Chartwell Dental Practice Limited

Chartwell Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 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 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

Chartwell Dental Clinic is a dental practice situated in the town of Croxley Green in Hertfordshire. It occupies a commercial property and has four treatment rooms over three floors.

Chartwell Dental Clinic offers general dental treatment to adults and children funded by the NHS or privately.

In addition the practice offers conscious sedation (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

The practice utilises both basic and advanced sedation techniques in the provision of care administered by inhalation of gases or intravenous injection, or a combination of both. Conscious sedation is offered to adults and children either funded by the NHS or privately, and subject to an individual risk assessment of the patient and their needs. Patients can be referred to the practice for these services.

The practice carries out a high volume of conscious sedation cases, and treats some patients under sedation that are at greater risk of complications; such as children. For this reason the report references the newest dental conscious sedation guidance even though this has not been fully adopted by dental practices in England as yet.

Summary of findings

The practice also accepts referrals for minor oral surgery under local anaesthetic (numbing injection) or conscious sedation.

The practice is open from 9 am to 5 pm on Monday to Friday and also offers appointments on a Saturday morning once a month.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We received feedback from 14 patients. These provided a very positive view of the services the practice provides. Patients commented on the quality of care, the professional and friendly nature of staff and the cleanliness of the practice.

Our key findings were:

- The practice was visibly clean and clutter free.
- The practice was taking on NHS patients at the time of the inspection and patients could expect to be offered an appointment within a few days.
- Comments from patients indicated that the staff were kind and caring and were skilled at putting nervous patients at ease.
- A routine appointment could be secured within a few days and emergency appointments would be arranged on the day they contacted the service.
- Appointments for minor oral surgery were usually offered within a couple of weeks of referral and an appointment for conscious sedation within a month.
- The practice had policies in place to assist in the smooth running of the service.
- The practice had medicines and equipment to treat medical emergencies.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice met the standards set out in national guidance regarding infection control although they had not completed an infection control audit since September 2014.
- The practice offered conscious sedation. In some aspects of the provision of care the service met the most recent guidance, however not in all aspects.

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

- Review the provision of conscious sedation in the primary care setting giving regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'. Particular reference should be made to the use of advanced sedation techniques, the treatment of children and the timing of consent.
- Review the practice's governance protocols to monitor the completion of required risk assessments and clinical audits within the appropriate timescales.
- Review the security of prescription pads in the practice and implement systems to monitor and track their use.
- Review the practice's protocols for completion of dental records giving regard to guidance provided by the Faculty of General Dental Practice on clinical examinations, record keeping and justification and grading of X-rays taken.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification are requested and recorded suitably.

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

The practice had appropriate medicines and equipment to manage medical emergencies in line with national guidance. All staff had undertaken training and the practice carried out occasional scenario training.

Staff were appropriately recruited, though some improvements could be made in the recording of references and proof of identification

Equipment was maintained in line with manufacturers' guidance.

The process of decontamination of used dental instruments was demonstrated effectively.

We found areas where improvements should be made relating to the safe provision of treatment. This was because the provider had not reviewed or completed required risk assessments relating to health and safety and fire for several years. These were completed following the inspection.

Protocols were in place in the provision of conscious sedation, however the practice were not fully compliant with the requirements of The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'.

Are services effective?

No action

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

The dentists used the principals of nationally recognised guidance in the care and treatment of patients.

A comprehensive screening of patients was carried out at check-up appointments, however was not always fully recorded in the dental care records.

Appropriate clinical monitoring of patients undergoing conscious sedation was demonstrated.

Are services caring?

No action

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

Patients commented that staff were friendly and professional and that the whole team were skilled at putting nervous patients at ease.

Staff described and demonstrated appropriate methods of maintaining patient confidentiality in the reception area.

Dental care records which were stored away from patient areas were not secured overnight. This was amended following the inspection.

Summary of findings

Are services responsive to people's needs?

No action

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

Staff made every effort to assist patients with restricted mobility, including clinicians moving to ground floor treatment room to see patients who could not manage the stairs.

