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The Dental Implant Clinic

Inspection Report

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Date of inspection visit: 16 January 2017
Date of publication: 17/02/2017

Overall summary

We carried out an announced comprehensive inspection on 16 January 2017 to ask the practice the following key questions; are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The Dental Implant Clinic is an implant training clinic based in Bath. The practice also provides other specialist dental treatment including restorative dental treatment, periodontics (specialised gum treatments) and adult orthodontics (the treatment of jaw and tooth irregularities). Patients who use the service are sometimes referred by their own dentists, and others self-refer. Treatment under conscious sedation is provided for patients who are very nervous about undergoing the surgical element of dental implant treatment. Given the nature of the treatments offered, very few, if any, patients under the age of 18 are treated at the clinic**.**

The practice is based in an adapted domestic dwelling situated near Bath. The practice had five dental treatment rooms, two of which are based on the ground floor. There was a separate decontamination room used for cleaning, sterilising and packing dental instruments. The practice opening hours are 8.45am - 5. 30pm Monday to Friday, the practice is closed at weekends. There were arrangements in place to ensure patients receive urgent medical assistance when the practice was closed.

The practice owner/ 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.

We reviewed seven CQC comment cards that had been left for patients to complete prior to our visit and spoke

Summary of findings

with four patients. Patients commented they found the practice exemplary and staff were welcoming, friendly kind and caring. Several patients commented that staff go out of their way to help.

Patients commented staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained to them so they could make an informed decision which gave them confidence in the care provided. Thank you cards seen in the practice and on the website and the comment cards reviewed corroborated these comments.

Our key findings were:

- We found the practice ethos was to provide high quality patient centred implant and other specialist treatment in a relaxed and friendly environment.
- Staff we spoke with were committed to providing a quality service to their patients.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- Infection control procedures were effective and the practice followed published guidance. The practice appeared clean and well maintained.
- Patients' needs were assessed, and specialist care and treatment were delivered, in accordance with current legislation, standards and guidance.
- Conscious sedation was provided in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists.
- Patients received information about their care, proposed treatment, costs, benefits and risks and were involved in making decisions about it. They had access to a treatment co-ordinator who ensured patients fully understood the proposed treatment.
- We were shown a comprehensive system was in place to gain valid informed consent from patients prior to treatment.
- Patients could access treatment and urgent and emergency care when required.
- There was a policy and procedure in place for recording adverse incidents and accidents. Evidence seen demonstrated learning from incidents took place and was shared across the practice team.
- We saw the practice had clinical governance and risk management structures in place although these could be strengthened to improve their effectiveness. For example in closer monitoring of staff training and the renewal of risk assessments by competent persons e.g. fire.
- Staff had received training appropriate to their roles and were supported in their continuing professional development by the principal dentist
- CQC patient comment cards gave a positive picture of a caring, professional and high quality service.
- Patients were treated with kindness, dignity and respect, and their confidentiality was maintained.
- The appointment system met the needs of patients, and emergency appointments were available.
- Services were planned and delivered to meet the needs of patients and reasonable adjustments were made to enable patients to receive their care and treatment.

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

- Review the practice infection control procedures and provide an annual statement about the practices' infection control systems and processes giving due regard to the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review policies and practices relating to fire management and ensure fire risk assessments are completed in a timely manner and identified actions implemented.
- Review systems for staff recruitment to ensure all relevant information is current.

Review systems for monitoring staff training and ensuring mandatory training is up to date.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had effective arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency. All the equipment used in the dental practice was well maintained.

We were shown the practice had implemented effective governance systems to underpin the provision of safe conscious sedation. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. The practice carried out and reviewed risk assessments to identify and manage risks for the safety of patients.

Are services effective?

No action

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

The practice kept detailed electronic records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. Conscious sedation was provided in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists.

We saw examples of good teamwork within the practice and evidenced good communication with other dental professionals. The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition. (DBOH). Comments received via the CQC comment cards reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced. In the waiting rooms we saw evidence of health promotion information.

