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Rudgwick Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 November 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

Rudgwick Dental Practice was established 18 years ago. It is located on the first floor of a purpose built medical centre and comprises of two surgeries, a separate decontamination room, an office and a reception area combined with the waiting room. The practice provides general NHS dentistry to the local population and private dentistry either on a fee per item or through a practice payment plan. The practice also has a private contract with a local Japanese school.

There is one full time principle dentist, two part time associate dentists, a hygienist, and a dental therapist. The practice employs four qualified dental nurses and a practice manager who is also a qualified nurse. The principle dentist is also the registered manager. 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.

The practice is open Monday to Friday 8.45am 5.30pm. In 2014 the practice introduced an additional clinic on Mondays from 5.30pm to 8pm to provide an opportunity for NHS examinations outside normal working hours. The practice is open alternate Saturdays from 9am to 1pm for private patients.

Summary of findings

We reviewed 26 completed Care Quality Commission (CQC) comment cards and obtained the views of seven patients on the day of the inspection. Patients commented on the caring, friendly nature of professional staff delivering an excellent service.

Our key findings were:

- The practice appeared visibly clean, was bright and clutter free.
- Staff were polite, friendly and kind. Staff had an excellent knowledge of their patients.
- Staff had made all reasonable adjustments to enhance access to the practice and provided domiciliary visits when required.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Staff had been trained to deal with medical emergencies and emergency medicines and equipment were readily available.
- Patients were able to make routine and emergency appointments when needed.
- Infection control procedures exceeded published guidance.
- Clinical staff had the necessary skills to carry out their duties in line with the requirements of their professional registration.
- Dental nursing staff had completed extended duties to perform enhanced roles.
- The governance arrangements for the practice were extremely organised and efficient.
- Information from 26 completed Care Quality Commission (CQC) comment cards gave an entirely positive picture of a friendly and caring service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice operated effective systems for recording and reporting significant events and accidents. Staff had a good understanding of necessary policies and procedures to follow including the reporting of injuries diseases and dangerous occurrences regulations (RIDDOR) 2013. The principle dentist acted as the safeguarding lead and all staff understood their responsibilities for reporting any suspected abuse. Medicines and equipment for use in a medical emergency were stocked in addition to mandatory requirements and were being appropriately checked. Staff were confident in dealing with a medical emergency. Staff were suitably qualified for their roles and staff were meeting the regulations as set out by the dental professionals' regulatory body, the General Dental Council (GDC). The practice maintained an effective system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. Essential quality requirements for infection control were being exceeded. Equipment checks were carried out in line with the manufacturer's recommendations and medicines were stored appropriately. All elements necessary for the safe working of X-ray units were present.

No action ✓

Are services effective?

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

The dental care provided at the practice focused on the needs of the patients. The practice integrated current professional guidance such as that issued by the National Institute of Care Excellence (NICE). The practice updated patients' medical histories at each examination. Patients' oral health was monitored and the practice was committed to providing a minimally invasive approach to treatment through promoting better oral health. Staff maintained their continuing professional development (CPD) training appropriate to their roles and learning needs and some staff had undertaken additional training to allow them to work in extended duty roles. Dentists referred patients onto primary and secondary services as necessary. All staff understood the principles of informed consent.

No action ✓

Are services caring?

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

We obtained the views of 33 patients who had recently received treatment at the practice. They gave an entirely positive view of the practice. Patients commented on the kind, caring, professional and excellent service they received. We observed staff being very welcoming and friendly when patients came in to the practice. It was evident that the staff knew their patients very well and maintained good patient-dentist relationships.

No action ✓

Are services responsive to people's needs?

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

No action ✓

Summary of findings

The practice had a well organised booking system to respond to patients' needs. There was an effective system for dealing with patients' emergency dental needs.

There was a procedure for responding to patients' complaints and this information was clearly visible for patients attending the practice. Information on the fees for both private and NHS treatment was clearly displayed.

The practice had worked hard to make every reasonable adjustment to enable access to the practice and completed domiciliary visits when necessary. The practice had opened an extended hour's clinic to provide an opportunity for NHS examinations outside of normal working hours.

Are services well-led?

No action

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

Leadership at the practice was provided by the principle dentist and practice manager. The governance arrangements such as policies and procedures for the practice were well organised and effective. All staff had good understanding of these. The culture of the practice encouraged openness and the team worked closely together and were happy working at the practice. Staff commented that they felt listened to and that their learning needs were supported. The practice actively sought feedback from staff through staff satisfaction surveys.

