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Queens Road Dental and Cosmetic Centre

Inspection Report

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Ratings

Overall rating for this service

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

Overall summary

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We carried out an announced comprehensive inspection of this service on 26 October 2015 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?

Summary of findings

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

Queens Road Dental and Cosmetic Centre provides predominantly (99%) NHS treatment with a small amount (1%) of private treatments.

The practice opening times were displayed in the practice and in the patient leaflet. The practice was open Monday to Wednesday from 9am to 5.30pm, Thursday from 9am to 7pm, Friday from 9am to 5pm and Saturday from 9am to 1pm.

The staff structure of the practice consists of one dentist and a dental therapist who are supported by four registered dental nurses who work part time and two trainee dental nurses. The dental nurses also cover the reception desk. One of the dental nurses is training to become a dental hygienist.

The dentist is the registered person. 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.

There was a reception desk separate to the waiting area, two treatment rooms were on the ground and first floor. There was also a separate decontamination room. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and oral hygiene.

Before our inspection we left CQC comment cards and asked patients to share their views and experiences of the service. We received 21completed comment cards all of which reflected positive comments about the staff and the services provided. Patients commented on the newly refurbished premises, the cleanliness and approachability of staff.

We also spoke with four patients attending the practice for appointment. Each patient told us they were involved in treatment planning and given enough information to make choices.

Our key findings were:

- Effective safeguarding processes were in place relating to child protection and safeguarding adults and who may be vulnerable.
- There were systems in place to ensure equipment was serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray set.
- The practice supported staff to maintain the necessary skills and competence to meet the needs of patients.
- Oral health assessments and planned treatment was carried out in line with current best practice guidance or example from the Faculty of General Dental Practice (FGDP).
- Patients were able to make routine and emergency appointments when needed. There was information for patients explaining how to access emergency treatment when the practice was closed.
- There was a wide range of policies and procedures in relation to health and safety and safe working practices. However the policies were not dated so it was difficult for us to know when they were written.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice sought feedback from staff and patients about the services they provided.
- Patients commented that they felt the practice offered an excellent service and staff were polite, helpful, caring and treated them with respect.
- The practice did not have all the equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. The dentist had placed on order to purchase these items during the inspection and we received confirmation that it had been received in the surgery the day after the inspection.
- There was a business continuity plan detailing the arrangements in place to manage unexpected events that may disrupt the running of the practice.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.

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

Summary of findings

- Ensure the clinical waste bin in the yard is securely locked to prevent the risk of contaminated materials being accessed.
- Review the accessibility of the air compressor in the first floor treatment room. Compressor and dryer plant should ideally be installed in a well-labelled, locked, dust-free, dry, cool, well-ventilated room.
- Update the local rules to reflect the recommendations of the Radiation Protection Advisor.
- Monitor and record fridge temperatures to ensure dental equipment and medicines remain effective.
- Ensure there is a written record of the daily and weekly checks of emergency equipment and medicines in line with the Resuscitation Council guidelines.

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.

A Legionella risk assessment had been carried out by an external contractor in October 2015.

There were infection control procedures in place and staff had received training. Radiation equipment was suitably sited and used by trained staff only. Local rules were displayed clearly where X-rays were carried out.

Staff had been trained to respond to medical emergencies and appropriate emergency medicines were available. The practice did not have all of the emergency equipment such as an automated electronic defibrillator (AED a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm). The dentist had placed on order to purchase these items during the inspection and we received confirmation that the AED had been received in the surgery the day after the inspection.

Staff were aware of their responsibility to report serious incidents or accidents in accordance with the Reporting of injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff had completed training in child protection and adult safeguarding and were able to describe the signs of abuse and who to report them to.

Are services effective?

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

Patients received an assessment of their dental needs including taking a medical history. Treatment was delivered in line with evidence based guidelines, for example the National Institute for Health and Care Excellence (NICE) for example, with regard to prescribing antibiotics and the frequency of dental recalls.

Dental care records were detailed and showed patients were given health promotion advice appropriate to their individual oral health needs such as; diet and smoking cessation.

The dentist and dental nurses were registered with the General Dental Council (GDC). In order to maintain their professional registration they were required to provide evidence of their continuing professional development (CPD).

Staff were aware of their responsibility in relation to consent taking into account the Mental Capacity Act and the Gillick competency in relation to children under the age of 16.

Are services caring?

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

Feedback in comment cards and from patients we spoke with on the day of our inspection was overwhelmingly positive. Patients commented that they were treated with respect and privacy was maintained. We saw patients were welcomed in a friendly and polite manner and privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Patients told us they were involved in discussions about the various treatment options available to them which included risks, benefits and costs.

Summary of findings

Patients who had dental emergencies were seen in a timely manner, usually on the same day or within 24 hours.

