SpaDental Southampton Ltd

SpaDental Southampton

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 December 2016 to ask the practice the following key questions;

Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Spa Dental Southampton is a dental practice providing NHS and private treatment for both adults and children. The practice is based in a retail unit in Southampton, a town situated in south Hampshire.

The practice has three dental treatment rooms. One of which is based on the ground floor and two separate decontamination rooms used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs three dentists, two hygienists, one dental nurse, one trainee dental nurse, one decontamination assistant, two reception staff and a practice manager who is also a registered dental nurse.

The practice's opening hours are between 9am and 8pm on Monday, 9am and 5pm Tuesday and Wednesday, 8am and 5pm Thursday and 8am and 2pm on Friday.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

Summary of findings

The provider, Mr. John Webley, is registered as an individual and is legally responsible for making sure that the practice meets the requirements relating to safety and quality of care, as specified in the regulations associated with the Health and Social Care Act 2008.

We obtained the views of 15 patients on the day of our inspection.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Leadership was provided by a recently appointed empowered practice manager and the practice owner.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.
- The practice appeared clean and well maintained.
- There was appropriate equipment for staff to undertake their duties, and equipment was properly maintained.
- Infection control procedures were effective and the practice followed published guidance.
- The practice had a safeguarding lead with effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the practice owner.
- Staff we spoke with felt well supported by the practice owner and the practice manager and were committed to providing a quality service to their patients.
- The practice generally had effective clinical governance and risk management structures in place. These were considered as work in progress because the practice owner had recently acquired full ownership of the practice from a corporate body.

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

- Review arrangements for accessing the practice website to bring it up to date.
- Consider providing details of all the dentists working at the practice including their General Dental Council (GDC) registration number in accordance with GDC guidance issued in March 2012 on NHS Choices website.
- Review patient information and responses to patient comments on the NHS Choices website.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the availability of hearing loops for patients who are hearing aid users.
- Provide an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.
- Review the safety arrangements of the window blinds in the practice, this could include either ensuring the pull cords are made secure or carrying out a suitable risk assessment in relation to the pull cords.
- Consider making the first-floor decontamination room secure to prevent unauthorised access to substances under the control of substances hazardous to health by the public.
- Review the system of pre-employment checks to ensure that any gaps in employment history are explored prior to new staff commencing employment at the practice.
- Provide a recruitment policy for the new organisation.
- Review the fire safety governance systems and processes for the practice including fire safety training.
- Review the security of the domestic waste bin adjacent to the practice as this presents an arson risk.
- Review the ordering arrangements for emergency medicines so that they are replaced in a timely manner.

Summary of findings

- Consider replacement of the carpet on the first-floor landing and the area at the bottom of the stair on the ground floor to prevent trips slips and falls by the public and members of staff.
- Consider repair of the cover to the hygienist stool.
- Consider carrying out a systematic review of all policies to ensure that they contain a date and version number.
- Promote the greater use of the Family and Friends Test as part of the ongoing system for seeking the views of patients on the quality of care provided by the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had arrangements in place for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found that all the equipment used in the dental practice was well maintained.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

No action

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs.

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 15 patients on the day of our visit. These provided a positive view of the service the practice provided.

All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

No action

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and took these into account in how the practice was run.

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

The practice had one ground floor treatment room and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

No action

Summary of findings

Are services well-led?

No action

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

Leadership was provided by the practice owner and empowered practice manager. Staff had an open approach to their work and shared a commitment to continually improving the service they provided.

There was a no blame culture in the practice. The practice generally had effective clinical governance and risk management structures in place. These were considered as work in progress because the practice owner had recently acquired full ownership of the practice from a corporate body.

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council.

Staff told us that they felt well supported and could raise any concerns with the senior clinicians and practice manager. All the staff we met said that they were happy in their work and the practice was a good place to work.

SpaDental Southampton

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 13 December 2016. Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of seven members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of 15 patients on the day of our inspection.

Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

A practice manager demonstrated a good awareness of RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

Records showed that three accidents occurred during 2015-16 and were managed in accordance with the practice's accident reporting policy. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). Where relevant, these alerts were shared with all members of staff by the practice manager.

We discussed with the practice manager the action they would take if a significant incident occurred, they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Reliable safety systems and processes (including safeguarding)

We spoke to the practice manager about the prevention of needle stick injuries. 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 used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked a nurse how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The dentists followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

The practice had a safeguarding lead who was the point of referral should members of staff encounter a child or vulnerable adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults 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. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

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

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Although we did note that on the day of our inspection the practice was waiting for the delivery of a replacement for the expired Midazolam, an emergency medicine used to treat epileptic seizures. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the

Are services safe?