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

Are services caring?

No action

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

Summary of findings

We reviewed seven completed CQC comments and obtained the views of four patients on the day of our visit about the care and treatment they received at the practice. These provided a positive view of the service the practice offered. Patients commented on the excellent service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was fully explained to them.

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

Are services responsive to people's needs?

No action 

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

We obtained the views of four patients on the day of our visit. These provided a positive view of the service the practice provided. All patients told us the quality of care was very good. Patients commented on the friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed. There were clear instructions for patients requiring urgent care when the practice was closed.

The practice had steps into it however we observed there was a portable ramp available to enable patients in wheelchairs or with mobility difficulties to access the practice. There were two ground floor treatment rooms once in the practice.

The service was aware of the needs of patients who were referred to them and took these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required.

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

Are services well-led?

No action 

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

The practice had a management structure and governance arrangements in place which consisted of the principal dentist, the practice manager and lead dental nurse who were responsible for the day to day running of the practice. We saw the practice had clinical governance and risk management structures in place although these could be strengthened to improve their effectiveness. For example greater attention to review risk management processes requiring an external competent person. The practice carried out a programme of audits as part of a system of continuous monitoring, improvement and learning.

Effective clinical leadership was provided by the principal dentist. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There were arrangements for sharing information across the team, including holding practice based staff meetings and the use of email. All information shared was documented for those staff unable to attend meetings.

Summary of findings

Staff told us they felt well supported and could raise any concerns with the principal dentist. All the staff we met said they were happy at the practice and enjoyed the opportunities presented to gain knowledge and skills which enhanced their professional development. They told us the practice was a good place to work.

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

The Dental Implant Clinic

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 function. 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.

The inspection took place on 16 January 2017 and was led by a CQC Inspector assisted by a dental specialist advisor.

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

During the inspection we spoke with the principal dentist, dentists, practice manager, qualified dental nurses, treatment coordinator and the receptionist. We reviewed policies, procedures and other documents and observed procedures. We spoke with four patients and reviewed seven CQC comment cards which we had sent prior to the inspection, for patients to complete about the services provided at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

We discussed with the lead dental nurse the action they would take if a significant incident occurred. They described a detailed process which involved a discussion and feedback with any patient that might be involved. The lead dental nurse described a medical incident that had occurred at the practice in 2015. This indicated an understanding of their duty of candour.

Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Records seen showed five accidents had occurred during 2015-16 and were managed in accordance with the practice accident and incident reporting policy. We noted the practice did not have a system in place to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) or the central alerting system (CAS). We pointed this out to the lead dental nurse who immediately set up an account with the MHRA to receive such alerts.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. These did not include contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission, however all staff were aware of how to obtain these details if required via the computer. Given the specialist nature of this practice the chance of needing these was remote. The practice had a safeguarding lead professional who was the point of referral should members of staff encounter a safeguarding issue.

Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities.

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

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). We spoke with the lead dental nurse about the prevention of needle stick injuries. They explained the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases.

The practice used a system whereby needles were not manually resheathed using the hands following administration of a local anaesthetic to a patient. A single use local anaesthetic delivery system was in place. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

The practice provided specialist root canal treatment as a referral service. We asked the lead dental nurse how they treated the use of instruments used during root canal treatment. They explained these instruments were single patient use only. They also explained all dentists in the practice carried out root canal treatment where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). We were shown a comprehensive kit of rubber dam

instruments confirming their use. Patients can be assured the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

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

Medical emergencies

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

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff. We discussed a medical emergency that occurred in the practice during 2016. We found the practice handled the emergency well. The notes detailing the way the emergency was handled gave a comprehensive description of the way the patient was dealt with throughout the episode. This demonstrated the practice could competently deal with such an emergency.

The practice offered training sessions annually for the team to ensure they maintained their competence in dealing with medical emergencies. However records seen demonstrated some staff had not completed this training within the required timeframe of the last 12 months. In discussion with the practice manager we were told they would address this immediately with the relevant staff. Staff spoken with demonstrated they knew how to respond in the event of a medical emergency.

