and learning. At the time of the inspection, one incident had been reported. This had been reviewed by one of the dental partners; the patient had received an apology. It had been raised at a practice meeting and staff had used the opportunity to improve their communication.

An accident book was also in place. A member of staff described a minor accident that had involved a visitor to the practice who received appropriate first aid. This accident had not been recorded.

The practice had not signed up to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. The dentists sought our advice on how to do this and agreed to take action.

Reliable safety systems and processes (including safeguarding)

We spoke with staff about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. The dentists and nurses used a needle protection device to recap needles safely. Staff were also able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps. There had been no needle stick injuries since the practice opened a year ago. Although staff were knowledgeable, training records did not show that all staff had received training in the safe handling of sharp instruments including the removal of matrix bands.

We asked two dentists about the instruments used during root canal treatment. They explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). We saw that rubber dam was available for use in the treatment rooms. Patients can be assured that the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

One of the dental partners acted as the safeguarding lead and had completed appropriate training for this. They acted as a point of referral should members of staff encounter a child or adult safeguarding issue. A policy was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records were unclear as there was no training log in place to demonstrate staff training that was due or that had been completed. However, some staff files indicated that staff had received some safeguarding training and staff we spoke with were knowledgeable about the process. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

The practice had provided a patient with conscious sedation for treatment on one occasion during the last year. These are techniques in which the use of a drug or drugs produce a state of depression of the central nervous system enabling treatment to be carried out. Verbal contact with the patient is maintained throughout the period of sedation. We found the treatment had been offered by staff who were appropriately skilled and completed safely. The practice did not offer the treatment at the time of our inspection and were considering the procedures they could offer in the future in line with guidance set out by the Department of Health in 2003.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had access to an automated external defibrillator (AED), which is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. This device was stored in the GP practice situated in the other

half of the building. Staff had received training in how to manage medical emergencies in November 2015. The practice was considering the purchase of their own AED in the future.

The practice had appropriate emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. These were checked each week and we found the medicines were all within the expiry dates. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. Records demonstrated that the oxygen was checked on a daily basis. All of the emergency kit was stored in a central location known to all staff. The practice team had not practiced any emergency scenarios although this was planned in the near future.

Staff recruitment

All of the dentists, dental hygienists and dental nurses, except the trainee dental nurse, had current registration with the General Dental Council, the dental professionals' regulatory body.The practice had a recruitment policy that detailed the checks required to be undertaken before a person started work.However, this did not include the dental practice's policy on requesting a Disclosure and Barring Services (DBS) check for staff in different roles. These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We reviewed five sets of recruitment records that demonstrated proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references for most staff. However, the file for a member of the administrative team did not include evidence of employment history and experience. DBS checks from previous employers had been accepted by the provider for staff appointed within the last year. This was not in line with the information required by Regulation 18, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2015. There was no risk assessment to demonstrate the reason for not completing the checks. Staff recruitment records were stored securely in a locked cabinet to protect the confidentiality of staff personal information.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies although further improvement was needed. The practice had a risk assessment policy in place but there were no general environmental risk assessments to cover issues such as trip hazards and accidental eye injuries. A fire risk assessment had been completed in March 2016, fire equipment serviced in April 2016. A fire evacuation plan and fire drill had been completed.

Staff were able to access information relating to the Control of Substances Hazardous to Health (COSHH) as an electronic file. Other assessments included radiation, water quality checks and the regular safety checks of electronic equipment. The practice had a detailed disaster plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice manager was the lead for decontamination process. An appropriate infection control policy was readily available to staff working in the practice that made reference to HTM 01-05. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. A cleaning contractor was employed to address the general cleaning of the dental practice. Cleaning logs were maintained and equipment was stored in accordance with NHS guidelines.