Resuscitation Council UK guidelines. The emergency medicines available for use along with the oxygen cylinder were all in date and stored in a central location known to all staff.

The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. Staff we spoke with demonstrated they knew how to respond if a person suddenly became unwell.

Staff recruitment

All dentists, the dental hygienists and the qualified dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body.

The practice did not have a recruitment policy that detailed the checks required to be undertaken before a person started work.For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We looked at five staff recruitment files and records confirmed staff had mostly been recruited in accordance with the regulations. We noted that employment history gaps were not recorded as being investigated for two staff. One member of staff did not have current medical indemnity in place. We have since received evidence to confirm this shortfall has been addressed.

Staff recruitment records were stored securely to protect the confidentiality of staff personal information.

We saw that almost all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are 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. We noted two non-clinical staff had not received DBS checks and three clinical staff's checks had been carried out by their previous employers. We have since received evidence to confirm this shortfall has been addressed.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a 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. Fire safety checks were carried out weekly. An annual fire drill was carried out in September 2016 but the staff present or evacuation time was not recorded. We were told staff training in Fire Safety had not been carried out. We spoke with the practice manager about these shortfalls and were assured a fire drill and training would be carried out as soon as practicably possible.

The practice had in place a well-maintained 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.

We noted the carpet on the first-floor landing and the area at the bottom of the stairs on the ground floor was ripped in places. Window blinds in the practice with hanging pull cords were insecure and available to unauthorised people. We noted that the domestic waste bin to the rear of the practice was not secure and could pose an arson risk. We pointed this out to the practice manager who assured us that this would be attended to as soon as practically possible.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice had in place a robust infection control policy that was regularly reviewed. It was demonstrated through direct observation of the cleaning process and a review of practice protocols that HTM 01 05 (national guidance for infection prevention and control in dental practices) Essential Quality Requirements for infection control was being met. It was observed that audit of infection control processes carried out in January and July 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the three dental treatment rooms, waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of two treatment rooms were inspected and these were clean, ordered and free from clutter. Each

treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors. A third room which was known as the hygienist's room contained a stool which was torn.

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

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in July 2016. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice had two separate decontamination rooms, one on each floor for instrument cleaning, sterilisation and the packaging of processed instruments. The first-floor decontamination room was not secure and could be accessed by patients and visitors.

The practice employed a decontamination technician to carry out the processing of contaminated instruments. They demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of an ultra-sonic cleaning bath and manual scrubbing using the two sinks model for the initial cleaning process in each decontamination room. Following pre-sterilisation cleaning instruments were inspected with an illuminated magnifier; the instruments were then placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure 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 complete and up to date. All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

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

We saw that general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

The practice carried out the placement of dental implants. We noted that the practice used a single use surgical drape pack system for patients undergoing the placement of dental implants to reduce the spread of infection. These packs consisted of single use surgical drapes to cover all non- essential areas of the treatment room and for the patient, surgeon and nurse gowns, head covers for both staff and patients. The practice also used single patient use surgical irrigant packs used in the placement of dental implants.

We found the practice did not produce an annual statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections and related guidance.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in July 2016. The practice's three X-ray machines had been serviced and

calibrated as specified under current national regulations during either 2014, 2015 and 2016 and were due to be tested again three years following their respective testing date.

Portable appliance testing (PAT) had been carried out in July 2016.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely.

The practice had in place a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions.

We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We saw that the practice carried out audit of the quality dental radiographs taken by the dentists. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. Both dentists we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient along with the various treatment options.

Where relevant, preventative dental information was given to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown to us by the dentists demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care.

Both dentists explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. Adults at a higher risk of tooth decay were prescribed high concentration fluoride tooth paste. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

They went on to describe the advice that they gave which included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This advice along with the preventative interventions such as optimum fluoride use and fissure sealants was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that the dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

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

We noted on NHS Choices the names of the dentists working at the practice did not include their General Dental Council (GDC) registration number in accordance with GDC guidance issued in March 2012.

All of the patients we asked told us they felt there was enough staff working at the practice. Staff told us there were enough staff. Staff we spoke with told us they felt supported by the practice owner and practice manager. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

Are services effective?

(for example, treatment is effective)

The practice employed three dentists, two hygienists, one dental nurse, one trainee dental nurse, one decontamination assistant, two reception staff and a practice manager who was also a registered dental nurse.

There was a structured induction programme in place for new members of staff.

