Smile Lincs Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 26 January 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Smile Lincs Limited is situated in Grimsby, Lincolnshire. It offers a mix of NHS and private dental treatments to patients of all ages. The services include preventative advice and treatment, routine restorative dental care, dental implants, orthodontics and conscious sedation. The practice also accepts private referrals for endodontic treatments, dental implants and cone beam computerised tomography imaging. It is also a NHS referral centre for orthodontics and minor oral surgery.

The practice has seven surgeries, two decontamination rooms, an X-ray room, two waiting areas and two reception areas. One reception area, waiting area and three surgeries are on the ground floor. The other reception area, waiting room and four surgeries are on the first floor. There are ground floor toilet facilities.

There are six dentists, a specialist oral surgeon, three dental hygienists, seven dental nurses, five receptionists, a practice co-ordinator and a practice manager.

The opening hours are Monday to Thursday from 8-00am to 7-00pm and Friday from 9-00am to 2-00pm.

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

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

During the inspection we received feedback from 23 patients. The patients were positive about the care and treatment they received at the practice. Comments included that the staff were professional, polite, friendly and attentive. Patients also commented that the surgeries were clean and hygienic.

Our key findings were:

- The practice was clean and hygienic.
- Staff were qualified and appropriately trained.
- The practice had systems in place to assess and manage risks to patients and staff including infection control, health and safety and the management of medical emergencies.
- Patients were involved in making decisions about their treatment and were given clear explanations about their proposed treatment including costs, benefits and risks.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- We observed that patients were treated with kindness and respect by staff. Staff ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood.
- Staff worked well as a team and it was evident that they shared a goal of improving the patients' experience.
- Patients were able to make routine and emergency appointments when needed.
- There were clearly defined leadership roles within the practice and staff told us that they felt supported, appreciated and comfortable to raise concerns or make suggestions.

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

- Complete the Infection Prevention Society (IPS) audit every six months.
- Complete an audit of dental care records and X-rays on a more regular basis.
- Document in the X-ray audit the reason why an X-ray is not of optimum diagnostic quality.
- Conduct an audit of the conscious sedation services.
- Complete immediate life support training for staff members involved in the provision of conscious sedation.
- Analyse results from the patient satisfaction surveys so that feedback can be given to staff and patients.

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.

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff had received training in safeguarding and knew the signs of abuse and who to report them to.

The staff were suitably qualified for their roles and the practice had undertaken the relevant recruitment checks to ensure patient safety.

Patients medical histories were obtained before any treatment took place. The dentists were aware of any health or medication issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. However, we noted that staff involved in the provision of conscious sedation had not completed training in immediate life support as advised in the Intercollegiate Advisory Committee for Sedation in Dentistry.

All emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patient's oral health and made referrals for specialist treatment or investigations where indicated.

The practice followed best practice guidelines when delivering dental care. These included Faculty of General Dental Practice (FGDP), National Institute for Health and Care Excellence (NICE) and guidance from the British Society of Periodontology (BSP). The practice focused strongly on prevention and the dentists were aware of 'The Delivering Better Oral Health' toolkit (DBOH) with regards to fluoride application and oral hygiene advice.

Conscious sedation was carried out safely and in line with the current guidance from the Intercollegiate Advisory Committee for Sedation in Dentistry.

Staff were encouraged to complete training relevant to their roles and this was monitored by the registered provider. The clinical staff were up to date with their continuing their professional development (CPD).

Referrals were made to secondary care services if the treatment required was not provided by the practice. Referrals received from other dental practices were logged, treatment provided as appropriate and then discharged back to the referring dentist with aftercare advice.

Are services caring?

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

During the inspection we received feedback from 23 patients. The patients were positive about the care and treatment they received at the practice. Comments included that the staff were professional, polite, friendly and attentive.

Summary of findings

We observed the staff to be welcoming and caring towards the patients.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood. Patients commented that they were well informed and involved in treatment decisions.