There were systems in place for testing and auditing the infection control procedures. However there was no analysis of the findings and no evidence this was discussed with staff.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of

Are services safe?

amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05).The practice had a dedicated decontamination room and there were clear systems in place for transferring dirty and clean instruments to and from the treatment rooms. Dental instruments were cleaned in an ultrasonic washer although staff did not monitor the temperature of it. Only heavily soiled instruments were manually cleaned before placing in the ultrasonic washer.. Instruments were then examined using an illuminated magnifying glass before being sterilized in an autoclave (a device for sterilising dental and medical instruments). At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We checked that the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were daily records to demonstrate the decontamination processes and to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

Within the treatment rooms there were dirty and clean areas, and there was a clear flow to reduce the risk of cross contamination and infection. The dental nurses followed very clear protocols for managing the treatment rooms during each session.

Records showed us that staff had received inoculations against Hepatitis B. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting this blood borne infection.

The practice had a risk assessment for the management of Legionella that had been completed in January 2015. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The risk assessment identified the practice was a low risk with regard to Legionella. The practice was flushing the dental unit water lines used in the treatment rooms. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing in the dental unit water lines. This followed the published guidance for reducing risks. Monthly water temperature checks were also recorded.

Equipment and medicines

There were systems in place to check that the equipment had been serviced regularly and in accordance with the manufacturer's instructions. Items included the autoclaves, the compressor, ultrasonic washers, firefighting equipment, and the X-ray equipment.

Emergency medicines were kept securely and no other stocks of medicines were held at the practice. Local anaesthetics were used, and these were stored securely. Prescription pads were also stored securely and one prescription was issued per surgery each day. If unused they were returned to secure storage. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records.

Radiography (X-rays)

We were shown the radiation protection file and saw that practice was in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).The file contained the name 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 critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years, the last full service had taken place in March 2016.

We saw training records that showed all staff where appropriate had received training for core radiological knowledge under IRMER 2000. We saw that radiographic audits were completed regularly although the quality of the audits could improve so that original grading and results for each practitioner could be further analysed. Dental care records included information when X-rays had been taken, how these were justified, reported on and quality assured. This showed the practice was acting in accordance with national radiological guidelines to protect both patients and staff from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists were able to describe 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 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. The dentists took time to explain and discuss any dental issues with patients including the condition of their oral health, any changes since their last appointment and any relevant treatment options.

We saw clear evidence that dental care records were 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.

Dental records included detailed oral health assessments and included the condition of the patient's gums 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 treatment needed in relation to a patient's gums. These were carried out where appropriate during a dental health assessment and appropriate referrals were made to the dental hygienists.

Health promotion & prevention

Preventative dental information was given to adults and children in order to improve their health outcomes. This included dietary smoking and alcohol advice where appropriate in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that dentists had given oral health advice to patients.

The waiting room and reception area contained leaflets that explained the services offered at the practice. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums. The practice used a computer software system that included dental health information for patients and the digital photography software had been upgraded so that clear images could be shared with the patient to explain their diagnosis and help patients reduce the risk of poor dental health. The practice also planned to implement screens in the waiting area which could also be used for dental health promotion. 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 patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate.

Patients could be referred to one of the hygienists who were employed at the practice. We spoke with one who told us they had full access to dental records when they worked under the prescription of a dentist and were able to discuss treatments and progress with them if required. They also accepted patients who referred themselves for hygiene treatment.

Staffing

The practice was led by two dental partners and employed three associate dentists, an orthodontist and a dentist providing a private hygiene service. They were supported by a team of four trained dental nurses and one trainee dental nurse. In addition there was a practice manager who was also a qualified dental nurse, two hygienists and two receptionists. Staff told us they had sufficient numbers of staff to meet patient's needs. They usually worked with one spare dental nurse to ensure appropriate cover was available. In addition the practice manager was able to support the dental nurses in the event of any unplanned staff absence.

All of the patients we asked on the day of our visit said they had confidence and trust in the dentists. This was also reflected in the Care Quality Commission comment cards and the compliment cards that were displayed in the practice. We observed a friendly atmosphere at the practice. A dentist had recently been employed there to enable the partners time for developing the service. There were also plans to recruit an additional receptionist.

We found the practice had not yet established a system to monitor staff training although there was good evidence to

Are services effective?

(for example, treatment is effective)

demonstrate that staff could access, and were supported to attend training. Training certificates demonstrated that staff had received core training such as safeguarding adults and children and responding to medical emergencies.