Staff spoken with showed us documentary evidence which demonstrated regular checks were carried out to ensure the equipment and emergency medicines were in date and safe to use.

Staff recruitment.

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

We looked at the recruitment files for two members of staff and found that some information was not consistently recorded or available. For example, one file had no written references and two files had DBS checks from previous employers which did not comply with national guidance.

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

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

Monitoring health and safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, Legionella (legionella is a term for particular bacteria which can contaminate water systems in buildings), fire safety, general health and safety.

However the fire risk assessment and fire equipment monitoring was out of date. Following the inspection visit we received information from the practice manager they had arranged for a full fire risk assessment from a competent person who would also check the fire extinguishers to visit the practice the following week.

Are services safe?

The practice had in place a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

Infection control

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

The practice had in place an infection control policy which was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 requirements were being met. Documentary evidence demonstrated audit of infection control processes was carried out in December 2016 which confirmed compliance with HTM 01 05 guidelines.

We saw the five dental treatment rooms; waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available and bare below the elbow working was observed.

The drawers of the treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The lead dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria they described the method they used which was in line with current HTM 01 05 guidelines. We were shown a Legionella risk assessment had been carried out at the practice by a competent person which was to be reviewed again in August 2017. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured patients' and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination room for instrument processing. The lead dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing and an automated washer disinfector for the initial cleaning process, following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure the washer disinfector and autoclaves used in the decontamination process were working effectively. We were shown the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles which had been completed and were up to date. We also noted weekly protein tests were carried out.

The lead dental nurse explained the systems in place to ensure safe infection control procedures for implant procedures. The dental nurse told us the single use items that formed part of the dental implant system were for single patient use only. They explained that during the placement of implants the dentists used a single use surgical drape pack system for the treatment room. These surgical drapes were used to cover all non- essential areas of the treatment room and the patient. Included in the pack were surgeon and nurse gowns, head covers for both staff and patients to prevent the spread of infection during the procedure. The dentists also used sterile single use bags of irrigant which was used as a coolant for the dental drills during the procedure. On the day of our inspection an implant procedure took place and we saw the infection control processes for implant procedures were being followed.

Are services safe?

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. Clinical waste was stored in special clinical waste bins adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured they were protected from the risk of infection from contaminated dental waste.

We were shown general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines. Patients could be assured they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

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

A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use. The electrical wiring certificate was not available and the practice manager told us they would arrange for this to be tested and certified as soon as possible. Other equipment checks were regularly carried out in line with the manufacturer's recommendations.

For example, the autoclaves had been serviced and calibrated in July and November 2016 and the washer disinfector used in the decontamination processes had been serviced in November 2016. The practices' seven X-ray machines had been serviced and calibrated as specified under current national regulations in June 2015 and were due to be tested again in 2018. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients.

The practice also dispensed their own medicines as part of a patient's dental treatment for certain oral surgery procedures. These medicines were a range of antibiotics, the dispensing procedures were in accordance with current dispensing guidelines and medicines were stored according to manufacturer's instructions.

We saw there was a recording system for the prescribing and recording of medicines used in the provision of conscious sedation this included the reversal agent for the sedative medicine. We saw the recording of dose and amount of medicines prescribed along with the batch number and expiry date was always recorded. There was an effective written system of stock control and the secure storage for the medicines used in intravenous sedation was demonstrated to us.

We observed the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage. We were shown evidence that all staff had completed basic first aid training.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The documentation in this file consisted of the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, local rules and the necessary documentation pertaining to the maintenance of the X-ray equipment.