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day.

Patients commented they could access treatment for urgent and emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

There was a procedure in place for responding to patients' complaints. This involved acknowledging, investigating and responding to individual complaints or concerns. Staff were familiar with the complaints procedure.

The practice was accessible for patients with a disability or limited mobility to access dental treatment.

Are services well-led?

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

There was a clearly defined management structure in place and all staff felt supported and appreciated in their own particular roles. The practice manager was responsible for the day to day running of the practice and they were supported by a practice co-ordinator.

The practice had recently completed audits of dental care records and X-rays. However, these had not been regularly completed prior to this. The practice had been completing the Infection Prevention Society audit on an annual basis. This audit should be completed every six months. We also noted that an audit relating to the provision of conscious sedation had not been completed in line with the Intercollegiate Advisory Committee for Sedation in Dentistry guidance.

The practice regularly undertook patient satisfaction surveys and was also undertaking the NHS Family and Friends Test. However, we noted that the results of the patient satisfaction surveys had not been compiled so that results could be discussed with staff.

There were good arrangements in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend.

Smile Lincs Limited

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We informed local NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we received feedback from 23 patients. We also spoke with four dentists, five dental nurses, the practice manager and the practice co-ordinator. To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

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 clear guidance for staff about how to report incidents and accidents. Staff were fully aware of the need to report, analyse and act on accidents or incidents. There had not been any incidents in the last 12 months. However, we saw that historically these had been appropriately recorded in the accident book which was kept in the office. Any accidents or incidents would be discussed at staff meetings in order to disseminate learning.

Staff were aware of the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and guidance was available within the practice's health and safety policy.

The practice manager received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. These would then be discussed with staff and actioned if necessary.

Reliable safety systems and processes (including safeguarding)

The practice had child and vulnerable adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. These contact details were in the safeguarding policy and also in the staff room. The practice manager was the safeguarding lead for the practice and all staff had undertaken safeguarding training within the last two years. There had not been any referrals to the local safeguarding team; however staff were confident about when to do so. Staff told us they were confident about raising any concerns with the safeguarding lead or the local safeguarding team.

The practice had systems in place to help ensure the safety of staff and patients. These included the use of a safe needle disposal system and clear guidelines about responding to a sharps injury (needles and sharp instruments). We were told that only the dentists handle sharps. The practice's sharps policy and procedures for dealing with sharps injuries was displayed in each surgery. This included photographic guidance.

Rubber dam (this is a square sheet of latex used by dentists for effective isolation of the root canal and operating field and airway) was used in root canal treatment in line with guidance from the British Endodontic Society.

We saw that dental care records were computerised and password protected to keep people safe and protect them from abuse. Any paper documentation relating to patients' dental care records were stored in lockable cabinets when the practice was closed.

Medical emergencies

The practice had procedures in place which provided staff with clear guidance about how to deal with medical emergencies. This was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). Staff were knowledgeable about what to do in a medical emergency and had completed training in emergency resuscitation and basic life support within the last 12 months. However, we noted that staff involved in the provision of conscious sedation had not received training in immediate life support. The Intercollegiate Advisory Committee for Sedation in Dentistry guidance states that all persons involved in the provision of conscious sedation should complete immediate life support training on an annual basis.

The emergency resuscitation kits, oxygen and emergency medicines were stored behind the ground floor reception desk. There were also two additional oxygen cylinders on the first floor. Staff knew where the emergency kits were kept. The practice had an Automated External Defibrillator (AED) to support staff in a medical emergency. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

Records showed weekly checks were carried out on the AED, emergency medicines and the oxygen cylinder. These checks ensured that the oxygen cylinder was full, the AED was fully charged and the emergency medicines were in date.

Staff recruitment

The practice had a policy and a set of procedures for the safe recruitment of staff which included seeking references, proof of identity, checking relevant qualifications and professional registration. We reviewed a sample of

recruitment files and found the recruitment procedure had been followed. The practice manager told us they carried out Disclosure and Barring Service (DBS) checks for all newly employed 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 reviewed records of staff recruitment and these showed that all checks were in place.