The dental hygienist did not work with chairside support. We pointed this out to the practice manager and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team', specifically standard 6.2.2 working with other members of the dental team.

Working with other services

The practice manager explained how the dentists worked with other services. Dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers. These were maintained on the computerised records system. We saw examples of referrals made and found that the referral forms were completed in full and were appropriate for the clinical problem ensuring patients were seen by the right person, in the right place and at the right time.

Consent to care and treatment

Both dentists we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentists explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options.

The dentists went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed always when patients were with dentists.

Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored in an electronic format only. Computers which contained patient confidential information were password protected and regularly backed up to secure storage. The practice uploaded medical history forms, NHS and private treatment planning forms and any other correspondence into the patient's records, following which this confidential information was shredded.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of 15 patients on the day of our visit. These provided a complete positive view of the service the practice provided. All of the patients commented that the dentists were good at treating them with care and concern. Patients commented that treatment was explained clearly and the staff were caring and put them at ease. They also said that the reception staff were helpful and efficient. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area and on the practice website that detailed the costs of both NHS and private treatment.

The dentists we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable and estimates and treatment plans for private patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection, we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. The practice website also contained useful information to patients such as how to provide feedback to the practice, details of out of hours' arrangements and the costs of treatment under NHS and private care. We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist.

The dentists decided how long a patient's appointment needed to be and considered any special circumstances such as whether a patient was very nervous, had an impairment and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers that may hamper them from accessing services.

The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

To improve access for patients who found steps a barrier, the practice had level access at the rear of the building and a ramp available at the front. One treatment room was on the ground floor. Space did not allow for a wheelchair accessible toilet.

The practice did not provide a hearing loop for patients who used hearing aids.

Access to the service

The practice's opening hours were between 9am and 8pm on Monday, 9am and 5pm Tuesday and Wednesday, 8am and 5pm Thursday and 8am and 2pm on Friday.

We asked 15 patients if they were satisfied with the hours the surgery was open; all but one patient said yes. This patient said they did not know when the surgery was open.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information booklet kept in the waiting area, NHS Choices website and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. We asked 15 patients if they knew how to make a complaint if they had an issue and 10 said yes, four said no and one was not sure.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within three working days and a full response would be given in 28 days. We saw a complaints log which listed four complaints received over the previous year which records confirmed three had been concluded satisfactorily and one was ongoing.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of an empowered practice manager and the practice owner who was responsible for the day to day running of the practice.

The practice generally had effective clinical governance and risk management structures in place. These were considered as work in progress because the practice owner had recently acquired full ownership of the practice from a corporate body and the practice manager was relatively new in post. We did find some areas where improvements could be made, details of which are contained in the summary section of the report.

All the staff we spoke with were aware of the policies and how to access them. We noted management policies and procedures were mostly kept under review by the practice manager. There were a few instances where policies had not been dated because the practice was in a transition period due to a change of ownership.

Leadership, openness and transparency

Leadership was provided by the practice manager and the practice owner. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the practice owner. There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. We found staff to be hard working, caring and committed to the work they did.

Staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff reported that the practice manager was proactive and aimed to resolve problems very quickly. As a result, staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Learning and improvement

We saw evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example, we observed that all staff received an annual appraisal.

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control, clinical record keeping and X-ray quality. The audits demonstrated the practice had analysed the results to discuss and identify where improvement actions may be needed. For example, audit of the dental care records in September and October 2016 highlighted several shortfalls in terms of the detail recorded. Dental care records we saw on the day of our inspection showed that significant improvements had been made. Records we saw were detailed and fit for purpose.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Staff told us that the practice ethos was that all staff should receive appropriate training and development.

The practice owner encouraged staff to carry out professional development wherever possible. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and participating in online courses.

The practice ensured that all staff underwent regular mandatory training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and dental radiography (X-rays).

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area.

The practice was listed on NHS Choices website. Information was not completely up to date and patient feedback was not responded to.

Are services well-led?

Information on the practice website required updating. We spoke with the practice owner who told us they were experiencing difficulties with accessing the website in order to update it.

Results of the most recent survey, carried out in November 2016, indicated that 100% of patients, who responded, said they would recommend the practice to a family member or friend. However, the number of patients who completed this survey was very low. We were assured future surveys would be promoted more effectively.

As a result of patient feedback the practice added new chairs to the landing of the first floor of the practice for patients to sit and wait.

Staff told us that the dentists were very approachable and they felt they could give their views about how things were done at the practice. Staff told us that they had frequent meetings and described the meetings as good with the opportunity to discuss successes, changes and improvements. For example, changes included the fitting of covers to lights in the decontamination room.