The practice shared learning through formal team meetings and a structured plan was in place to audit quality and safety.

The practice ethos focussed on providing patient centred care and patient feedback was sought verbally and through utilising the NHS Friends and Family Test (FFT).

Rudgwick Dental Practice

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.

The inspection was carried out on 17 November 2016 by a CQC inspector who was supported by a specialist dental advisor.

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

During the inspection, we spoke with the principle dentist, dental nurses, a receptionist and the practice manager. We reviewed policies, procedures and other documents. We also reviewed 26 comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice. We obtained the views of seven patients on the day of the inspection. We carried out a tour of the practice observing the decontamination procedures for dental instruments. We looked at the storage of emergency medicines and equipment. We were shown the systems which supported patients' dental care records.

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 an effective system for the reporting of and learning from serious incidents. All staff we spoke with had a good understanding of the reporting of injuries diseases and dangerous occurrences regulations (RIDDOR) 2013. All staff were clear in the actions they should take should a serious incident happen at the practice.

Each surgery had its own log book for the reporting of any incidents. The practice manager told us that this was to ensure that no incidents were missed. Should an incident happen we were told that the practice would review their systems to assess whether a change in practice could prevent recurrence. The practice had a significant events and accident reporting policy as well as major incidents response procedure. All were reviewed in July 2016. We saw the practice accident book. No accidents had occurred within the last year but previous accidents had been completed appropriately and there was evidence of learning from these to prevent recurrence.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Agency (MHRA). The practice manager was able to tell us about recent alerts which were relevant to dental practices and demonstrated that the practice kept up to date with necessary information and shared this with staff via regular staff meetings.

Reliable safety systems and processes (including safeguarding)

The practice had very organised and effective safety systems and processes and was proactive in its approach to preventing risk. The practice had a thorough general health and safety risk assessment and all necessary policies and procedures were regularly updated.

The practice policy for prevention and management of blood-borne virus exposure was reviewed in October 2016. We spoke with dental nurses on duty about the prevention of needle stick injuries. They told us that the practice used safer sharps which are not manually resheathed following use. They explained that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice had a sharps risk assessment which was reviewed in July 2016. There was evidence of risk reduction following completion of this assessment. Used sharps containers were collected by an appropriate waste disposal company.

We asked the principle dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed guidance issued by the British Endodontic Society in relation to the use of a rubber dam where practically possible. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice was latex free and used latex free rubber dams.

The principle dentist acted as the safeguarding lead and as a point of referral should a safeguarding issue be encountered. A policy was in place for staff to refer to which contained the necessary contact details and protocol should a member of staff identify a person who may be the victim of abuse or neglect. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. The practice policies for safeguarding children and adults had been reviewed in October 2016. As a result local safeguarding contact details were changed. This information was kept on display in the office where staff could easily access it. Staff demonstrated a good understanding of safeguarding issues and the protocols to follow. The practice manager gave one example where staff had been proactive in identifying a potential safeguarding risk and had used the protocol to respond to this appropriately.

A full fire risk assessment had been completed by an appropriate company in 2010. All necessary actions had been taken. The assessment contained individual risk assessments for specific hazards such as the use of the autoclave (a device for sterilising dental and medical instruments) and compressed gases. A fire evacuation procedure had been carried out recently. The risk assessment was reviewed regularly and most recently in October 2016. A fire safety audit had been carried out and there was evidence of action plans being completed. For example, the risk assessment had identified the need for a new fire exit directional sign. The practice had

Are services safe?

subsequently arranged for this to be fitted. A weekly fire alarm test was carried out and a log of this was available for us to see. Fire fighting equipment was checked on an annual basis.

Medical emergencies

The practice had appropriate arrangements to deal with medical emergencies and the medical emergencies policy had been reviewed in September 2016. All staff were up to date with their medical emergencies training and when asked were confident in how they would deal with a medical emergency. The practice itself did not have an automated external defibrillator (AED). This had been risk assessed by the practice and because the medical centre located downstairs had this equipment, it was unnecessary for the dental practice to hold an additional device. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

The practice had access to emergency oxygen and other equipment as set out in the Resuscitation Council UK guidelines. The practice also had access to additional equipment such as a pulse oximeter and a blood pressure monitoring machine. The working conditions of the oxygen cylinder were checked as per the guidelines. All emergency medicines as set out in the British National Formulary (BNF) guidance for dealing with common medical emergencies in a dental practice were present. The practice had an efficient system for storing these medicines in separate labelled boxes which were clear for all to use. We also saw that the practice had a medical emergency handover sheet to provide to ambulance staff should they attend the practice.

