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The Oaks Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 November 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.

Background

The Oaks Dental Surgery is located in the London Borough of Bromley. The premises are situated on the ground floor of a converted residential building. There are four treatment rooms, a dedicated decontamination room, a reception room, a waiting room, an administrative office, and a patient toilet.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, and oral hygiene.

The staff structure of the practice comprises of a principal dentist (who is also the owner), three associate dentists, three hygienists, eight dental nurses, and two receptionists. Some of the dental nurses also worked on reception and one provided administrative support for the principal dentist.

The practice opening hours are on Monday from 8.45am to 7.00pm, Tuesday from 8.45am to 5.00pm, Wednesday, Thursday, and Friday from 8.00am to 7.00pm, and Saturday from 9.00am to 12.00pm (for private patients only).

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor. A trainee CQC inspector also attended the inspection.

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

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Most equipment, such as the air compressor and autoclave (steriliser), had been checked for effectiveness and had been regularly serviced; although we noted that some records for other equipment, including one of the ultrasonic baths and the fire extinguishers were not up to date.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- There were governance arrangements, including the use of regular audits, to monitor performance, but these were not always used effectively to drive improvement in the quality and safety of the services.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review the practice's audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Review staff awareness of, and training in relation to, Gillick competency to ensure all staff are aware of their responsibilities as it relates to their role.
- Review staff training to ensure that all of the staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review the practice's current Legionella risk assessment arrangements giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

There were some areas where improvements could be made to safety systems. For example, a risk assessment for Legionella needed to be carried out and acted on. Staff understood their responsibilities in relation to safeguarding, but had not received any formal training at the time of the inspection. Risks to patients having treatment could be further minimised through consistent use of current, national guidelines by all clinicians, for example, in relation to the use of rubber dam for root canal treatment.

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). The practice monitored patients' oral health and gave appropriate health promotion advice. The practice worked well with other providers and followed patients up to ensure that they received treatment in good time. However, improvements could be made to the recording of information in the dental care records. Staff also needed some additional training in relation to their understanding of Gillick competency.

Clinical staff worked towards meeting professional standards and completing continuing professional development (CPD) standards set by the General Dental Council (GDC). Staff told us they were well-supported by the principal dentist through informal supervision and had recently been engaged in a formal, appraisal process.

Are services caring?

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

We received positive feedback from patients through comment cards, speaking with patients, and by checking the results of the practice's own patient satisfaction survey. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. Patients were invited to provide feedback via a satisfaction survey. The needs of people with disabilities had been considered and there was wheelchair access to the waiting area and three of the treatment rooms on the ground floor. The dentists described effective strategies for supporting patients with some hearing or visual impairments.

Summary of findings

There was a complaints policy in place and we saw that complaints received in the past year had been acted on in line with this policy. Relevant investigations had been carried out and the outcomes of these were recorded. The practice disseminated the outcomes of these investigations by holding discussions with individual members of staff with a view to preventing a recurrence of any problems.

Are services well-led?

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

The practice had clinical governance and risk-management structures in place. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose. However, improvements could be made to strengthen the governance structures and protocols. For example, although a system of audits and patient feedback was used to monitor performance, the outcomes of audits were not effectively disseminated among staff to drive improvement. Opportunities could be improved for staff to share learning around governance issues through the use of regular staff meetings.

The Oaks Dental Surgery

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 26 November 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

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

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. Only one accident had happened in the past year and it had been suitably recorded. There was a practice policy for staff to follow for the reporting of incidents or accidents. Staff told us they understood the process for incident or accident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). None of the accidents recorded had required notification under the RIDDOR guidance.

The practice had a 'Duty of Candour' policy in place. We noted that this policy stated that patients would be told when they were affected by something that went wrong and they would be offered an apology.

Reliable safety systems and processes (including safeguarding)

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice followed a written protocol and risk assessment to minimise needle stick injuries, whereby needles were not resheathed by hand following administration of a local anaesthetic to a patient, which was in line with current guidelines. It was the dentist's responsibility to handle the syringes. Staff demonstrated a clear understanding of the protocol with respect to handling sharps and for what to do in the event of a needle stick injury.

We checked whether the practice followed national guidelines on patient safety. For example, we checked how the practice treated the use of instruments which were used during root canal treatment. A rubber dam is recommended for use in root canal treatment in line with the guidance supplied by the British Endodontic Society. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.] The use of rubber dam was inconsistent across the practice. Some dentists routinely used the rubber dam. However, other dentists told us that they only rarely used rubber dam. The principal dentist told us that a rubber dam was used in some, but not in all root canal treatments. It was not clear what the rationale was for not using rubber dam. They subsequently confirmed that all dentists would now consistently use rubber dam.