The practice made every effort to see emergency patients on the day they contacted the practice.

The practice had a complaints policy which directed patients in how to raise a complaint. They also invited comment through their website.

Are services well-led?

No action

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

Policies were available to assist in the smooth running of the service. These were available for staff to review in hard copy form.

The practice used clinical audit as a tool to highlight areas where improvements could be made, however an infection control audit had not been carried out since September 2014. This was completed immediately following the inspection.

Staff felt supported and encouraged to approach the management team with ideas or concerns.

Governance systems had failed to identify that certain risk assessments and clinical audit had not been completed within the required timescales.

Comprehensive clinical audit had been completed on the safety and outcomes of the provision of conscious sedation in the practice.

Chartwell Dental 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 functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 10 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the provider for information to be sent this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with members of staff and patients during the inspection.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system in place for reporting and learning from untoward incidents, although they had not recorded an incident in the year preceding our visit. The practice had an accident and incident policy which was due for review in September 2017 as well as a serious incident / never event reporting protocol.

These identified the need to investigate the concern, report the findings and highlight areas for improvement.

The last incident recorded was in March 2013, a patient undergoing conscious sedation experienced an adverse event, the patient was recovered appropriately and the practice documented the incident and analysed the causes. The staffs' candour was evident in the reporting. 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.

The practice's standard operating procedure in respect of the provision of conscious sedation was reviewed following every incident pertaining to conscious sedation in the practice.

The practice received communication from the Medicines and Healthcare products Regulatory Agency (MHRA). These were e-mailed to the practice and relevant alerts disseminated to staff.

The practice were aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE). Information was available for staff to reference on how to make a report.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place regarding safeguarding vulnerable adults and child protection. These were recently reviewed and dated. The policies documented the types of abuse that might be seen and contact numbers to raise a concern. These numbers were displayed in the treatment rooms.

The practice had designated two members of staff as leads in safeguarding. Staff we spoke with were able to identify the leads and had all undertaken safeguarding training.

The practice had an up to date Employers' liability insurance certificate which was due for renewal in August 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed the use of rubber dam with the dentists in the practice. A rubber dam is a thin, rectangular sheet, usually of latex rubber. It is used in dentistry to isolate a tooth from the rest of the mouth during root canal treatment and prevents the patient from inhaling or swallowing debris or small instruments. The British Endodontic Society recommends the use of rubber dam for root canal treatment. We found that a rubber dam was being used where possible by the dentists.

A protocol was in place detailing the actions required in the event of a sharps injury. This was also displayed in the decontamination room and directed staff to seek advice in the event of an injury. The practice were not using 'safer sharps' at the time of the inspection. These are medical sharps that have an in built safety features to reduce the risk of accidental injury. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 require that practices switch to 'safer sharps' where it is reasonably practicable to do so. Following the inspection we received evidence that the practice were trialling safer sharps systems.

Several safety systems were in place in the provision of conscious sedation. Patients referred to the practice for sedation were triaged and individually risk assessed from the referral letter for their suitability to treat in a primary care setting. This risk assessment took into account patient factors such as age, weight and medical history as well as dental factors such as the complexity of the treatment required, whether it involved both sides of the mouth, or posterior teeth. This risk assessment was carried out by the sedationist who is a registered medical doctor. On the results of this assessment patients were either rejected for

treatment in the practice, offered an appointment for treatment (with the caveat that treatment may not be carried out), or offered an appointment for a face to face assessment. We saw examples of this process in action.

The anaesthetic machine used to administer the inhaled sedatives had a safety feature which ensured that during the procedure it was not possible to administer the patient less than a certain percentage of Oxygen.

Oxygen was piped through the premises from large cylinders in the basement. There was always a spare cylinder attached and the system automatically switched to the new cylinder if the in use cylinder ran out. An alarm would sound outside the sedation room to alert staff to the fact that it had moved to the second cylinder and they would replace the empty cylinder. This system assured staff that oxygen was available at all times.