Are services responsive to people's needs?

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

We observed staff treating patients in a polite and sensitive manner treating each patient as an individual.

Patients were able to access routine and urgent or emergency treatment to suit them. There were dedicated emergency slots that enabled patients with dental pain to be seen on the same day.

Patients told us treatments were fully explained in a way they understood, and included any risks, benefits and costs. Feedback from patients in comment cards and from speaking with patients indicated they were involved in planning their treatment.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients. Staff were aware of how to respond to any concerns or complaints. The practice had not received any complaints or concerns in the past 12 months.

Are services well-led?

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

The dentist was responsible for the day to day running of the practice and they were supported by the dental nurses. There was a clear line of responsibility and accountability and all of the staff we spoke with told us there was a culture of openness and transparency. Staff told us they felt well supported and confident about raising any issues or concerns with the dentist.

Regular practice meetings were held and these gave staff the opportunity to make suggestions and to give their views of the service.

There were effective clinical governance and risk management structures in place that included an audit of dental care records to ensure standards had been maintained.

The practice used the Friends and Family test (FFT this is survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) to gather patients views about the service they received. In addition the practice carried out an annual patient survey.

Queens Road Dental and Cosmetic Centre

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.

This inspection was carried out on 26 October 2015. The inspection was led by a CQC inspector, a dental specialist advisor and a second inspector.

The practice sent us their statement of purpose and a summary of complaints they had received in the last 12 months, the latest statement of purpose, and the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and consulted with other stakeholders. We informed the NHS England local area team that we were inspecting the practice and did not receive any information of concern from them.

The methods that were used, for example talking to patients using the service, interviewing staff, observations and review of documents. We toured the premises and spoke with the dentist and four dental nurses.

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 established a process for reporting and learning from significant events. Staff

had a clear understanding of their responsibilities in Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and had the appropriate recording forms available. There had not been any such incidents in the past 12 months.

The dentist was aware of the Duty of Candour and their professional responsibility to be open and transparent in the event of something going wrong. The dentists told us should there be an accident or incident that affected a patient they would be given an apology and informed of any actions taken to prevent a reoccurrence. Formal staff meetings were held every three months where any learning from incidents or audits would be discussed.

There were procedures in place for investigating, responding to and learning from complaints. There had been no complaints received by the practice in the last 12 months.

There was a policy and procedure to follow in the event of a member of staff sustaining a needle stick injury (where the skin is pierced by a used needle or other sharp instrument). The dentist used rubber needle guards to minimise the risks of such an injury in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations) and the European Council Directive 2010/32/EU (the Sharps Directive).

There were risk assessments in place relating to the Control of Substances Hazardous to Health (COSHH). These identified the types of substance used at the practice and any risks they posed to staff and patients and staff knew how to access this information.

Reliable safety systems and processes (including safeguarding)

The dentist was the designated lead for safeguarding. There were policies and procedures in place for safeguarding adults and child protection. These included the contact details for the local authority safeguarding teams. The staff we spoke with had completed training in relation to safeguarding in August 2015 and were able to describe the various signs of abuse and the action they would take should they suspect abuse was taking place or a patient disclosed information of concern.

The dentist told us they did not always use a rubber dam when carrying out root canal treatments. 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 prevent debris from being inhaled or ingested during treatment. The use of a rubber dam is considered good practice by the British Endodontic Society.

The dentist told us where they do not use a rubber dam they use dental floss to secure any small instruments to prevent them from being inhaled or ingested during treatment.

There were good supplies of personal protective equipment (PPE) including; gloves, aprons and eye protection.

Risk assessments were carried out in relation to fire safety, electrical installations, equipment and security of the premises.

Medical emergencies

The practice kept emergency medicines, in line with the guidance on emergency medicines issued by the British National Formulary (BNF), for dealing with medical emergencies in a dental practice. These medicines were all in date and fit for use. There was no documentary evidence to show the staff were carrying out a weekly/monthly check of the emergency equipment in accordance with the resuscitation council guidance. We did see there was a list of expiry dates on the wall for staff to check the emergency medicines were in date and safe to use.

The practice did not have an External Automated Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The dentist ordered an AED, face masks and a self inflating bag during the inspection and confirmed it was received in the practice 27 October 2015.

All staff had been trained in cardiopulmonary resuscitation (CPR) to enable them to respond to a medical emergency this included the use of an AED.

Are services safe?

There was a dedicated fridge for storing dental materials and medicines. However, there was no system for recording the temperature of the refrigerator.

We saw maintenance contracts were in place for the equipment used in the practice including; the X-ray sets, autoclaves and air compressor (to work the hand pieces). We saw these were carried out on a daily, weekly and yearly basis in line with the manufacturer's guidelines. Staff responsible for taking X-rays had received training the most recent being 22 October 2015.