All clinical staff at this practice were qualified and registered with the General Dental Council (GDC). There were copies of current registration certificates and personal indemnity insurance (insurance professionals are required to have in place to cover their working practice).

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. We saw the practice manager conducted a quarterly walk round of the practice to identify and health and safety risks including slips and trips and general maintenance of the premises. Where risks had been identified remedial action had been taken in a timely manner.

There were policies and procedures in place to manage risks at the practice. These included infection prevention and control, fire evacuation procedures and risks associated with Hepatitis B.

The practice maintained a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, and dental materials in use in the practice. The practice identified how they managed hazardous substances in its health and safety and infection control policies and in specific guidelines for staff, for example in its blood spillage and waste disposal procedures. Staff were familiar with the COSHH folder and its importance in dealing with any incidents involving substances used in the practice.

Infection control

There was an infection control policy and procedures to keep patients safe. These included hand hygiene, safe handling of instruments, managing waste products and decontamination guidance. The practice followed the guidance about 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 practice co-ordinator was the infection control lead for the practice.

Staff had received training in infection prevention and control. We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination rooms to be clean and hygienic. Work surfaces were free from clutter. Staff told us they cleaned the treatment areas and surfaces between each patient and at the end of the morning and afternoon sessions to help maintain infection control standards. There were hand washing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for patients and staff members. Posters promoting good hand hygiene and the decontamination procedures were clearly displayed to support staff in following practice procedures. Sharps bins were appropriately located, signed and dated and not overfilled. We observed waste was separated into safe containers for disposal by a registered waste carrier and appropriate documentation retained.

Decontamination procedures were carried out in dedicated decontamination rooms in accordance with HTM 01-05 guidance. There were two decontamination rooms in the practice. One was located on each floor. This avoided the need to transport instruments up and down the stairs hence reducing the risk of tripping whilst carrying instruments. An instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which minimised the risk of the spread of infection.

One of the dental nurses showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments; packaging and storing clean instruments. The practice either manually scrubbed or used a washer disinfector to clean the used instruments, examined them visually with an illuminated magnifying glass, and then sterilised them in a validated autoclave. The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate PPE during the process including disposable gloves, aprons and protective eye wear.

Are services safe?

The practice had systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. There were sufficient instruments available to ensure the services provided to patients were uninterrupted.

The practice had carried out an Infection Prevention Society (IPS) self- assessment audit in May 2015 relating to the Department of Health's guidance on decontamination in dental services (HTM01-05).This is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. The audit showed the practice was meeting the required standards. However, this audit should be conducted every six months. This was brought to the attention of the practice manager and we were told that this would be completed every six months from now on.

Records showed a risk assessment process for Legionella had been carried out in 2011(Legionella is a term for particular bacteria which can contaminate water systems in buildings). This risk assessment was reviewed on an annual basis to ensure nothing had changed to indicate that it was not valid anymore. The practice undertook processes to reduce the likelihood of legionella developing which included running the water lines in the treatment rooms at the beginning and end of each session and between patients, monitoring cold and hot water temperatures each month, the use of a water conditioning agent and also quarterly tests on the on the water quality to ensure that Legionella was not developing.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, the autoclaves, the washer disinfector and the compressor. We saw evidence of validation of the autoclave, washer disinfector and the compressor. Portable appliance testing (PAT) had been completed in May 2015 (PAT confirms that portable electrical appliances are routinely checked for safety). We saw that fire extinguishers were serviced on an annual basis.

Prescriptions were stamped only at the point of issue to maintain their safe use. Prescription pads were kept locked away when not needed to ensure they were secure.

The practice also dispensed a limited number of antibiotics for private patients. These were kept locked away and a log of which antibiotics was kept.

