Century Dental Clinic Ltd

Century Dental Clinic

Inspection Report

Century Dental Clinic
Century House
Ravenna Road
Putney
London
SW15 6AW
Tel: 020 8788 9999
Website: http://centurydentalclinic.co.uk/

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Overall summary

We carried out an announced comprehensive inspection on 17 June 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Century Dental Clinic is located in Putney, in the London Borough of Wandsworth. The premises are purpose built located on the ground floor only. The practice consists of four treatment rooms and two separate decontamination rooms. There are also toilet facilities, a waiting room and a reception and administrative area.

The practice provides private dental services only and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns, bridges, tooth whitening, orthodontics, implants, dentures and oral hygiene.

The staff structure of the practice is comprised of a director (who is the principal dentist), five associate dentists, a self-employed dentist, three dental nurses, three dental hygienists who are self-employed, a practice manager and one receptionist.

The practice is open Monday 1pm-8pm, Tuesday 9am-6pm, Wednesday and Thursday 8.30am-5.30pm, Friday 8.30am-2.30pm and Saturday 9am-1pm.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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.

Twenty six people provided feedback about the service. Patients we spoke with, and those who completed CQC comment cards, were very 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:

- The practice had good decontamination procedures for dental equipment and thorough checks of the decontamination equipment were carried out.
- The practice routinely completed a range of risk assessments to identify health and safety risks and provided regular checks and servicing for most equipment.
- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients were very positive about their care; they felt listened to, involved in their care and found practice staff helpful and friendly.
- From reviewing comments cards and speaking to patients, all patients felt they received an excellent and efficient service.
- The practice provided a responsive service; patients were able to access emergency appointments on the day they needed them.
- The practice had a stable leadership structure and staff told us they were well supported by the management team.
- We found that the governance arrangements including management of some risks and learning and improving from incidents and accidents were not assured.

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

- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the British National Formulary, the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Ensure that all staff have access to timely mandatory training updates including basic life support.
- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.
- Seek and act on information to assist in improving the quality of the service including gathering patient feedback.

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 some systems in place to minimise the risks associated with providing dental services such as policies and procedures. The practice had a number of risk assessments in place for health and safety. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had systems in place for the management of infection control, medical emergencies and dental radiography.

However, there were some areas where the practice should make improvements. Some equipment, dental materials and refrigerator temperatures were not adequately checked. Sharps procedures in the practice were not always assured for safety.

Although the practice reported staff accidents, systems for reporting and learning from incidents were not fully in place. The practice had recruitment processes in place, however not all necessary checks were carried out and recorded.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE) and The Department of Health (DH). 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.

There were systems in place for recording written consent for treatments. The practice maintained appropriate medical records and details were updated appropriately. The practice worked well with specialist colleagues and timely referrals were made, as they were frequently in house.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

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

We received highly positive feedback from speaking to patients and through comment cards that they were treated with dignity and respect. They reported a positive and caring attitude amongst the clinical and administrative staff. We found that patient 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.

Patients had good access to appointments, including emergency appointments, which were available on the same day. Staff were able to provide a very flexible service to meet the needs of patients. Members of staff spoke different languages which supported good communication between staff and patients. The needs of people with disabilities had been considered in terms of accessing the service.

Summary of findings

There was a clear complaints procedure and we saw that the practice responded to complaints in line with the stated policy.

Are services well-led?

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

Some governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings. We found that the outcomes of risk assessments or audits had been reviewed and acted on in a timely manner. However there were some areas where the practice should make improvements. Risk assessments, incident reporting, complaints, audits, assurances of staff mandatory CPD activities and staff meetings were not always being used effectively to monitor and improve the quality of care.

Century Dental Clinic

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 17 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. This included the practice's Statement of Purpose and complaints received over the previous 12 months.

During our inspection visit, we reviewed policy documents, staff records and dental care records. We spoke with three members of staff, which included the principal dentist, lead dental nurse and practice manager. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed a dental nurse carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Twenty six people provided feedback about the service. Patients we spoke with and those who completed CQC comment cards were very 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

The practice had a system and policy in place to report and record accidents in the practice for staff, and from reviewing records we saw some incidents recorded related to staff injuries, including a needle stick injury. The staff were aware of the need to report incidents as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR) but they had never had to do so.