An induction process was in place although we did not see records that this had been completed by new staff. We spoke with one new member of staff who confirmed they had worked alongside an experienced member of staff and had been informed about practice policies such as confidentiality and fire procedures. Access to eLearning training was also being arranged for them.

An appraisal system had been introduced for staff, some had taken place and others were scheduled . Three practice meetings had taken place since February 2015 although the partners had prioritised lunch and learn sessions when they first took over the service. There were plans to establish regular staff meetings.

Working with other services

Dentists were able to 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 oral surgery or special care dentistry. This ensured that patients were seen by the right person at the right time. The practice kept a log of the referrals made so that patients could be followed up in a timely manner. Patients were offered a copy of their referral letters.

Consent to care and treatment

The practice sought valid consent from patients for all care and treatment. Staff confirmed individual treatment options, risks and benefits were discussed with each patient who then received a detailed treatment plan and an estimate of costs. Staff described the importance of ensuring that patients were given time to consider and make informed decisions about their treatment options which were then recorded in their dental records. There were very few patients with limited English language skills registered at the practice. Some dental staff spoke alternative languages however, in the event that staff were unable to communicate information to a patient, access to an interpretation service was available.

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. We spoke to two dentists who were able to demonstrate their understanding of the MCA and how this applied to patients and their capacity to consent to dental treatment. This included assessing a patient's capacity to consent and when making decisions in a patient's best interests. They were also familiar with the Gillick principles to help them judge when children and young people were able to make their own decisions about their treatment. However other dental staff had not received this training.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and computers were password protected. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards to the practice for patients to share their experience of the practice. We collected 33 completed CQC patient comment cards and obtained the views of two patients on the day of our visit. These provided a positive view of the service the practice provided from all of the patients. They commented that staff were very professional and treated them with care and respect. During the inspection we observed that practice staff were polite, welcoming and friendly. One patient told us that staff treated their child who had a disability, in a reassuring way .

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 and private treatment costs was displayed in the waiting area and similar information could be found on the practice website. The dentists we spoke with paid particular attention to patient involvement when drawing up individual care plans. Patients we spoke with confirmed this. We found 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw that the practice waiting area displayed a variety of information including the practice information leaflet. This included details and qualifications of the staff team, the services available, opening times and access to appointments. It also included a summary of the confidentiality policy, how to raise a complaint and the aims of the practice. NHS and some private treatments were available and the costs were displayed in the waiting room. We looked at examples of information available to people in the waiting room. This included health information such as diabetes and oral health, a poster informing patients that the practice had a zero tolerance to abuse policy and a display about the General Dental council's standards for good dentistry.

Staff reported (and we saw from the appointment records) the practice had a system in place to schedule enough time to assess and undertake patients' care and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Emergency appointment slots for the dentists were held each day to ensure that some urgent requests from patients could be accommodated on the same day for patients experiencing dental pain and in need of prompt attention. Patients were also invited to come and sit and wait to be seen by a dentist if these slots had already been allocated. It was the policy to see all patients who required urgent treatment within 24 hours and on the same day if possible. The dentists decided how long a patient's appointments needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

Staff told us they treated everybody equally and welcomed patients from different backgrounds and cultures or with a disability and there was a comprehensive equality, diversity and human rights policy in place. The practice made a note on patient's dental records to indicate whether a patient had particular needs, for example if they were unable to access a treatment room on the first floor and required an accessible treatment room or they were deaf and unable to access their telephone messages.

The practice had a disability policy that reflected the Equality Act (2010). There was level access to the practice through the entrance of the GP Surgery within the same building. The practice did not have a portable hearing induction loop. The Equality Act requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

The practice had a small number of patients with limited English language skills. Access to an interpreter was available although most of these patients brought an adult with them who could interpret information on their behalf.

Access to the service

The practice opened weekdays from 8.45 until 5pm. The practice only saw private patients on a Saturday by arrangement, otherwise the practice was closed at the weekends. Patients we spoke with were satisfied with access to routine and emergency appointments.

Access for urgent treatment outside of opening hours was provided by the 111 telephone number for access to the NHS emergency dental service. Private patients were provided with an emergency contact number.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. Information for patients about how to make a complaint was seen in the patient leaflet and in a separate leaflet available at the reception desk.