We also saw that medicines involved in the provision of conscious sedation (midazolam) were stored securely in a safe in the office which only the practice manager had access to. Other than midazolam no other controlled drugs were kept in the practice.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. Records we viewed demonstrated that the X-ray equipment was regularly tested and serviced. However, we noted that at the critical examination of two X-ray machines completed in 2013 had indicated that these machines were producing more radiation than what was expected. It had been suggested in the critical examination report that these doses should be reduced. We were told that this had been done. However, this had not been documented. We were sent documentation after the inspection that these X-ray machines are safe to use.

The practice had recently installed a cone beam computerised tomography (CBCT) machine. CBCT is an X-ray based imaging technique which provides high resolution visualisation of bony anatomical structures in three dimensions. We saw evidence of appropriate documentation that the machine had been critically assessed prior to it being used and staff had been appropriately trained in its use. The practice accepted referrals for CBCT imaging. We were told that before taking an image that there was appropriate justification for the exposure.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. We found there were suitable arrangements in place to ensure the safety of the equipment. Local rules were available in all surgeries and within the radiation protection folder for staff to reference if needed. We saw that a justification, grade and a report was documented in the dental care records for all X-rays which had been taken.

A practitioner specific X-ray audit had been completed in January 2016. However, there had not been regular audits of the quality of X-rays prior to this. These X-ray audits should be completed on an annual basis. We also noted that the reasons as to why an X-ray was not of optimal diagnostic quality was not recorded in the audit. This means that the practice cannot identify whether the issue

Are services safe?

with an X-ray related to the practitioner or the developing of the radiograph. These issues were discussed with the practice manager and we were told that they would implement these for the next X-ray audit.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentists used NICE guidance to determine a suitable recall interval for the patients. This takes into account the likelihood of the patient experiencing dental disease. This was documented and also discussed with the patient.

We saw that the orthodontist carried out an assessment in line with the British Orthodontic Society (BOS). Patients were recalled at suitable intervals for reviews of the treatment. After finishing their orthodontic treatment, patients were recalled at specific intervals to ensure they were complying with the post-orthodontic care (wearing retainers).

We saw that the process involved in providing conscious sedation was generally in line with those set out in the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD). We saw patients' anxiety was assessed prior to undertaking conscious sedation and alternatives were discussed. The patient's ASA physical status was assessed and documented and if it was one or two then the dentist felt this was appropriate to treat the patient in the surgery. If the ASA was above two then the patient would be referred to secondary care. Prior to the induction of conscious sedation the dentist recorded the patient's blood oxygen saturation and heart rate (vital signs). Throughout the procedure these vital signs were regularly checked and documented in the sedation record. However, the practice should note that the new guidelines from the IACSD states that the patient's blood pressure should be monitored throughout the procedure. We saw the dose of sedative medicines were titrated to effect to ensure that the patient was not over-sedated. These doses were documented in the sedation records. We saw that an antagonist to the sedative medicines was readily available if needed. However, we were told that this had never been needed. After the procedure the patient's escort would be suitably briefed with regards to post-operative care. We were told that the day after any procedure involving sedation had taken place a member of staff would call the patient to check on their well-being. We were also told that for patients who underwent lengthy sedation procedures, the dentist would provide the patient with their mobile phone number to contact if there were any problems.

During the course of our inspection we discussed patient care with the dentists and checked dental care records to confirm the findings. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. During the inspection we noted the endodontist used a dental microscope whilst providing endodontic treatment. Dental microscopes provide the dentist with a degree magnification which improves visual acuity which helps in improving the outcome of endodontic treatment for patients.

Records showed patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The practice used current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, following clinical assessment, the dentists followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray, quality assurance of each x-ray and a detailed report was recorded in the patient's care record.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentist applied fluoride varnish to all children who attended for an examination. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

Are services effective?