The incident reporting system was not fully robust. There had been no reported significant events or incidents in the last year and there was not a culture of recording and discussing significant events over time apart from accidents that occurred, related to staff. The practice had a significant incidents policy in place that was reviewed annually and we saw an incident form template, however these had not been used, and the policy was not followed. From discussions with staff and reviewing minutes of meetings, significant events and accidents were not discussed, so learning from these did not take place in order to improve the quality and safety of care.

We were told that a significant event involving a patient had occurred in the practice where a patient had become unwell prior to treatment, and although staff responded appropriately, it had not been recorded as an incident.

We were told that if incidents arose where people who use services were affected, the practice would inform them where something had gone wrong, give an apology and inform patients of any actions taken as a result. There had not been any instances where service users had been affected.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults, which had been updated yearly. This included contact details for the local authority safeguarding team. This information was easily accessible to staff.

The practice manager and the principal dentist were the safeguarding leads for the protection of vulnerable children and adults. Most staff, apart from one clinician, had completed safeguarding training for adults and children to level two. Staff were able to describe potential signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager, however they had never had to do so. We saw the whistleblowing policy for the practice.

Patient records, including x-rays were stored electronically and all notes we saw were contemporaneous and secure.

Staff described systems in place to prevent wrong site surgery by cross referencing x-ray, mouth and patient checks. During procedures such as root canal surgery and fillings, the practice routinely used rubber dams. (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.)

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. The practice had comprehensive policies and procedures for the safe handling of sharps and guidance for the management of a sharps injury; however they did not have a sharps risk assessment in place. We found that dental nurses were removing needles from syringes prior to disposal in sharps containers. We were told that needle guards were being utilised by dental nurses as a means of prevention in most situations, however not at all times. We were told that dentists were re-capping needles after use. Shortly following the inspection, the practice completed a sharps risk assessment and shared this with us. We saw that the practice planned to use disposable needles and syringes as a result of the assessment.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. Most staff had received training in emergency resuscitation and basic life support. Staff were aware of the practice protocols for responding to an emergency and we saw the medical emergencies procedure.

Are services safe?

The practice had a range of emergency equipment in accordance with guidance issued by the Resuscitation Council UK, however we noted that some items such as a self-inflating oxygen bag, masks and portable suction equipment were on order at the time of inspection. The practice stocked a range of relevant emergency medicines, although some medicines did not fully align to the recommended guidance.

Oxygen and an automated external defibrillator (AED) were available in the practice. (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 medicines and equipment were regularly checked by staff and comprehensive records of these checks were kept.

Staff recruitment

The practice staffing consisted of a principal dentist who was the director, five associate dentists, a self-employed dentist, three dental nurses, three self-employed hygienists, a practice manager and a receptionist. Staff who were not directly employed by the practice also had a range of information in their personnel files including criminal records checks, evidence of professional registration and identification.

The practice had a recruitment policy in place which had been reviewed, however this did not include all the recruitment checks that were required for new staff. The practice had recruited two new permanent part time dental nurses in 2014 and we found that they had completed identity checks and had a copy of the CV for both members of staff. However disclosure and barring service (DBS) checks had not been completed for one staff member and they had an outdated copy of a criminal records check for the other employee. Written references were not taken for either employee, as verbal recommendations had been provided. There was an induction programme for new staff and staff were provided with an employee handbook to facilitate the process.

We were told that the practice was in the process of updating DBS checks for all staff, as it was practice policy to now update them every three years. We saw evidence of this for three members of staff who had worked with the practice for some time.

Monitoring health & safety and responding to risks

The practice had a range of health and safety risk assessments and policies in place that were updated annually. Policies included a general health and safety policy, a range of infection control policies, fire safety, latex and mercury handling. A health and safety risk assessment was carried out two yearly by an external company and we saw that health and safety training had been booked for staff.

The practice reported they had recently received fire training in April 2015. The practice completed a fire risk assessment during their fire training session. We saw documents demonstrating that fire alarms, emergency lighting and fire extinguishers had been recently checked in October 2014 and additionally, records showed that the practice carried out daily visual checks of emergency exits.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. This folder was updated annually. We saw that not all COSHH products were stored securely as some cleaning products were in a cupboard that was accessible to patients.

The practice did not have a business continuity plan in place, however during the inspection they agreed that this would be implemented as a result of the inspection. We saw a risk log where a premises risk assessment had been carried out with mitigating actions in place. The practice also completed a disability assessment audit two yearly and planned actions were to install a handrail where they provided ramped access to the premises.

The practice had assessed risks to staff and we saw an annual health and safety risk assessment for cleaning staff and risk assessments for expectant mothers.