Staff Recruitment

All clinical staff had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy which contained all necessary details as per regulatory guidance. The policy detailed the checks to be undertaken before a person started work. These included proof of identity, establishing the right to work in the United Kingdom, professional body registration, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and obtaining references.

All staff had been individually risk assessed and Disclosure and Barring Service checks (DBS) completed as appropriate. The Disclosure and Barring Service carries out checks to 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.

The practice had a loyal and established team of staff who had been at the practice for many years.

Monitoring health & safety and responding to risks

The practice had thorough and effective arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice.

The practice had a Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients. This was updated with new risk assessments as required. All of the assessments were available online and the overarching risk assessment had been reviewed in January 2016.

Infection control

There were effective systems to reduce the risk and spread of infection within the practice. The practice had an infection control policy in line with HTM 01 05 (national guidance for infection prevention control in dental practices) which had been reviewed in October 2016.

The practice had a large, well equipped decontamination room. This allowed complete separation of dirty and processed instruments and equipment. A member of staff showed us the procedures involved in disinfecting, inspecting and sterilising dirty instruments. Essential Quality Requirements for infection control were being exceeded. Instruments were transported in locked containers from the surgeries to the decontamination room. They were then manually cleaned before being rinsed in a separate sink and then placed in an ultrasonic cleaner (ultrasonic cleaning is the rapid and complete removal of contaminants from objects by immersing them in a tank of liquid flooded with high frequency sound waves). Instruments were then inspected under a magnifying glass before being placed in an autoclave (a device for sterilising dental and medical instruments).

Are services safe?

Instruments were then packaged and date stamped and were stored in clean transport boxes to be taken back to the relevant surgeries. The practice had a good system of storing instruments that provided ease of finding the correct instrument with minimal handling and effective stock rotation.

We were shown the systems to ensure that the autoclaves used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

We found that all treatment rooms, waiting areas, reception and toilets were very clean, tidy and clutter free. Dirty to clean zones were clearly defined in all treatment rooms. Each treatment room had the appropriate personal protective equipment available for staff to use. This included protective gloves, masks, aprons and eye protection.

Staff were responsible for carrying out the environmental cleaning of the premises and a cleaning rota was seen. The cleaning schedule of the decontamination room demonstrated daily, weekly and monthly tasks which had been completed. The practice cleaning plan was reviewed annually and the environmental cleaning followed their policy and procedures and was colour coded as appropriate.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Clinical waste was kept in separate locked containers with all necessary risk assessments having been completed. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice employed an appropriate healthcare waste contractor to remove clinical waste from the practice. Consignment notices for this were seen.

An infection prevention audit was carried out on a six monthly basis. The most recent results demonstrated 96% compliance. An action plan had been developed to further improve on this score.

We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2012. This had been updated recently and we saw management review certificiates issued by a water specialist company. A risk assessment for domestic water had been carried out, no actions were required. Dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria. Water temperature had been recorded on a weekly basis as per the recommended procedures outlined in the risk assessment; and digitally logged. These measures ensured that patients and staff were protected from the risk of infection due to Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Equipment and medicines

We saw that the practice had a suitable amount of instruments. All instruments labelled as single use were used once and discarded appropriately. The practice had plenty of personal protective equipment (PPE) available such as protective gloves, masks and eye protection as per its PPE policy.

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, we saw records that weekly tests were being carried out on the autoclave and ultrasonic bath. We saw maintenance and service certificates for all essential equipment such as X-ray sets, autoclaves and ultra-sonic cleaners as well as the pressure vessel certificate. For example, the autoclaves had been serviced and calibrated in July 2016. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in November 2015.

The practice had emergency medicines in line with the Resuscitation Council UK guidelines. These were all in date and stored in a location known to all staff. We saw that the batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. The practice did not keep antibiotics or medicines in stock except the emergency medications. Private prescriptions were issued on a computer which was password protected.

We saw that the practice had suitable equipment to deal with minor first aid problems and bodily fluids and mercury spillage safely in line with the practice policies.