(for example, treatment is effective)

The medical history form patients completed included questions about smoking and alcohol consumption. We were told by the dentist and saw in dental care records that smoking cessation advice was given to patients who smoked. There were health promotion leaflets available in the waiting room and surgery to support patients. We saw the orthodontist provided patients undergoing orthodontic treatment with detailed preventative advice sheets.

The practice also referred to in-house dental hygienists for those patients who required extra attention with regards to maintaining good levels of oral hygiene.

Staffing

The practice had a process for the induction of new staff. The induction process included making the new member of staff aware of the practice's policies, the location of emergency medicines, arrangements for fire evacuation procedures, record keeping and the decontamination procedures. However, there had not been any new members of staff join the practice since it was taken over by the new provider.

Staff told us they had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The practice organised in-house training for medical emergencies to help staff keep up to date with current guidance on treatment of medical emergencies in the dental environment. Records showed professional registration with the GDC was up to date for all staff and we saw evidence of on-going CPD.

Staff told us they had annual appraisals and training requirements were discussed at these. We saw evidence of completed appraisal documents. Staff also felt they could approach the registered provider or practice manager at any time to discuss continuing training and development as the need arose.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment including treatments under general anaesthetic and oral medicine. The practice completed detailed proformas or referral letters to ensure the specialist service had all the relevant information required. A copy of the referral letter was kept in the patient's dental care records. Letters received back relating to the referral were first seen by the referring dentist to see if any action was required and then stored in the patient's dental care records.

The practice received referrals for endodontics, implants, orthodontics and oral surgery. Upon receiving a referral letter the relevant dentist reviewed the letter and then the patient was contacted. An initial assessment appointment was arranged for the patient and they were made aware of the fee for the initial consultation. Once treatment had been completed, the patient was sent back to the referring dentist for on-going treatment. A letter would be sent back to the referring dentist with advice about what treatment had been provided and advice about on-going treatment which related to the treatment provided.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent. Staff described to us how valid consent was obtained for all care and treatment and the role family members and carers might have in supporting the patient to understand and make decisions. Staff were clear about involving children in decision making and ensuring their wishes were respected regarding treatment.

Staff had an understanding of the principles of the Mental Capacity Act (MCA) 2005 and how it was relevant to ensuring patients had the capacity to consent to their dental treatment. We saw signs up in the surgeries which referenced signs, symptoms and situations which may affect a person's ability to provide consent.

Staff ensured patients gave their consent before treatment began and this was either verbal or in the form of a signed treatment plan by the patient. We were told that individual treatment options, risks, benefits and costs were discussed with each patient. We saw in the dental care records that these discussions were well documented. We were told that for patients requiring more complex treatment plans they were advised to go home and take time to consider the options which had been provided.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Feedback from the patients was positive and they commented that they were treated with care, respect and dignity in a professional manner. Staff told us that they always interacted with patients in a respectful, appropriate and kind manner. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private, an empty room would be found to speak with them

Patients' electronic care records were password protected and regularly backed up to secure storage. Any paper documentation was stored in locked cabinets.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. An example of this would be discussions with patients prior to undertaking conscious sedation where the dentist would discuss other forms of anxiety management with the patient.

We were also told that children would be involved in decisions about orthodontic treatment. Staff felt that involving children in decisions with regards to orthodontic treatment was paramount to them complying with the strict oral hygiene regimes associated with completing orthodontic work.

Patients were also informed of the range of treatments available in literature and signs in the waiting room. The practice's website also provided patients with detailed information on different treatments which were available at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We found the practice had an efficient appointment system in place to respond to patients' needs. Staff told us that patients who requested an urgent appointment would be seen the same day. We saw evidence in the appointment book that there were dedicated emergency slots available each day. If the emergency slots had already been taken for the day then the patient was offered to sit and wait for an appointment if they wished.

Patients commented they had sufficient time during their appointment and they were not rushed. We observed the clinics ran smoothly on the day of the inspection and patients were not kept waiting.