We were shown a written standard operating procedure for the provision of conscious sedation at the practice. This included details from setting up the surgery, checking the emergency kit prior to every sedation case, checking and logging controlled drugs to explaining the procedure to the patient, ensuring valid and educated written consent was obtained and baseline observations (for example blood pressure, oxygen saturation and pulse) were taken before the sedation commenced.

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. These were stored together and all staff we spoke with were aware how to access them. Emergency medicines were in date, stored appropriately, and in line with those recommended by the British National Formulary. These were checked and logged monthly.

Equipment for use in medical emergency was available in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

In addition to the equipment and medicines recommended for all dental practices, the practice carried other medicines and equipment for use by one of the two doctors that were present during the provision of conscious sedation. This included medication and equipment to intubate and ventilate a patient in the event that they stop breathing.

All staff had undertaken training in basic life support and all staff involved in the provision of conscious sedation had undergone training in immediate life support for adults and paediatric immediate life support for children. This training covers basic life support and cardio-pulmonary resuscitation as well as use of an AED and airway management, and is recommended training for the sedation team by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'.

Staff we spoke with were able to describe where the medical emergencies equipment could be located as well as being able to describe which specific medicines may be required for certain medical emergencies.

Staff recruitment

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had a recruitment policy which detailed that DBS checks be sought for all members of staff and as well as confirming good conduct in previous employment by way of references.

We reviewed the staff recruitment files for seven members of staff and found that DBS checks had been sought or were available for all staff. On the whole appropriate pre-employment checks had been carried out; however the practice was not always recording references or proof of identification. Missing information pertaining to the recruitment files we were shown was provided following the inspection.

Are services safe?

Monitoring health & safety and responding to risks

The practice had systems in place to monitor and manage risks to patients, staff and visitors to the practice. A health and safety policy was available for staff to reference and was reviewed in September 2016. This included topics such as personal protective equipment and pressure vessels.

A full practice risk assessment had been carried out, and included hazards such as trip and fall hazards, but had not been reviewed since 2012. Following the inspection we received evidence that this had been reviewed and updated.

A fire risk assessment was carried out in September 2012, but we were not shown any recent review of this document; the practice were checking the fire alarm system weekly. Fire drills were carried out every six months, most recently in July 2016. The induction checklist for new starters to the practice contained the fire evacuation plan, and staff we spoke with were able to describe their actions in the event of a fire and identify the external meeting point. Following the inspection the fire risk assessment was reviewed and updated.

The practice had business continuity plans in place to ensure appropriate actions were in place should the building become unusable due to an unforeseen event.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a file of information pertaining to the hazardous substances used in the practice and actions described to minimise their risk to patients, staff and visitors. A separate data sheet for the cleaners listed the products they used.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy which was reviewed on 19 October 2016. This included separate policy documents on hand hygiene and decontamination.

The practice appeared clean and clutter free and patients commented that the practice was clean. We noted a tear in the head rest of one of the dental chairs and a further tear in one of the operator stools which made them difficult to effectively clean. Immediately following the inspection we received evidence that arrangements had been made to repair these.

The practice had appointed the head dental nurse as the infection control lead.

The practice had a dedicated decontamination facility with clear zoning of 'clean' and 'dirty' areas. A dedicated hand wash sink was available as well as a dedicated cleaning and separate rinsing sink for the manual cleaning of instruments prior to sterilisation in an autoclave.

We observed a dental nurse completing the decontamination process effectively and meeting the standards set out in HTM 01-05. The practice aimed to have a dedicated decontamination nurse available.

The practice were carrying out the appropriate tests and checks to ensure that the decontamination and sterilisation process remained effective.

All staff had documented vaccinations against Hepatitis B, although one staff member did not have confirmed immunity. Staff who are likely to come into contact with blood products, or are at increased risk of needle stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had a risk assessment regarding Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had been carried out by an external company on 9 September 2015 and highlighted that monthly water temperatures should be checked. This was being carried out but one sink had not made the minimum hot water temperature in the records we were shown. This had been highlighted in the report. Following the inspection the practice sought advice and raised the water temperature to reduce the risk of Legionella proliferation.