Radiography (X-rays)

We were shown a radiation protection file in line with the Ionising Radiation Regulations 1999 (IRR 1999) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER

Are services safe?

2000).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary records relating to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the maintenance logs, Health and Safety Executive (HSE) notification and a copy of the local rules. The local rules describe the operating procedures for the area where X-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each X-ray set on the premises. The local rules set out the dimensions of the controlled area around the dental chair/patient; and state the lowest X-ray dose possible to use. Applying the local rules to each X-ray taken means that X-rays are carried out safely. The X-ray units are contracted for safety and performance checks with an approved company who is also the Radiation Protection Advisor.

We saw training records that showed that all staff where appropriate had received necessary radiography training to maintain their knowledge under IRMER 2000 and IRR 1999 regulations. A radiography audit had been carried out in August 2016. This demonstrated that staff were justifying, reporting on and quality assuring their X-rays as well as documenting the outcome for the patient.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with the principle dentist on the day of our inspection. They told us that their consultations, assessments and treatments were carried out in line with recognised professional guidance. We saw evidence of this in patients' dental care records.

Patients' medical histories and consent were updated at each examination utilising a computer system and tablets which patients signed. Paper copies were also available.

The dentist started the patient assessment by reviewing the patient's medical history. This included noting any medical conditions suffered, medicines being taken and any allergies the patient had. They then examined the patient's teeth, gums and soft tissues and signs of oral cancer were checked. The dentists used screening tools such as the Basic Periodontal Examination (BPE) and carried out a caries risk assessment. These are widely used tools to assess the risk of dental decay and conditions of the gums. These tools helped the dentists to systematically check and monitor any changes in the patients' soft and hard tissues. This information would then be used to determine at what intervals patients would need to attend for further checks and screenings and recall intervals followed National Institute for Health and Care Excellence (NICE) guidelines.

We saw in the patients' dental care records that these findings, together with the findings of any X-rays taken, where applicable; were used to create a treatment plan. There was evidence in the records that this was discussed in detail with patients alongside information on any cost estimates and that patients were required to sign to acknowledge that they had received this information.

The practice had a very clear record keeping policy which was updated in July 2016. The policy gave details of the information which clinicians were required to record and this was in addition to that required by the GDC. We saw evidence in patients' dental care records that clinicians complied with the policy. In addition to mandatory audits required by the dental professional's regulatory body the practice also carried out a clinical record audit. As a result of this audit the practices' system for recording information on alcohol consumption and smoking was amended.

Health promotion & prevention

The practice was very focussed on the prevention of dental disease and the maintenance of good oral health and was committed to adopting the protocols of the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The practice appointed a dental hygienist to work alongside the dentists. Clinicians worked to the principle of providing a minimally invasive approach to treatment through promoting better oral health.

The principle dentist told us that children at high risk of tooth decay were offered fluoride applications to keep their teeth healthy. They placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children) on the teeth of children particularly vulnerable to tooth decay. They prescribed high concentration fluoride toothpaste where appropriate to adults where a high risk of dental decay had been identified. Where relevant, preventative dental information such as general oral hygiene instructions and brushing technique advice was given. Dentists referred patients to the hygienist as appropriate.

We saw evidence in patients' dental care records that clinicians provided dietary advice as well as advice on smoking cessation and reducing alcohol consumption. This was supported by a wide range of posters and patient information in the waiting area of the practice. A range of oral health products were sold.

Staffing

In addition to the principle dentist the practice employed two part time associate dentists, a dental therapist who assisted with children's treatment, a hygienist and four dental nurses; one of which performed a dual role as receptionist. The practice manager is also a registered nurse and there is a part time receptionist. A locum nurse also works on a regular basis. In times of absence staff worked very well as a team to provide necessary cover. When working the hygienist was supported by a dental nurse.

There was an induction programme for new staff members. Staff were encouraged to maintain their own records of continuing professional development (CPD), confirmation of General Dental Council (GDC) registration and current professional indemnity cover where applicable.

The Care Quality Commission comments cards we received reflected that patients had the upmost confidence and trust in the clinicians.

Are services effective?