The practice were not aware of specific Medicines and Healthcare products Regulatory Agency (MHRA) alerts. If there were any medicines alerts we were told these were sent through from the medicines companies. The practice were aware of other safety alerts such as public health alerts that were disseminated by the local authority and we were shown the pandemic flu alert and action plan the practice had put in place.

Infection control

Are services safe?

There were systems in place to reduce the risk and spread of infection. There was an infection control policy with detailed infection control procedures which included the decontamination of dental instruments, hand hygiene, use of protective equipment, the segregation and disposal of clinical waste, sharps safety, dealing with spillages, and immunisation for staff. One of the dental nurses was the infection control lead. The infection control lead, we were told, had completed online infection control training, but this was not recorded. The infection control lead provided regular infection control training and updates for staff internally, however there were no records of this. We saw a detailed hand-out that had been provided to update staff as to the changes that had occurred with department of health infection control guidance.

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)'. 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 area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There were two dedicated decontamination rooms. Each decontamination room was shared by two treatment rooms and the layout meant that staff were entering into the decontamination areas from different access points. Entrance was by means of a sliding door activated by a button to press, which minimised the spread of infections. Each decontamination room had clearly marked 'dirty', 'clean', 'wash', rinse' and 'inspect' areas. One of the dental nurses demonstrated how they used the room and showed a good understanding of the correct processes.

Dental nurses wore appropriate protective equipment, such as heavy duty gloves and eye protection. All staff were manually cleaning instruments in each of the decontamination rooms. One decontamination room did allow for such cleaning to take place in it with dedicated sinks for cleaning, rinsing and hand washing. The second decontamination room did not have a hand washing sink, but one was available just inside the treatment areas, accessed via the sliding doors.

Following manual cleaning, equipment was placed in an ultrasonic bath. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were pouched and date stamped and placed in a vacuum autoclave (steriliser) after cleaning. The date stamps indicated an expiry date, identifying how long they could be stored for before the sterilisation became ineffective. We noted during the inspection that in three treatment rooms, equipment was within expiry dates but in one of the treatment rooms there was a drawer with pouched equipment that had expired in 2014 and 2015. We were told that equipment was checked monthly but checks were not logged. We alerted practice staff to this during the inspection and they reported they would remove this equipment.

The practice had a robust system of daily logs used by the dental nurses, for the checking of the ultrasonic cleaner and autoclave at the beginning and the end of the day, along with a comprehensive decontamination room checklist. There were also completed weekly and monthly logs with testing strips attached to the log books.

Clinical areas and decontamination rooms were clean and free of clutter. The practice had sealed floors and work surfaces. Cleaners gave the practice a thorough clean once weekly, however practice staff ensured the practice areas including dental chairs, work surfaces, treatment room floors and toilet facilities were cleaned on a twice daily basis. The leather seating in the waiting room was cleaned monthly. We noted that some items such as the computer equipment in one of the treatment rooms had an accumulation of dust. A cleaning schedule was in place; however this did not detail all equipment and areas that were to be cleaned. Cleaning equipment provided took into account national guidance on colour coding equipment, to prevent the risk of infection spread.

We saw adequate hand washing facilities including hand soap and paper towels by all hand washing sinks. Sufficient stocks of personal protective equipment (PPE) including gloves and eye protection were available, but at the time of inspection the practice did not have any disposable aprons. We were told these had been ordered.

There had been regular, annual infection control audits with the last one completed in January 2015, however the practice were planning on starting six monthly audits. The infection control audits seen were adequately detailed, following HTM 01-05 guidance and they had not identified

any issues. However, we noted a number of minor issues which had not been picked up through this audit. For example, one of the dental room chairs had a small tear which may have posed a risk as adequate infection prevention could not be maintained. The practice told us this chair was spare and was not used, but they agreed to remove the chair on the day of inspection.

The practice had an on-going contract with a clinical waste company. We saw a track record of waste consignment notices for the last two years. This included the collection of clinical waste including amalgam and safe disposal of sharps. We were shown a secure, locked area outside of the practice where waste, including sharps, were stored. A waste audit was carried out in September 2014. We were told that occasionally, sealed sharps containers were placed in a cupboard in the decontamination rooms before being taken to the storage area; however this was discussed with the practice and they agreed to ensure staff stored sharps containers safely. We saw that all staff including those self-employed and associate dentists had Hepatitis B immunization records in their files. All staff were required to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Practice staff showed us the methods they used to assure dental water line safety. The practice used dental chairs with a water bottle attached. They used fresh distilled water in each water bottle each day, and the practice had water distillers in the decontamination rooms, which were emptied daily. In addition, water treatment tablets were used in each dental chair bottle on a daily basis. According to the manufacturer's guidelines for the dental chairs and tablets, this eliminated the need to purge water at night. Dental water lines were flushed at the start of the day for two minutes.