The practice had a well-designed safeguarding policy which referred to national guidance and included local authority telephone numbers for escalating concerns that might need to be investigated. This information was held in a policy file located in the administrative office, but was not displayed elsewhere in the practice for quick reference.

Staff were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia. However, we checked six staff files and found that only the dental nurses had been trained in safeguarding children to an appropriate level (Level 2). The dentists and reception staff had not received any formal training in safeguarding children. None of the staff had undergone training in protecting vulnerable adults. We discussed this with the principal dentist and administrative staff. They sent us an email the following day confirming that they had contacted their local authority safeguarding board in order to book staff on to the correct training courses as soon as possible. They sent us documents two days after the inspection demonstrating that staff had completed online training in safeguarding children to the correct level.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The practice held emergency medicines in line with guidance issued by the British National Formulary (BNF) for dealing with common medical emergencies in a dental practice. However, we noted that although adrenaline was present in the emergency medicines kit, it was not at the dose recommended by the BNF. The practice subsequently confirmed that they had ordered the correct dose.

Are services safe?

The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment. The head dental nurse told us that the equipment was checked weekly for effectiveness, although there was no written record of this. The expiry date for medicines was monitored using a record indicating dates for renewal.

Staff recruitment

The staff structure of the practice comprises of a principal dentist, three associate dentists, three hygienists, eight dental nurses, and two receptionists.

There was a recruitment policy in place. The majority of the practice staff had been employed for a number of years. There was only one member of staff recruited in the past five years. They had commenced work in 2015.

We checked six staff files, including the file for the staff member who had recently joined the practice. This showed that pre-employment checks of staff had been carried out in line with the relevant regulations. This included proof of identity, a review of employment history, evidence of relevant qualifications, and a check of registration with the General Dental Council (where required). Clinical staff were asked to provide information about their immune status in relation to Hepatitis B. However, we found that copies of references for new staff were not routinely kept. We raised this with the principal dentist and one of the dental nurses, who also acted as an administrator. They told us that a verbal reference had been obtained for the new member of staff, although a record of this had not been kept.

The principal dentist told us that it was their policy to carry out a Disclosure and Barring Service (DBS) check for all staff members prior to employment and periodically thereafter. Information about the outcome of the DBS check was held in each staff member's file. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place.

There were 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 associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. The COSHH file was updated regularly and a systematic annual review was carried out to check that all relevant substances had been identified and assessed.

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

There was a business continuity plan in place. There was an arrangement in place to use another practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts in the local area were displayed in the staff room for prompt access in the event that a maintenance problem occurred at the premises.

The practice had been assessed for risk of fire and there were procedures in place, which staff were aware of, for what to do in the event of a fire. However, the fire extinguishers had not been checked within the past year. The practice arranged for an external company to service the extinguishers immediately after the inspection.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The head dental nurse was the infection control lead. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff told us that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. The sent us documentary evidence in relation to this two days after the inspection.

Are services safe?

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

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. They ensured that the working surfaces, dental unit and dental chair were cleaned down. This included the flushing of the dental water lines. Environmental cleaning was carried out in accordance with the national colour coding scheme.

We checked, along with the dental staff, the contents of the drawers in the treatment room. There were appropriate supplies of personal protective equipment, such as gloves and aprons, available for staff and patient use. Instruments were generally pouched, but others had been stored unlidded in an open tray in a drawer within the treatment zone. We discussed this with the principal dentist who assured us that these items would now be pouched or otherwise covered.

Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and towels in the treatment room, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

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

Items were cleaned in one of two ultrasonic baths. Some items were also manually cleaned, although we observed that items were not cleaned below the water, in line with HTM01-05 guidance. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. After sterilisation, instruments were placed in a clean, lidded box, transferred to a treatment room, and pouched. This was a protocol developed following a risk assessment due to lack of available space in the decontamination room. A date stamp was used to indicate when the sterilisation became ineffective. The autoclave and ultrasonic baths were checked daily for performance. For example, the autoclave was checked in terms of temperature and pressure.

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

The practice had carried out practice-wide infection control audits every six months, with the last audit having been completed in October 2015. However, the practice could not show what actions had been taken in response to the outcomes of these audits. For example, the most recent audit had identified some issues with handwashing sinks. This had not been discussed with practice staff, or otherwise considered, and there were no clear actions taken as a result.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). One of the dental nurses described the method they used which was in line with current HTM 01-05 guidelines. However, a Legionella risk assessment had not been carried out by an appropriately-trained person. There was no schematic of the water system. Monthly and six-monthly checks of the hot and cold water temperatures had not been carried out. There was a Legionella policy, which had not been followed, that stated these assessments would be carried out. We did find that an annual test for Legionella in the hot water had been carried out, with the most recent taking place in August 2015.