(for example, treatment is effective)

Working with other services

The dentists explained to us how they would work with other services. We saw that there was a good referral process to primary and secondary services in both Surrey and Sussex as the practice covered both counties. The referral details were recorded and evidence was seen of referral letters to specialists and copies given to patients. We saw evidence that the referrals were tracked and recall time frames followed those set out in National Institute for Care Excellence (NICE) guidelines. Most referrals were electronic.

The practice had excellent links with other practices and reciprocal arrangements in place for patients unable to access the service or for business continuity plans.

Consent to care and treatment

The staff we spoke with explained to us the processes they used within the practice to ensure that the principles of informed consent were implemented at each point of dental care delivery. We reviewed dental care records and saw evidence that dentists explained individual treatment options, risks, benefits and costs and that where appropriate patients signed consent forms.

Staff demonstrated an understanding of the principles of the Mental Capacity Act (MCA) 2005. We saw evidence in the staff records of attendance at MCA training. Staff told us how its guidelines would inform their work with patients who may suffer from any mental impairment that may mean they might be unable to fully understand the implications of treatment.

Staff were familiar with the concept of Gillick competency with regards to gaining consent from children under the age of 16. The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The practice's consent policy had been reviewed in April 2016.

Clear information on any costs of treatment was available in the patient waiting area, practice website and patient information leaflet.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed staff in the reception area. It was evident that staff knew their patients very well and to the extent that a patient was known by the sound of their voice on the phone before they had said who they were. Staff were observed to be polite, friendly and provided a welcoming and relaxed greeting. The practice confidentiality and data protection policies were updated in September 2016 and we saw evidence that staff complied with these. Staff ensured patients confidentiality and did not recite personal information. Computers were password protected and regularly backed up. The reception computer screen was not visible to patients. Paper records were stored in lockable cupboards. Treatment rooms were situated away from the main waiting area and doors remained closed at all times when patients were present. Conversations between patients and dentists could not be overheard.

We collected 26 completed CQC patient comment cards. We obtained the views of a further seven patients on the day of the inspection. These provided an entirely positive view of the service. From the feedback we received it was evident that staff had an excellent relationship with their patients. Patients commented on the friendly and helpful staff and reported that they felt listened to, cared for, that staff treated them with dignity and respect and that treatment was thorough but gentle.

Involvement in decisions about care and treatment

We saw evidence in the dental care records we looked at that dentists discussed the findings of their examinations and corresponding treatment plans thoroughly with patients. All treatment options available were discussed before the treatment started and treatment plans signed by patients as appropriate. We saw that clear information was given to patients on any fees applicable. Posters and patient information leaflets in the waiting area provided clear information on the costs of both NHS and private treatment. In feedback we received from patients they told us that treatment was explained thoroughly and that they were given time to think about any treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a well organised booking system with no evidence of overbooking. This included dedicated daily emergency appointments. The dentists decided how long a patient's appointment needed to be and took account of any circumstances which may have impacted upon the length of time needed such as patient nervousness or complexity of treatment.

We reviewed the clinical records for patients who attended emergency appointments and saw that patients were given clear explanations for their dental issues and treatment options.

The practice waiting area clearly displayed information on opening hours, out of hour's access, complaints and the fees for private and NHS treatment. This information was also found in the patient information leaflet and on the practice website.

The patient information leaflet also contained information on methods of payment, contact details, confidentiality and information on encouraging optimum oral health. Fire procedures were clearly signposted. The Friends and Family Test questionnaire cards were accessible on the reception desk. Previous results were not displayed in the waiting area but were displayed on the practice website.

Tackling inequity and promoting equality

The practice had a policy for persons with disabilities to ensure that they met the needs of their patients. This had been reviewed in January 2016. The practice had made all reasonable adjustments including seeking advice on whether they could put a stair lift in the premises to provide easier access from the medical centre downstairs to the dental practice upstairs. We were told that the local council could not grant this. In addition, the practice had a disability and discrimination act access policy statement and action plan. Patients who were no longer able to attend the practice were referred to another practice locally; however, the principle dentist completed domiciliary visits for general dental treatments only. On these occasions the principle dentist told us that the patient was always accompanied by a family member or friend.

The practice had an equality, diversity and human rights policy which was reviewed in May 2016. The practice also had contact details of local interpreting services and an interpreter and consent policy was seen for the Japanese school which the practice had a private contract with.

Access to the service

The practice was open from 8.45am – 5.30pm Monday to Friday. There was an additional clinic on Mondays from 5.30pm to 8pm and on alternate Saturdays from 9am to 1pm for private patients.