The practice had also carried out annual water quality testing, the last in March 2015. Records showed that a Legionella risk assessment had been carried out by an external company in April 2015 and no issues were identified. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings.)

Equipment and medicines

We found that most of the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor and autoclaves had all been serviced. We saw the recent pressure vessel certificate dated April 2015. Portable appliance testing (PAT) was completed in March 2015 in accordance with good practice guidance. (PAT is the name of a process during which electrical appliances are routinely checked for safety.) We noted that one of the ultrasonic baths was new, however the other had last been checked in 2011 and was due a service. Not all the dental chairs had regular maintenance checks. One chair was new and we saw it had been purchased in January 2015; however the three other dental chairs were due to be serviced. The practice had booked dates for these to be completed.

The practice was well stocked with single use equipment, however there was no structured system for the re-ordering and monitoring of dental materials kept in the refrigerator. We found two out-of-date tubes of dental material, which expired in June 2014. There were no checks carried out for the monitoring of the refrigerator temperature and there was no thermometer attached.

All prescriptions were printed off the computer systems, ensuring that risks were reduced for the practice. Prescription pads were not used. Prescriptions were stored in patient electronic records and the practice also kept a file of previous prescriptions issued.

Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients. The practice used an external company for all treatments requiring sedation. This company brought all necessary equipment including equipment for monitoring patients' vital signs. Intravenous sedation was not carried out at the practice.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of x-ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in each treatment room that housed an x-ray machine. An external radiation protection advisor (RPA) gave support to the practice and the practice had two identified radiation protection supervisors (RPS). The procedures and equipment had been assessed and critical examination packs were available for two x-ray machines as well as on-going maintenance records for the other two machines.

Are services safe?

Not all the critical examination packs were available to view on the day of inspection. All clinical staff had completed radiation training and most evidence of this training was in the radiation protection file, apart from training evidence for one dental nurse. X-rays were electronic and were stored within patient records. We saw radiography audits undertaken in 2014 and 2015 with actions identified, that the local rules needed to be updated. This action had been completed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed a sample of dental care records and discussed patient care with the principal dentist. We found that the dentists regularly assessed patients' gum health, and soft tissues (including lips, tongue and palate) were regularly examined. Dentists took x-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). They also recorded the justification, grading, findings and quality assurance of images taken.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening

tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) If scores were indicative of advanced gum disease, patients were referred to specialists that worked within the practice where a full charting was carried out

The principal dentist was aware of and complied with National Institute for Health and Care Excellence (NICE) guidance in relation to deciding appropriate intervals for recalling patients and antibiotic prophylaxis.

Records showed thorough and detailed dental records, including medical histories and clear records that patients were involved in care decisions, with documented price discussions.

Health promotion & prevention

The practice promoted maintenance of good oral health. Staff told us they discussed oral health with their patients, for example, effective tooth brushing, oral hygiene, prevention of gum disease and dietary advice. Dentists identified patients' smoking status and discussed smoking cessation; the principal dentist being a certified smoking cessation practitioner. Dentists also carried out examinations to check for the early signs of oral cancer. Prescription of high fluoride toothpastes were evident in patient records and high risk patients were identified for fluoride varnish applications.

We observed that there were some health promotion materials displayed in the waiting area, particularly for dental care in children and also smoking and oral health leaflets.

Staffing

The practice benefited from employing a range of dental staff across dental specialisms in order to provide effective care for patients and a diverse skill mix. Opportunistic advice could be sought from peers where needed. The majority of staff at the practice worked part time, as they worked in other dental practices or hospitals. We were shown how the practice manager used an electronic system to ensure adequate staff were available. Due to the range of staff employed, the practice could provide comprehensive staff cover and we were told that the practice used an agency to secure dental nurses if the need arose.

Staff told us they received appropriate professional development and training from the practice and were given time to attend courses. We reviewed some staff files and saw evidence of training certificates. The training covered some of the mandatory requirements for registration issued by the General Dental Council (GDC). The practice ensured they had up to date details of registration with the GDC for all dental staff. The practice however, did not have full assurances that all dental staff working at the practice had undertaken all appropriate mandatory training as part of their CPD.