Equipment and medicines

We found that the majority of equipment used at the practice had been regularly serviced and well maintained. For example, we saw documents showing that the air

Are services safe?

compressor and X-ray equipment had been inspected and serviced. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in November 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

However, one of the ultrasonic baths had not been serviced within the past year. We discussed this with the head dental nurse on the day of the inspection. They agreed that a service for the ultrasonic cleaner would be booked and that the other ultrasonic bath would be the only one in use until the service had been completed.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

Single-use items were clearly identified and disposed of appropriately. We noted one exception, in relation to the use of use of steel burrs. The practice employed a robust sterilisation processes in between treatment sessions. We noted that this adequately addressed infection control issues. However, these burrs were designed for single use and there was an increased risk of the product becoming rusty or blunt if re-used after sterilisation .The principal dentist told us they would now use these items on only one occasion prior to disposal.

Radiography (X-rays)

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three-yearly maintenance logs and a copy of the local rules. We also saw evidence that staff had completed radiation training, although we noted that one of the associate dentists needed to renew their training as the last course attended was over five years ago (June 2010).

A copy of the most recent radiological audit was available for inspection. This noted that the outcome of the audit had been discussed with the relevant dentist on an individual basis. We also checked the dental care records to confirm the findings. The audits and records showed that dental X-rays were justified, reported on and quality assured, although there was some variability in the quality of the recording of this information in the dental care records that we checked. Overall we found that X-rays were taken in line with the Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The staff working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The principal dentist and associate dentists told us they were aware of current National Institute for Health and Care Excellence (NICE) guidelines regarding assessing patient's risks and needs in relation to antibiotic prescribing and wisdom teeth extraction.

We discussed the process of carrying out a patient assessment with the principal dentist and two of the associate dentists. They told us the assessment began with a verbal update of each patient's medical history. Each patient was also asked to complete a written update of their medical history on a yearly basis. The dentists then carried out an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

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

We were shown a sample of dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded, though could be improved regarding some relevant details. For example, the principal dentist told us that the condition of the gums and soft tissues lining the mouth was assessed using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out where appropriate during a dental health assessment. However, the dental care records did not always show that this had been done.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentists were aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, alcohol use and weight management. The dentists were aware of, and were following, the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. The dentists also carried out examinations to check for the early signs of oral cancer.

There were two hygienists working at the practice. Where required, the dentists referred patients to a hygienist to further address oral hygiene concerns.

We observed that there were some health promotion materials displayed in the waiting area; including information aimed at engaging children in good dental hygiene practices. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. The principal dentist told us that they had, together with one of the dental nurses, visited local schools to talk to children about diet and good oral hygiene.

Staffing

Staff told us they received appropriate professional development and training. We checked six staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, infection controls and X-ray training. However, not all of the dental nurses and dentists had attended relevant safeguarding training.

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

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

Are services effective?

(for example, treatment is effective)

they were supportive of staff who wanted to attend additional training. They were aware that some of the dental nurses wanted to complete further, specialist X-ray training in the coming year, and supported these plans.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals were made to other dental specialists when required.

The principal dentist and practice manager explained how they worked with other services. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the dentists referred patients to other providers for specialist oral surgery. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. A copy of the referral letter was always available to the patient, if they wanted this for their records.

The practice kept a log of the referrals that had been made and kept track of when patients had been booked for treatment. They encouraged patients to call the practice if they experienced any delay with their referral so that the practice could contact the other provider for an update. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care.

Consent to care and treatment

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

Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments. However, we also found that verbal consent was not consistently recorded in the dental care records and there was not always a full record of the options discussed in the dental care records.

Staff were aware of the Mental Capacity Act 2005. They could 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. 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. However, staff were not aware of the Gillick competency and the requirement possibly to treat young people below the age of 16 years, without parental permission, following an assessment of their capacity to provide informed consent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from twelve patients. They described a positive view of the service. The practice had also collected feedback through the NHS 'Friends and Family Test', and used their own patient survey throughout 2015. The results of the survey indicated a high level of satisfaction with care.

During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. There was a good awareness of the need to support anxious patients. The principal dentist and reception staff described strategies for supporting patients, including minimising waiting times, and the use of a local cognitive behavioural therapy (CBT) team for psychological support in reducing dental-associated anxiety.

Staff were aware of the importance of protecting patients' privacy and dignity. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format and stored in locked cupboards behind the reception desk. Computers were password protected and regularly backed up to secure storage; screens at the reception desk were placed in a manner which ensured patients' confidential information could not be viewed.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the private dental charges and fees. The practice provided care on the NHS only for patients who were exempt from paying fees. This information was also displayed in the waiting area. There were a range of information leaflets in the waiting area which described the different types of dental treatments available.