The practice had contracts in place for the disposal of contaminated waste and waste consignment notes were seen to confirm this. Clinical waste was stored in a locked bin prior to its removal; however the bin itself was not secured to prevent it being wheeled away. Following our inspection we received photographic evidence that this was now secured.

Are services safe?

Environmental cleaning was completed by employed cleaners who conformed to the national system of colour coding cleaning equipment.

Equipment and medicines

The practice had a full range of equipment to carry out the services they offered and in adequate number to meet the needs of the practice. Staff confirmed that they never ran out of instruments.

Portable appliance testing had been carried out in November 2016. The suction pump had been services in October 2015. Appropriate servicing and testing of the compressors and autoclaves had been carried out in the year preceding our inspection.

The fire alarm had been serviced in February 2016 and the fire extinguishers in August 2016, at this time we noted that one of the fire extinguishers was condemned and was immediately replaced by the practice.

The equipment used in the provision of conscious sedation had also been serviced on 23 May 2016. This included the monitoring equipment, the machine for delivery of inhaled sedative gases, monitors and electric suction.

The practice utilised both basic and advanced sedation techniques in the provision of conscious sedation for dental treatment. The difference between the two is the use of multiple sedative medicines in the advanced techniques; medicines that have a narrower margin of safety than would be used in the simpler techniques. Advanced techniques for conscious sedation should only be carried out by practitioners with the appropriate skills and experience to do so.

Advanced techniques were only carried out by the two medical doctors who worked at the practice providing sedation. We spoke with one of the doctors during our visit, but the other was not available.

The doctor we spoke with was the only practitioner who sedated children in the practice and used a combination of simple and advanced techniques to do so.

One dentist and two oral surgeons at the practice also carried out sedation, but only using simple, single medicine techniques, in line with the guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry, Department of Health 2003.

The practice were aware of the updated guidance published in April 2015 by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'. In some areas they were meeting this guidance (such as the training recommendation for the whole team in immediate life support and paediatric immediate life support). In others they were not meeting the more recent guidance; for example the guidance indicated that taking consent on the day of treatment was only acceptable in an emergency situation, however this practise was commonplace.

The practice dispensed antibiotics and painkillers to private patients. We examined the stock and found all medications were in date however a central log was not kept of the dispensing or stock control. We received evidence following the inspection that this was now in place.

NHS prescription pads were held securely on the premises, but a log of serial numbers was not kept; again this was amended immediately following the inspection.

We examined the controlled medicines and found that the storage and logging of controlled medicines met national standards.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice had four intra-oral X-ray machines that were able to take an X-ray of one or a few teeth at time (one of which was a hand held machine) and one panoramic machine that takes an X-ray of the whole jaws.

Rectangular collimation on intra-oral X-ray machines limits the beam size to that of the size of the X-ray film. In doing so it reduces the actual and effective dose of radiation to patients. We saw that rectangular collimators were in use on one of the X-ray machines, and following the inspection we received evidence of one more.

Are services safe?

The required three yearly testing of the intra-oral equipment was carried out in October and November 2016 and included the annual service. The panoramic machine was tested upon installation in October 2015.

We saw from the dental care plans we were shown that clinicians were not always noting the justification for taking an X-ray as well as the quality grade and report of the findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we saw patient care records to illustrate our discussions.

A comprehensive medical history form was completed by patients at every examination appointment, and updated verbally at each attendance. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

Discussions with dentists indicated that they regularly checked gum health by use of the basic periodontal examination (BPE). This is a simple screening tool that indicates the level of treatment need in regard to gum health. Scores over a certain amount would trigger further, more detailed testing and treatment.

Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate serious pathology.

Although the dentists we spoke with were able to clearly describe the process of thorough assessment this was not always reflected in the dental care records we were shown which lacked some detail of this assessment and options available for the patient.