Working with other services

Most referrals to other services were in house, to other specialist colleagues that worked within the practice such as the orthodontist, prosthodontists and hygienists. A few referrals were made to secondary care for complex cases.

All written protocols were issued by printing off referrals from the computer system and sending these on immediately. Referrals to both internal and external professionals were detailed. Patients were given a copy of the referral letter and it was visible in the patient record.

Consent to care and treatment

The practice ensured signed, valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with

Are services effective?

(for example, treatment is effective)

each patient. Notes of these discussions were recorded in the clinical records and signed price estimates were also evident. Further detailed written consent was also obtained for complex dental procedures.

We saw evidence that dental staff had an understanding of the requirements of the Mental Capacity Act 2005 (MCA). Staff could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. A number of staff had completed MCA training in April 2015. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

From reviewing CQC comments cards, we noted that 100% of feedback was positive about the practice. Patients felt that the service was exceptionally good, patient friendly, highly professional and caring. The patients we spoke with all commented positively on their experience at the practice and felt it was a very efficient service. Parents were pleased with the level of care their children received.

Patients who reported some anxiety about visiting the dentist commented that the dental staff were good about providing them with reassurance. Staff told us how their electronic record system could bring up alerts if patients were anxious, so staff could support patients appropriately. Staff always called patients following complex dental work in order to reduce any anxieties and to ensure patients were recovering after their procedures.

We observed that clinical and administrative staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointment and when speaking to patients on the telephone. The practice provided patients with refreshments in the waiting area.

Patients indicated they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. All patient records were stored electronically and only accessed via staff. We saw details of the confidentiality policy in the reception area for patients and staff to see. Patients we spoke to had no concerns about confidentiality.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the dental fees for the range of procedures that the practice offered. CQC comments cards and patients we spoke with indicated that patients felt involved in their care and were always given adequate information about their treatment and fees.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. We saw that records contained consent forms and additionally a signed price estimate. There was a range of information leaflets in the waiting area which described the different types of dental treatments available and the practice website also detailed these treatments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. We found that the service was very flexible and was able to adapt to needs of the patients due to the pool of staff available. Staff readily assisted on days they did not normally work so that patient needs could be met. Staff told us they had enough time to treat patients and that patients could always book to see the dentist of their choice.

The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled to receive treatment. We saw during the inspection how the practice fitted in a child requiring a routine dental appointment at the same time as the parent, at short notice.

Staff told us that as well as lengthy discussions with patients about treatment options, the team often provided further telephone calls to patients if additional information was required. Oral care products were available to purchase in the waiting area.

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. Staff spoke different languages, however the practice did not currently utilise a telephone translation service.

The practice had updated policies in place for equal opportunities and equality and diversity. A patient provided an example where staff had acted equitably to accommodate a person with a disability.

The electronic patient record alerted staff if a patient was a wheelchair user. The practice provided ramped access through a side door for wheelchair users. All treatment rooms were wheelchair accessible and dental treatment chairs were seen to be adjustable to provide easy access for patients. Dental equipment could be adjusted if patients were unable to leave a wheelchair. The practice provided a toilet with wheelchair access and an emergency alarm.

A disability assessment audit was carried out every two years by an external contractor to monitor access to the service. The practice planned to install a hearing loop, braille signs and a handrail outside next to the ramped access.

Access to the service

The practice was open Monday 1pm-8pm, Tuesday 9am-6pm, Wednesday and Thursday 8.30am-5.30pm, Friday 8.30am-2.30pm and Saturday 9am-1pm. The practice displayed its opening hours on their premises and on the practice website. Patients were also given a practice information leaflet which included the practice contact details and opening hours.

Online appointments could be booked via the practice website. Patients told us they were given text message reminders for their appointments and the practice also used email and phone calls to communicate with patients.

We asked the practice manager and other staff about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access out of hours emergency treatment. Patients called the practice manager out of hours, who recorded patient details on an emergency log form. The practice manager then directed the patient to speak to a dental nurse or dentist for clinical advice. Staff felt this system worked well.

The practice kept two emergency appointment slots per day, however where needed they would always see patients requiring urgent treatment and had the flexibility to call upon other dental associates. All patients we spoke to and all CQC comments cards were positive about their experience of getting an appointment, including emergency appointments.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. The practice had a dedicated complaints folder in the reception area which explained the process thoroughly for patients. The practice had a comments box and also a message facility via the practice website. The practice reported that no issues of concern had been raised via these methods.

There was a complaints policy in place. We reviewed complaints over the last 12 months and the practice had

Are services responsive to people's needs?