Staff recruitment

The majority of staff had been working at the practice for a number of years (between 7 and 20 years) we saw four staff recruitment files. There were two trainee dental nurses who had the relevant checks, such as references, carried out prior to starting their placements. All of the staff had a Disclosure and Barring Service (DBS) check to ensure they were not barred from working in roles where they may have contact with children or adults who may be vulnerable.

There was a recruitment policy that detailed the process for employing new staff. This included obtaining proof of identity, checking skills and qualifications and registration with professional bodies where relevant. The dentist was aware of his responsibility to undertake these checks if and when he employs any new staff.

There was a system in place for monitoring professional registration and medical indemnity.

Monitoring health & safety and responding to risks

There was a Health and Safety policy which included guidance on fire safety, manual handling and dealing with clinical waste. The practice had risk assessments in place relating to fire safety, equipment, radiation, accidents and incidents and the Control of Substances Hazardous to Health 2002 (COSHH) regulations.

The practice had developed clear lines of accountability and staff were allocated lead roles or areas of responsibility, for example; medicines management, safeguarding and infection control.

A fire risk assessment had been carried out in September 2015 that made a number of recommendations such as; developing a plan of the building and the provision of mains powered fire alarm.

We saw there were maintenance contracts in place to ensure the fire extinguishers were regularly serviced. Fire exit routes were clearly marked. The staff we spoke with were able to demonstrate that they knew how to respond in the event of a fire.

Infection control

We were taken on a tour of the practice and found that the two dental treatment rooms, waiting

area, reception and toilets were clean, tidy and clutter free. There was a cleaning schedule and checklist, which we saw were completed, and cleaning equipment was stored appropriately in line with Control of Substances Hazardous to Health Regulations 2002.The patients we spoke with told us that since the refurbishment, the practice was comfortable bright and clean.

The practice had undergone a programme of refurbishment in the last 12 months. The floors and work surfaces were sealed for easy cleaning to promote good standards of infection control. The walls of both treatment rooms had been lined with an easy clean material.

We saw free standing fans and a fan heater in the treatment rooms. The use of free-standing fans has the potential to disperse aerosols into the atmosphere. The dentist agreed to remove these items.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM 01-05)'.There was an infection control policy and procedure that covered the cleaning of used instruments, needle stick injuries (where the skin is punctured by sharp instruments or needles), general cleanliness of the practice, hand washing techniques and the safe disposal of clinical waste.

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed next to hand washing sinks.

Staff had completed training in relation to infection prevention and control. Training records showed this training had been updated in October 2015.

Are services safe?

There were service contracts in place to ensure regular maintenance by specialist engineers so that equipment was well maintained and safe to use.

The dentist carried out six monthly infection control audits in line with Health Technical Memorandum 01-05; Decontamination in primary care dental practices (HTM 01-05).

We examined the facilities for decontaminating dental instruments. The practice had a dedicated decontamination room. Instruments were transported between the treatment rooms and the decontamination room in rigid plastic lock boxes. This ensured the safe movement of instruments between treatment rooms and the decontamination area in accordance with Health Technical Memorandum 01-05; Decontamination in primary care dental practices (HTM 01-05).

One of the dental nurses explained the decontamination process. Used instruments were washed and scrubbed in the dirty sink, rinsed in the clean sink, checked for debris under an illuminated magnifying glass (re-washed if required), placed into one of the autoclaves for sterilisation.

The flow from dirty to clean zones in the decontamination room was not clearly identified. We discussed the advantages of labelling the sinks which would help minimise the risks of cross contamination. Staff wore appropriate personal protective equipment (PPE) during the process and these included heavy duty gloves, aprons and protective eye wear.

The staff we spoke with confirmed that they had received infection control training and were aware of their responsibilities to minimise the risks of cross contamination. The dental nurses told us how they cleaned the treatment room between patients. This included wiping surfaces, cleaning the chair, overhead examination lamp and spittoon.

Once the decontamination cycle is complete sterilised instruments were pouched and stamped with the use by date shown as the month and year. Recording the full date of sterilisation would demonstrate that the maximum storage time was not being exceeded.

We saw documentary evidence to show that equipment such as the autoclaves had been validated and the required daily checks were being carried out and appropriately recorded.

Patients we spoke with confirmed that staff wore gloves and aprons during treatment. We saw hand washing facilities in each treatment room and staff told us they had access to supplies of personal protective equipment (PPE) for patients (bibs and eye protection) and staff members.

The segregation and storage of dental clinical waste was in line with current guidelines laid down by the Department of Health. We saw clinical waste stored in a yellow bin prior to collection. The bin was stored in a yard but could not be locked easily by the dental nurse. The door from the yard to the street was open during the day because it was used as an escape route in the event of a fire. In order to minimise any risks of the waste material being tampered with the dentist said he would check the lock on the bin to ensure it was easier for the dental nurses to operate.