The dentists understood the principles of the current national guidance and used them in the care and treatment of patients.

Patients who attended for conscious sedation were assessed on the day of treatment by the sedationist and the dentist to confirm the treatment plan. Most patients had a cannula sited even if they were receiving inhalation sedation as a precautionary measure in case intra-venous medication became necessary.

The medical history form for patients having conscious sedation was usually sent to them in advance of the procedure and included details such as whether the patient had experienced previous conscious sedation or anaesthesia, the body mass index of the patient and whether the patient is known to have or carry sickle cell anaemia or trait.

The sedation team for advanced sedation techniques always consisted of a separate sedationist (who was a medical doctor) as well as a dentist to carry out the treatment. The sedationist was assisted by a dental nurse as was the dentist. Both the dental nurses had also received sedation training.

Where dentists were acting as both operator and sedationist they worked with a dental nurse and a medical nurse to monitor the patient during the procedure. Whenever there was sedation carried out on the premises one of the medical doctors was available on site.

During the sedation patients were monitored in accordance with the guidance published in April 2015 by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'. We were shown records of sedation as well and being shown the equipment.

After the treatment was complete, the patients recovered in the dental chair until they were able to stand and walk at which point they were escorted to the recovery room. The recovery room had beds for three patients to recover fully and was staffed by a dental nurse. Patients in the recovery room were not left unattended at any time.

The recovery room had equipment for monitoring patients as well as some emergency equipment for immediate access if required. The practice had a process for discharging a patient ensuring that they met certain criteria before they were allowed to leave with their escort. The sedationist had the overall responsibility for discharging the patients.

Written instructions were given to the patient and patient's escort at discharge.

Health promotion & prevention

All children who attended the practice for conscious sedation were given oral hygiene leaflets to take home; this included information on the use of fluoride in preventing dental decay.

The waiting area had free toothpaste samples available for patients and leaflets were available on smoking and oral health as well as gum disease, diet and oral hygiene.

We found a good application of guidance issued in the DH publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is a

Are services effective?

(for example, treatment is effective)

toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. We were shown examples where high fluoride toothpaste was prescribed to patients at high risk of dental decay.

Tooth brushing and interdental cleaning advice was available on the practice website as well as information on cleaning children's' teeth and smoking. The smoking cessation page lists the contact number for the NHS smoking helpline.

Staffing

The practice was staffed by a principal dentist, two medical doctors, four further general dentists, a periodontist (who specialises in gums), two oral surgeons and a hygienist. They were supported by a head dental nurse, six further dental nurses and a medical nurse. A dental nurse who was in the process of becoming registered worked as an anaesthetic assistant to the sedationists. The practice manager and reception manager were supported by two administrators and four receptionists.

Prior to our inspection we checked that all appropriate clinical staff were registered with the General Dental Council or General Medical Council and did not have any conditions on their registration.

The medical doctors had experience in dental sedation but were not specialist anaesthetists (not on the specialist list held by the General Medical Council). Similarly, although the principal dentist had many years of experience in treating children they were not a specialist in the area of children's' dentistry.

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 GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, dental technicians, and orthodontic therapists.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the treatment themselves and accepted referrals for treatment under conscious sedation and oral surgery (with or without conscious sedation).

Conscious sedation referrals received to the practice were triaged by the lead sedationist who was a medical doctor. They individually risk assessed each referral based on patient factors and dental factors before deciding whether they could be treated in a primary care setting (the practice). Rejected referrals were returned to the referring dentist in a timely manner.

Referrals made to the practice for minor oral surgery were triaged by the oral surgeons, again if treatment was considered too complex for a primary care setting the referral would be returned to the referring dentist without delay. If on the day of the appointment it became clear that the patient was not suitable to be treated in primary care a referral would be made to secondary care.

Referrals for suspicious lesions were made by fast track email to the hospital which was then followed up by a phone call from the practice to ensure it had been received.