We saw radiological audits had been carried out on annually. Dental care records we saw where X-rays had been taken showed dental X-rays were justified, reported upon and quality assured. These findings demonstrated the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

We saw training records which showed staff, where appropriate, had received training in core radiological knowledge under IRMER 2000 Regulations. Thus included some of the dental nurses who had undertaken training to provide an extended role in dental nursing.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic records of the care given to patients. We spoke with the principal dentist who provided specialised dental implant treatment. They explained they carried out consultations, assessments and treatment in line with recognised general professional guidelines with respect to implant treatment. The dentist described to us how they carried out their assessment of patients for a course of implant treatment.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits. This was followed for example by an examination of the patients jaw and tooth relationships and assessment of bone and gum health to ascertain if implant treatment was appropriate for the individual. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail. All of the dental care records we saw were very detailed, accurate and fit for purpose.

Where relevant, preventative dental information was given in order to improve the outcome of implant treatment for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments during the course of their treatment which could last many months.

The practice carried out intra-venous sedation for patients who were very nervous of the surgical component of dental implant treatment such as when bone grafts were proposed. We found the principal dentist had put in place effective governance systems to underpin the provision of conscious sedation. The systems and processes we observed were in accordance with guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists 2015.

The governance systems supporting sedation included pre-and post-sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We found patients were assessed for sedation in line with national guidelines We saw clinical records showed patients undergoing sedation had important checks made prior to sedation this included a detailed medical history, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. The records demonstrated that during the sedation procedure important checks were recorded at regular intervals which included pulse, blood pressure, breathing and the oxygen saturation of the blood. This was carried out using a pulse oximeter which measures the patient's heart rate and oxygen saturation of the blood. Blood pressure was measured using a separate blood pressure monitor.

The dentists who carried out sedation were supported by two appropriately trained nurses wherever possible. This was also recorded in the dental care records with details of their names. The measures in place ensured patients were being treated safely and in line with current standards of clinical practice.

Health promotion and prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health when proposing dental implants and other complex restorative work. To facilitate this the practice appointed a dental hygienist to work alongside the dentists in delivering preventative dental care. The principal dentist explained that preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate.

Dentists prescribed high concentrated fluoride toothpastes for those patients who were at a higher risk of suffering from dental decay. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Are services effective?

(for example, treatment is effective)

Patients reported they felt well informed about every aspect of dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

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

The practice had nine dentists and they were supported by eight dental nurses and a trainee dental nurse, a dental hygienist, a treatment co-ordinator, three reception staff and a practice manager

The dental hygienists always worked with chairside support as set out in the General Dental Council's guide 'Standards for the Dental Team' specifically standard 6.2.2 working with other members of the dental team. The lead nurse and practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The practice manager kept some records of training completed by staff however we were told a comprehensive record with details of all staff training collated to enable effective monitoring, and to ensure staff maintained their skills and knowledge was being developed. We saw documentary evidence to demonstrate this.

Mandatory training included basic life support and infection prevention and control and most staff had undertaken this training. We observed there were three members of staff for whom there was no recorded information regarding this training and six staff who had not completed basic life support training in the last 12 months. The practice manager told us they would ensure these staff attended training or supplied evidence of training in the forthcoming week. New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Dental nurses received day to day supervision from the dentists and support from the lead nurse.

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

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs. Two members of staff told us they had completed training to enable them to provide extended dental nurse duties for example in radiography (x-rays).

Working with other services

The practice was a referral practice and was relatively self-contained. However dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice.

Consent to care and treatment

The dentists described how they obtained valid, informed consent from patients by explaining their findings to them and keeping records of the discussions. Patients were given a treatment plan after consultation and assessment, and prior to commencing dental treatment.

The principal dentist explained how they implemented the principles of informed consent. They explained how 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.

In addition, the practice used a dental nurse treatment coordinator to reinforce the consent process especially when complex care was proposed. Following the initial appointment with the dentist, patients would then see a dental nurse treatment coordinator to go over the treatment options, risks and benefits of treatment so patients fully understood the treatment proposed. The sessions with the dental nurse coordinator could extend to extra appointments if necessary with the patient accompanied by a family member or friend to provide support to the patient.

The dentists told us given the specialist nature of the services offered they rarely saw young persons (under the age of 16 years). The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions

Are services effective?