(for example, to feedback?)

received one complaint in the past year. We saw detailed letters form the patient, acknowledgement from the practice and an appropriate response from the practice after investigating the complaint.

The complaints procedure stated that the practice were to create an action plan, log and to share complaints at practice meetings, but this was not being followed. Therefore there was limited evidence to suggest that the practice had shared any wider learning points from complaints or concerns, which could lead to improvements in their practice.

Are services well-led?

Our findings

Governance arrangements

The practice had a management structure in place. There was a lead clinician and principal dentist who was the director in terms of clinical governance, however day to day management of the practice was led by the practice manger with assistance from the lead dental nurse. The lead nurse had a responsibility for updating policies, procedures and undertaking audits and risk assessments.

There were relevant policies and procedures, including a range of health and safety polices. These were all frequently reviewed and updated annually by the lead dental nurse. Staff were aware of these policies and procedures and they were easily accessible to all staff in the reception area. We noted that the practice policies and procedures however, were not always followed; for example, sharps procedures, the significant incident policy and the complaints policy.

Governance and monitoring of equipment and procedures was managed suitably though improvements were needed. For example, we found that the practice were not adequately monitoring and stock checking pouched sterile equipment, dental materials in the refrigerator and refrigerator temperatures. Most servicing of practice equipment had been undertaken, but one of the practice dental chairs and ultrasonic baths had not been checked for some time. We also found some x-ray machine assessments and servicing records were not available.

The practice had completed a range of risk assessments in relation health and safety, control of substances hazardous to health (COSHH) and legionella. The practice also identified risk through scheduled audits including infection control and radiography. We noted that the practice had a list of actions identified from some of the risk assessment and audits and some of these had been implemented. The practice were not routinely utilising safety information to monitor risks through the use of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and we also found that the although the practice had a range of risk assessments, they did not have a business continuity plan in place to identify business risks and mitigating actions.

The practice did not have an effective system for recording and learning from incidents and reviewing accidents to identify themes. During the inspection we noted that staff accidents had been recorded in relation to needle stick injuries. There had not been investigation into these and future action points in order to learn from and prevent further occurrences. The practice had not completed a sharps risk assessment at the time of inspection to identify whether current sharps management was adequate, although this was carried out shortly afterwards.

Staff were being supported to meet their continuing professional development (CPD) standards set by the General Dental Council, although staff records did not provide full assurances that dental staff had carried out mandatory CPD and other mandatory training in order to perform competently in their role. Records, including those related to patient care and treatment, as well as staff employment, were kept accurately. However, recruitment checks were not fully robust to include Disclosure and Barring Service (DBS) checks and copies of identification for new staff.

Leadership, openness and transparency

Staff described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with either the principal dentist or the practice manager. Staff told us they enjoyed their work and were well supported by the management team.

Staff knew who to report to depending on the issue raised, for example, the lead dental nurse was also the infection control lead and the practice manager organised staffing and was the lead for complaints. Where boundaries between the leadership roles were blurred, this worked to the practice's favour as it allowed maintenance of adequate practice management during times of leave and continued clear lines of reporting for staff.

The practice manager outlined the practice's ethos for providing good care for patients. They shared with us their Statement of Purpose and a business plan that was being updated with the principal dentist.

The practice engaged with staff on a monthly basis through regular staff meetings and we saw minutes of these. The agenda included staffing cover and training requirements. From minutes we saw, complaints and incidents were not widely shared with staff. The practice used a weekly email sent to all practice staff to communicate updates, including those in relation to training and staff rotas.

Are services well-led?

Management lead through learning and improvement

We were told that clinical staff were up to date with their continuing professional development (CPD). All staff were supported to pursue development opportunities. We saw some 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). We also noted that the practice supported non-clinical staff to attend basic dental courses in order to gain context about the environment in which they worked. The practice did not currently engage staff in an appraisal process, however we were told that staff did have opportunistic discussions with either the practice manager or principal dentist, however these had never been recorded.

Appropriate audits were carried out, but we found that these were not always being used as effective tools for supporting continuous improvement. For example, the infection control audits had not identified minor issues noted by the inspection team during our site visit. The radiography audits were thorough and demonstrated a robust quality assurance process for X-rays.

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

The practice had tried to gather feedback from patients previously, but the response rate was poor. The practice did have a suggestions box in the waiting area for patients to complete, and an online comments form via the practice website.

Staff feedback was gained where the need arose as staff were happy to raise concerns opportunistically or during meetings.