Consent to care and treatment

We spoke to clinicians about how they obtained full, educated and valid consent to treatment. Comprehensive discussions took place between clinicians and patients where the options for treatment were detailed. However these were not always fully detailed in the patient care record.

Patients attending for minor oral surgery signed a written consent form indicating the risks in treatment.

Having been referred and triaged for conscious sedation most patients were sent information through the post detailing what to expect from their sedation appointment and giving instructions for before the sedation and after the treatment is complete.

On the day of the appointment patients were assessed by the sedationist and dentist and their understanding of the procedure and treatment confirmed. If everyone was happy for treatment to go ahead a consent form was signed and treatment commenced. The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015' advises that consent should only be obtained on the day of conscious sedation and treatment in an emergency situation and should routinely be sought before the day of the procedure. This would ensure that patients had adequate time to consider their options.

Are services effective?

(for example, treatment is effective)

Clinicians we spoke with demonstrated a good understanding of the situations where a child under the age of 16 may be able to consent for themselves. This relies on an assessment of their understanding of the procedure and the risks and benefits of having/ not having the treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Comments that we received from patients indicated consistently that the care and treatment they received was of a high standard. Staff were described as helpful, friendly and professional, and comments indicated that the dentists are very understanding and skilled at treating nervous patients. We witnessed patients being spoken to in a polite and courteous manner.

We discussed and witnessed how patients' information was kept private. The computers at the reception desk were below the level of the counter so they could not be overlooked by anyone stood at the desk. Reception staff demonstrated how paper records were kept out of sight and filed away in a timely manner.

Reception staff explained how they took care when speaking to patients on the telephone as a potential situation where care had to be taken not to divulge private information. In addition sensitive discussions with patients in the practice were taken away from the reception desk where they could be overheard by other patients in the waiting room, and would take place in private.

These measures were underpinned by practice policies on privacy and dignity and data protection.

Staff we spoke with were proud of the practice's team approach to treating nervous patients which started when they were on the phone or walked into reception and first spoke with a receptionist and continued through the clinical processes to discharge.

Patient dental care records were in paper form, and were stored in staff areas where patients did not access, however, they were not secured from external cleaning contractors. Following the inspection the areas where dental care records were stored were locked at night and staff undertook cleaning of these areas themselves.

Involvement in decisions about care and treatment

Following examination and discussion with the clinician patients were all given a copy of a treatment plan to consider.

Comments received from patients indicated that they felt listened to and dentist took the time to respond to their concerns.

The NHS and private price list was displayed in the waiting area.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered.

At the time of the inspection the practice were taking on new NHS patients, and patients could expect to be offered a new appointment within a couple of days of contacting the service.

Patients referred for minor oral surgery could expect to receive an appointment within a couple of weeks of referral and patients referred for conscious sedation could look to receive an appointment within a month.

Patients were able to contact the practice by telephone, but also a contact form was available on the website and the practice would contact the patient back.

We examined appointments scheduling and found that although busy there was enough time allocated for assessment and discussion of the patients' needs.

The practice offered general dental appointments and hygienist appointments on a Saturday once a month. This afforded flexibility to patients who had commitments during normal working hours.

A patient commented that staff went out of their way to arrange appointments at a convenient time for patients.

The waiting area had a range of toys and books for children.

Tackling inequity and promoting equality

Staff we spoke with expressed that they welcomed patients from all backgrounds and cultures, and all patients were treated according to their individual needs.

The practice had undertaken a disability discrimination audit which had highlighted that two treatment rooms were accessible on the ground floor for patients who used wheelchairs or had restricted mobility. In addition the car park had direct access to the basement treatment room which staff told us was a preferred access route by some patients.

The practice were open and flexible in their approach, and were happy to swap treatment rooms for patients so that they could be seen more easily.

The practice had access to interpreting services to assist those patients for whom English was not their first language. However, they did not have a hearing loop in the reception area to assist patients that used hearing aids.

Access to the service

The practice was open from 9 am to 5 pm Monday to Friday and on Saturday mornings once a month.