(for example, treatment is effective)

on behalf of adults who lack the capacity to make decisions for themselves. The dentists and staff we spoke with had a good understanding of the MCA and its application in practice. Staff had received MCA training.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. Feedback given by patients on the seven CQC comment cards and by the four patients spoken with during the inspection demonstrated patients felt they were always treated with kindness and respect, the quality of care was good and staff were friendly, caring and helpful.

Patients commented treatment was explained clearly and the staff were caring and put them at ease. During the inspection, we observed staff in the reception area. We saw they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

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

Involvement in decisions about care and treatment

The dentists discussed treatment options with patients and allowed time for patients to decide before treatment was commenced. We saw this documented in the dental care records. Patients commented in all seven CQC comment cards they were listened to and involved in their care. Patients confirmed treatment options, risks and benefits were discussed with them and they were provided with helpful information to assist them in making an informed choice.

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. The principal dentist paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet and on their website. The services provided included prevention advice and treatment alongside the specialist dental care available**.** During our inspection we looked at examples of information available to patients. We saw the practice waiting area displayed a variety of information including leaflets about the services the practice offered. The practice website also contained useful information for patients such as different types of treatments and how to provide feedback about the services provided.

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

We observed the appointment diaries were not overbooked and this provided capacity each day for patients with problems to be fitted in with each dentist. The dentists decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

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

The practice had not completed a Disability and Discrimination Act (DDA) 2005 assessment however they had made adjustments. For example there was wheelchair access to the practice via a portable ramp to the downstairs waiting area and facilities on the ground floor. Information was in English but translation services could be utilised if necessary via access to a language line.

Access to the service

We saw evidence patients could access treatment and care in a timely way. The practice opening hours were 8.45am - 5. 30pm Monday to Friday and it is closed at weekends. The practice opening hours and out of hours were displayed in the practice and on the practice website. There were arrangements in place to ensure patients receive urgent medical assistance when the practice was closed.

The seven CQC comment cards seen reflected patients felt they had good access to the service and appointments were flexible to meet their needs. The four patients spoken with during the inspection corroborated this.

Concerns and complaints

The practice had a complaint policy and procedure which set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the waiting area and on the practice website. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patient's satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the practice manager or principal dentist they ensured these were responded to appropriately and in a timely manner.

The practice had not received any written complaints during 2016. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response. The practice manager told us complaints would be discussed amongst the team and any learning identified would be implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements consisted of the principal dentist, the practice manager and lead dental nurse who were responsible for the day to day running of the practice. We saw the practice had clinical governance and risk management structures in place although these could be strengthened to improve their effectiveness. For example keeping comprehensive records of when risk assessments by competent persons external to the practice had been completed and their renewal dates.

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

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks for example, use of equipment and infection control. Lead roles in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

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

These included guidance about confidentiality, record keeping, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. There were regular practice meetings to discuss practice arrangements. We saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed.

All the staff spoken with were aware of the policies and how to access them. We saw and were told management policies and procedures were mostly kept under review by the practice manager and lead dental nurse.

Leadership, openness and transparency

Effective clinical leadership was provided by the principal dentist and a trio of empowered personnel including the practice manager, lead nurse and treatment co-ordinator. The practice had a statement of purpose that described their vision, values and objectives. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards we saw and the patients we spoke with reflected this approach.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal dentist. There was a no blame culture within the practice. Staff felt they were listened to and responded to when they did raise a concern.

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

All the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. We found staff were highly motivated, enjoyed working at the practice and were proud of the service they provided to patients.

Management lead through learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system. For example, we were shown the dental nurses received an annual appraisal from which personal development plans were formulated.

Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

Are services well-led?

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

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

We saw patients and staff were engaged and involved. The practice had systems in place to seek and act upon feedback from patients using the service. The practice manager and lead nurse told us they had not analysed the most recent feedback received from patient surveys. However we saw lots of thank you cards and comments of appreciation about the service offered in the waiting room and on the practice website.

Staff told us they felt valued and involved and were encouraged to challenge any aspect of practice which raised concern.