The practice had a system for patients requiring urgent dental care when the practice was closed. Patients were signposted to the 111 service or a number of clinics in the local area. Additionally, the practice was part of an on-call rota system that offered a call-out service to any patient on a private basis. Out of hours information was available on the telephone system and visible in the waiting area and on the practice website.

Concerns & complaints

The practice had a clear complaints policy and procedure which was reviewed in April 2016. This set out how complaints would be addressed, who by and the time frames for responding. The contact details for external agencies such as NHS England and the Dental Complaints Service were also provided. Information for patients about how to make a complaint was seen in the waiting area and on the patient information leaflet. This information was also available in full on the practice website.

We saw that the practice had received two complaints within the last year. These were dealt with as per the practice complaints policy and were not regarding clinical treatment.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for the day to day running of the practice. The practice used a compliance tool to store and review their governance documents. We found that the governance arrangements for the practice were very organised and effective. All necessary policies were in place and reviewed regularly. All of the staff we spoke with were aware of the practice policies and procedures and there were processes in place to ensure that all staff were made aware of any updates. The practice had gone to great lengths to ensure that all possible risks had been identified and assessed to ensure the safety of patients and staff members. For example, we saw risk assessments relating to trainee dental nurses, fire, manual handling, hand hygiene, violence and harassment and pandemic flu. The practice's COSHH file was reviewed and up to date. It was evident that the practice reviewed these systems regularly in order that any improvements could be made.

The practice had a clear business contingency plan which was reviewed in November 2016. This gave details of other practices that had agreed to allow Rudgwick Dental Practice to use their premises in the event that their own premises could not be used. It also gave details for external contacts such as the local primary care trust, dental committee and suppliers.

Leadership, openness and transparency

Leadership was provided by the principal dentist and practice manager. The practice ethos focussed on understanding the needs of the practice patient population and providing patient centred care in a relaxed and friendly environment. The culture of the practice encouraged candour. It was evident that the staff were very happy working at the practice and worked as a close team. Staff told us that communication between management and staff was very open and transparent. Staff we spoke with said that they felt listened to and supported in their roles and comfortable and confident to raise any concerns they may have, but that they rarely had any concerns.

The practice had necessary policies relating to duty of candour and whistleblowing and staff we spoke with were aware of processes to follow.

Learning and improvement

New staff received a practice induction and there was evidence in the staff records that continuing professional development (CPD) training was maintained in line with the practice CPD and training policy and General Dental Council regulations. Individual staff had responsibility to maintain their own CPD but we were told that the practice was implementing a training log to track and identify staff training needs. Staff we spoke with told us that they felt their learning needs were supported in the practice and we found that staff were proactive in their own learning and development. Some staff had completed courses in addition to their mandatory training requirements that gave them opportunities to work in extended dental nursing roles.

We reviewed staff appraisals and found that staff did not always have an action plan or personal development plan. The practice manager told us that staff were due for their annual appraisals in November and December and that this process would be formalised and that staff would receive an action plan for the upcoming year.

The practice held formal staff meetings every six weeks. These were rotated on different days allowing part time staff the opportunity to be present. Minutes for each meeting were recorded and emailed to all staff to ensure that information was shared. We saw evidence that meetings were used to share any feedback that had been received from patients, to discuss any complaints or incidents and how the practice could learn from these and how improvements to the running of the practice could be implemented. We could not always identify whether actions had been completed. We brought this to the attention of the practice manager who would review previous actions at future meetings.

The practice had a structured plan in place to audit quality and safety and was carrying out audits in addition to those that are mandatory. For example fire safety, clinical records and dental unit water lines audits had been completed. We saw evidence that for all audits a clear action plan was in place in order for the practice to learn and improve.

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

The practice was committed to assuring quality and sought feedback from its staff through a yearly staff satisfaction survey. Results found that staff confidence in the practice

Are services well-led?

and communication amongst the practice staff was high. Staff we spoke with reported feeling happy and confident to provide feedback to the principal dentist and practice manager. They told us that this was acted on quickly. For example, part time reception staff found that information was sometimes not documented or shared amongst the part time staff and as a result actions not completed. Reception staff fed this back to the manager and a system was implemented to ensure that information was shared in an effective way.

The practice undertook the NHS Friends and Family Test (FFT). This is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. Results of this test were available on the practice website.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.