Emergency slots were set aside daily and the practice endeavoured to offer an appointment to any emergency patient on the day they contacted. Staff always endeavoured to arrange an emergency appointment with the patient's own dentists, but in the event that they were not available an emergency appointment would be offered with another clinician.

Out of hours arrangements were available for patients to hear on the answerphone. The arrangements in place were to contact the NHS 111 out of hour's service.

Concerns & complaints

The practice had a complaints policy dated for review in September 2017 which gave information for staff in how to handle complaints. A separate guide for patients in how to make a complaint was displayed in the waiting area and included contact numbers for patients to raise a complaint external to the practice.

Patients were also invited through the web page to give feedback and negative feedback would be handled in line with the practice policy.

We saw records of recent complaints made to the service. These were investigated and fed back to the complainant, with apologies where necessary in line with the practice policy.

Complaints were discussed in staff meetings to attempt to reduce the chance of reoccurrence.

Are services well-led?

Our findings

Governance arrangements

The principal dentist took responsibility for the day to day running of the practice, supported by the practice manager and the reception manager. In addition other staff members had been assigned lead roles in areas of the practice. We noted clear lines of responsibility and accountability across the practice team.

The practice had a meeting every one to two months. Staff were able to request topics to discuss at these meetings and minutes were taken to feedback to any staff member who was unable to attend.

The practice had policies and procedures in place to support the management of the service, and these were available for staff to reference in hard copy form. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults, data protection and whistleblowing. All policies had been reviewed in the previous year.

Governance arrangements had not recognised that certain required risk assessment and clinical audits had not been completed within the required timescales (although they were completed following the inspection).

Leadership, openness and transparency

Staff we spoke with reported an open and honest culture across the practice and they felt fully supported to raise concerns with the principal dentist or practice manager. Staff we spoke with indicated that the management team were very open to taking on views and opinions from all members of staff.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern, including the contact details of outside agencies where a staff member could obtain independent advice. The policy was due for review in September 2017 and was available for staff to reference in the policy folder.

Staff we spoke with were clear on their responsibilities to raise concerns about co-workers if they had them, and who they would contact should they wish to speak to someone external to the practice.

Patients were individually risk assessed for conscious sedation. One of the final checks before commencing the sedation the sedationist would discuss the patient with the team involved in the sedation and confirm with them that they were all happy. If a team member had a concern about any aspect of the sedation or treatment of the patient they were empowered to raise that concern.

Learning and improvement

The practice sought to continuously improve standards by use of quality assurance tools, and continual staff training.

Clinical audits were used to identify areas of practice which could be improved. An audit of X-ray quality had been carried out in 2016, and reported results on line with national standards. However the audit was not operator specific and so would not necessarily recognise if one clinician was scoring lower than another.

The practice had undertaken infection control audits, most recently on September 2014. The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health requires that these audits should be carried out every six months. Following the inspection the practice completed an infection control audit and assured us that these would be carried out at six monthly intervals going forward.

The practice had carried out several audits in relation to the provision of conscious sedation. Most recently (May to August 2016) they audited the use of an inhalation sedative on children assessing its safety and effectiveness as a dental sedative.

Across 2014 the practice audited every patient that underwent sedation, the type of sedation they received, outcomes and if any adverse events happened.

The practice used an online monitoring system to track the continuous professional development needs of all staff, this would flag up any required training that was about to expire.

The practice had comprehensive in house training in regard to conscious sedation. A training folder contained protocols pertaining to all aspects of conscious sedation including how to set up the equipment and change to gas

Are services well-led?

cylinders, the use of particular sedative medicines, protocols for the treatment of patients with particular medical conditions and protocols or assessing certain higher risk groups of patients for sedation.

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

The practice sought feedback for patients and staff through various sources. They invited comment through the NHS friends and family test and the results of this were displayed in the reception area of the practice.

In addition reception held a comments book and invited remarks from patients and periodically patient questionnaires were utilised to ascertain any concerns with the service.

The practice website also invited comments anonymously or otherwise by way of a web form.