Tackling inequity and promoting equality

The practice had a fair and accessible care policy to support staff in understanding and meeting the needs of patients. Reasonable adjustments had been made to the premises to accommodate disabled patients. These included wheelchair access through the rear of the building, a grab rail at the front of the building and high back chairs in the waiting room for those with limited mobility. The ground floor surgeries were large enough to accommodate a wheelchair or a pram.

One patient commented that deaf awareness had been applied. This included the use of the RNID typetalk system. We were also told that some of the dentists were multilingual. These languages included Spanish, Romanian and Arabic.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. The opening hours are Monday to Thursday from 8-00am to 7-00pm and Friday from 9-00am to 2-00pm.

Patients told us that they were rarely kept waiting for their appointment. Patients could access care and treatment in a timely way and the appointment system met their needs. Where treatment was urgent, patients would be seen the same day. This was confirmed by feedback from patients. The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the 111 service or a local out of hours emergency dental service on the telephone answering machine. Information about the out of hours emergency dental service was also displayed in the practice.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. The practice's complaints policy was available in the patients' information booklet which was available in each of the waiting rooms. The practice manager was responsible for dealing with complaints when they arose. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Staff told us that they aimed to resolve complaints in-house initially.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients. We found there was an effective system in place which helped ensure a timely response. This included acknowledging the complaint within three working days and providing a formal response within 10 working days. If the practice was unable to provide a response within 10 working days then the patient would be made aware of this.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the service. The practice manager was supported in-house by the practice co-ordinator. There was also an area manager and the practice manager had a buddy arrangement with another practice manager for any help or assistance when needed.

There was a range of policies and procedures in use at the practice. We saw they had systems in place to monitor the quality of the service and to make improvements.

The practice had an approach for identifying where quality or safety was being affected and addressing any issues**.** Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire safety, the use of equipment and infection control.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff told us that they felt supported and were clear about their roles and responsibilities.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. Any issues raised would be discussed at informal staff meetings and staff felt that they contribute to discussions and believed that their opinions would be considered. It was obvious that staff worked well as a team and patients' wellbeing was of the utmost importance. We were told staff socialised as a team with their families every year out of work. This helped bond the team and improve working relationships.

Staff were aware of whom to raise any issue with and told us that the practice administrator was approachable, would listen to their concerns and act appropriately. We were told there was a no blame culture at the practice and that the delivery of high quality care was part of the practice's ethos.

Learning and improvement

Quality assurance processes were used at the practice to encourage continuous improvement. The practice audited areas of their practice as part of a system of continuous improvement and learning. This included clinical audits such as dental care records, X-rays and infection control. The most recent clinical record audit was completed in January 2016 and showed the dentists were generally performing well. However, we noted that audits of X-rays and dental care records had not been completed on a regular basis prior to this. We discussed this with the practice manager and we were told that a more regular audit process would be implemented to ensure that audits were conducted at appropriate intervals.

Staff told us they had access to training and this was monitored to ensure essential training was completed each year; this included medical emergencies and basic life support. Staff working at the practice were supported to maintain their continuous professional development as required by the General Dental Council.

All staff received annual appraisals at which performance, learning needs, general wellbeing and aspirations were discussed. We saw evidence of completed appraisal forms in the staff folders.

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

The practice had systems in place to involve, seek and act upon feedback from people using the service including carrying out patient satisfaction surveys and an on-line feedback system on the practice's website. The satisfaction survey included questions about the cleanliness of the practice, the quality of the treatment, the ease of getting an appointment, whether they felt involved in treatment decisions and the friendliness of the team. We saw completed patient satisfaction survey forms and these appeared very positive. However, the practice had not formally analysed the results of the survey results. This would enable them to provide feedback to staff and also patients. This was brought to the attention of the practice manager and we were told that this would be done and results would be discussed at staff meetings, displayed in the waiting room and also on the practice's website.

The practice also undertook the NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services

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should have the opportunity to provide feedback on their experience. The latest results showed that 94% of patients asked said that they would recommend the practice to friends and family.