Patients we spoke with had not had need to raise any complaints and told us they felt comfortable raising issues with any of the staff. The practice had received two complaints within the last year, one was still being reviewed. The other had been investigated, the patient had received an apology and the learning had been shared at a practice meeting. Staff told us they responded to any patient concern by discussing it with them in an attempt to resolve the issue as soon as practically possible. Patients would receive an immediate apology when things had not gone well.

Are services well-led?

Our findings

Governance arrangements

The responsibility for governance and quality monitoring issues was shared by the dental partners. They were supported in this by the practice manager who had been appointed in the last two months. The management team was in the process of developing systems to strengthen governance processes.

There was a quality assurance policy in place which set out the governance process and procedures to help ensure that quality care was being provided. A range of policies and procedures were in use, many had been written by the dental partners who were keen to continually improve the service they had first established a year ago. Staff we spoke with were aware of the policies and how to access them. They could demonstrate knowledge of the key policies used to support their practice such as infection control and reporting safeguarding concerns. Some policies had been reviewed at staff meetings and this needed to continue so that staff were familiar with them as part of their everyday practice.

We found that some staff meetings had taken place in the last year although a regular pattern for these had not yet been established. Staff told us that issues were discussed informally at the start of each day so that ideas for improving the patient experience could be improved.

Systems were in place to ensure the safety of equipment such as X-ray machinery and fire safety equipment. Some risk assessments were in place although there were no general environmental risk assessments.

Leadership, openness and transparency

There was a clear leadership structure in place and staff understood their roles and responsibilities within the practice. Some staff had worked at the practice for a number of years and the small size of the team helped them to communicate change or improvements very easily. The dental partners had led some staff meetings although these needed to be established on a more regular basis. Other lunch and learn sessions had taken place so that team knowledge and skills were given priority.

The partners had a clear vision for the development of the service and had several plans for extending the facilities and treatments offered to patients.

All staff knew how to raise any issues or concerns and were confident that action would be taken by the management team without fear of discrimination. They told us they had an open culture and they prioritised the delivery of high quality care.

It was apparent through our discussions with the staff that the patient was at the heart of the practice. We found staff to be hard working, caring and committed to the work they did.

Learning and improvement

It was clear that training and development was a key priority to the partners. Both partners were completing dental training courses to enhance their skills and expertise: this was in restorative dentistry and sedation. Staff had access to, and were supported to receive core training such as safeguarding, infection control and medical emergencies. In addition two dental nurses had received training on dental implants to support the dentist who had introduced this as a new treatment at the service. We saw evidence that registered dental professionals maintained their professional development, as required through the General Dental Council (GDC), through completion of eLearning updates and attendance at dental training updates. Records demonstrated that these staff all had a valid GDC registration. The practice had an appraisal system and a plan was in place to complete these for all staff.

A process was in place to report incidents, significant events and accidents. Although this was not yet well embedded due to a limited number of reports, there was some evidence that the resulting learning had been shared with staff.

The practice had completed audits for infection control and dental X-rays although we found there were improvement that could be made to the scope of the X-ray audits to maximise the learning between the dental practitioners. We also found that good data had been collected for the infection control audits but the results had not been analysed or discussed within the team. Audits of the dental records had not taken place but there were plans to complete these in the near future.

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

Are services well-led?

The partners had gathered feedback from staff when they first took over responsibility for running the service. This had included questions to seek staff opinion about service developments and the level of job satisfaction. A repeat of the survey was planned to help measure progress and the ongoing level of staff satisfaction. Staff told us they felt included in the running of the practice, the management team listened to their opinions and respected their input at meetings.

The practice monitored the responses to the NHS Family and Friends Test on a regular basis. They received a steady rate of feedback each month. During April 2016 for example, they received 52 responses with 51 patients extremely likely or likely to recommend the service to others.

A survey of patients who attended appointments with the new dentists was in progress. The aim was to monitor the satisfaction level of patients treated by the new member of the team. This had, at the time of our visit resulted in positive feedback.

A comments box was had been placed in the waiting room. Feedback from patients had resulted in the installation of a water dispenser.