We spoke with the principal dentist, two of the associate dentists and two of the dental nurses, on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies.

The patient feedback we received via comments cards, and through speaking to patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation 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. The feedback we received via comments cards, speaking with patients, and from the practice's satisfaction survey indicated that patients felt they had enough time with clinicians and were not rushed.

During our inspection we looked at examples of information available to people. We saw that the patient information leaflet displayed in the reception area contained a variety of information including opening hours, emergency 'out of hours' contact details and reference to practice policies, for example, in relation to confidentiality. The practice had a website which reinforced this information.

Tackling inequity and promoting equality

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

The principal dentist told us the service provision was predominantly to an English-speaking population. However, some patients had attended with their own translators, and they could offer to arrange for translation services, if necessary. They were also able to provide large print, written information for people who were hard of hearing or visually impaired. The dentists cited examples of when they had deployed the use of these strategies to promote patient understanding and ensure that they were able to obtain informed consent prior to treatment.

The practice was wheelchair accessible with a portable ramp used to access the reception area and level access to three of the treatment rooms. However, there was no access to a disabled toilet. The practice had not carried out a formal Disability Discrimination Act Audit to systematically identify any further reasonable adjustments which could be made to the practice to promote access for those with limited mobility.

Access to the service

The practice opening hours were on Monday from 8.45am to 7.00pm, Tuesday from 8.45am to 5.00pm, Wednesday, Thursday, and Friday from 8.00am to 7.00pm, and Saturday from 9.00am to 12.00pm (for private patients only).

Reception staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could generally get an appointment when they needed one.

The practice manager told us that the dentists always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case. The appointment schedules showed that patients were given adequate time slots for appointments of varying complexity of treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. There had been two complaints recorded in the past year. These complaints had been responded to in line with the practice policy. A record was kept of what had occurred and actions taken at the time to address the problem. Patients had received a written or verbal response following the investigation of any complaint. We noted some examples where the records showed that an apology had been offered.

We asked one of the dental nurses, who also acted as an administrator, how staff were informed about the outcomes of complaints with a view to sharing learning points and preventing a recurrence. They told us the complaints were discussed on a one-to-one basis with individual members of staff, but were not also reviewed at staff meetings.

Information about how to make a complaint was contained in the patient information leaflet displayed in the reception area.

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Our findings

Governance arrangements

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

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. However, there was one area where this process had not been used to develop an appropriate risk-reduction strategy. For example, the practice had not carried out a full Legionella risk assessment which included a survey or schematic of the water systems and instructions for carrying out checks of the water temperatures at monthly and six-monthly intervals.

We also noted that the practice had not fully recognised the risks and its responsibilities in terms of ensuring staff had received appropriate safeguarding training, although they responded quickly to feedback in this area.

The principal dentist told us that if any governance issues arose then these were dealt with by speaking with individual members of staff. We saw staff meeting minutes which showed that the nursing staff also convened their own staff meetings, as did the administrative staff, intermittently, depending on their own requirements. Governance issues concerning for example, infection control or employment status, were discussed at these meetings. However, there were no formal practice-wide staff meetings.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. We found the principal dentist provided effective clinical leadership to the whole dental team. They were supported by a head nurse, and a dental nurse who also worked as an administrator. They took the lead in key areas such as infection control and clinical audit.

Staff told us they enjoyed their work and were supported by the principal dentist. They had recently received an appraisal which commented on their own performance and described their goals for the future.

Learning and improvement

The principal dentist had a clear vision for the practice which included plans for improving the premises and equipment. For example, there were plans to refurbish three out of the four treatment rooms over the coming year, and longer term plans to upgrade the computer systems.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

The practice had a rolling programme of clinical audit and risk assessments in place. There were audits for infection control, X-ray quality, dental care records and referrals. We found one example in relation to the audit of dental care records, where the process of repeating the audit had led to an improvement in recording feedback given to each dentist individually. We found that other audits, such as those relating to infection control and referrals, had not been reviewed by the principal dentist, or other lead staff, in order to identify actions that would improve the quality of the service.

Our check of the dental care records found that some further improvements could be made in the recording of discussions and assessments in line with the guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.

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

The practice gathered feedback from patients through the use of a suggestions box in the waiting area, patient satisfaction survey and through the 'Friends and Family Test'. The majority of feedback was positive about the quality of care received. However, there was some feedback about the quality of the communications between the practice and patients which could be used to drive improvements. We discussed this with the administrator who told us they were aware of these issues, but there were

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no formal systems for responding to issues raised in the feedback. They noted that ad hoc discussions with individual staff members were held whenever negative feedback was received.

Staff told us that the principal dentist was open to feedback regarding the quality of the care. The appraisal system also provided appropriate system for staff to give their feedback.