A Legionella risk assessment had been undertaken the week before our inspection and the dentist was awaiting receipt of the document which would be shared with CQC. Legionella is a bacteria found in the environment which can contaminate water systems in buildings. Dental nurses told us the water lines were flushed daily and weekly.

Equipment and medicines

We saw that a portable appliance test (PAT - a process by which electrical appliances are routinely checked for safety) had been carried out on all electrical equipment. Fire extinguishers were checked and serviced regularly by an external company and staff had been trained in the use of equipment and evacuation procedures.

Maintenance contracts were in place for the equipment used in the practice. autoclaves and the air compressor. A specialist company calibrated the X-ray sets to ensure they were operating safely.

The practice had oxygen and medicines for use in the event of a medical emergency such as asthma, anaphylaxis, epileptic seizure were available. This was in line with the British National Formulary (BNF) and the Resuscitation Council (UK) guidelines. Oxygen cylinders were checked to ensure the levels and flow rate was sufficient for use in an emergency.

Are services safe?

We checked the emergency medicines and saw these were accessible to all staff and securely stored. The dental nurses had responsibility for checking the expiry date of medicines to ensure they were safe to use however the checks were not clearly recorded.

The practice did not have an External Automated Defibrillator (AED). An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The dentist had placed on order to purchase these items during the inspection.

One of the dental nurses checks the dates of dental materials in the ground floor surgery. However, we found outdated dental materials stored in the first floor treatment room for example; Porcelain etch (a substance to improve the adhesive bonding of porcelain veneers) expired 2013, Protemp (a temporary crown material) expired 2013 and Endoperox (a whitening material) expired 2014. The dentist arranged to remove them to minimise the risk of them being used in error and will ensure there is a more robust system of checks for this surgery.

Radiography (X-rays)

There was a radiation protection file that identified the dentist as the radiation protection supervisor (RPS) and an external radiation protection adviser (RPA). This was in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) and The Ionising Radiation Regulations 1999(IRR99). A copy of the local rules for each X-ray machine was available in the treatment rooms for staff reference.

The local rules did not include the name of the RPA the dentist arranged for this to be added during the inspection. In addition the RPA had recommended adding to the local rules that the connecting door between the upstairs surgery and waiting room should be kept locked while carrying out X-rays to prevent patients entering and being accidentally exposed to radiation. This had not been added to the local rules in the surgery.

There was X-ray equipment situated in each treatment room. We found the equipment was maintained and calibrated under contract and inspected at the manufacturers recommended timescales. Clinical staff responsible for taking X-rays had completed radiation training as required by the General Dental Council (GDC) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).

We looked at a sample of four dental care records and saw the reason for taking dental X-rays was justified, reported on and quality assured every time. An audit of the quality of X-rays was carried out on a regular basis.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We looked at a sample of four dental care records and saw an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) This was in line with recognised guidance from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines.

The dentist carried out an assessment of the soft tissue of the mouth including the tongue, palate and lips to check for oral cancers.

The dentist undertook X-rays at appropriate intervals, in line with guidance issued by the Faculty of General Dental Practice standards. They also recorded the justification, findings and quality of X-ray images.

Dental care records were held electronically access was password protected and files were backed up to secure storage at the end of the day to ensure patient information was held securely. Dental care records were detailed and contained an explanation of why specific treatments were recommended.

Patients were asked to provide a medical history covering health conditions, current medicines being taken and whether they had any allergies. Patients told us that at each visit, the dentist checked if there had been any changes to their general health or medications and any changes were entered into the patient record.

Health promotion & prevention

There were health promotion leaflets available in the practice promoting effective dental hygiene. The dentist provided advice about smoking cessation and healthy eating in line with the Department of Health - Delivering Better Oral Health guidelines.

Adults and children attending the practice were advised during their consultation of how to maintain healthy teeth. Tooth brushing techniques were explained to children in a way they understood. We spoke with parents who had brought their children for an appointment. The children said the dentist had told them they should drink milk or water and not fizzy drinks.

Products for maintaining oral health were available for patients to purchase such as; mouthwash, toothpaste and toothbrushes.

The dentist visited primary schools in the area to apply fluoride varnish. This was done on a voluntary basis in order to promote good oral health amongst children and reduce tooth decay

Staffing

The practice had sufficient dental nurses to support the dentist and the hygienist. Staff told us they had easy access to a range of policies and procedures to support them in their work.

The dentist, dental therapist and dental nurses were responsible for their own continuing professional development (CPD) and required to complete a specific number of hours training in order to maintain their registration with the General Dental Council (GDC). We looked at individual training portfolios that demonstrated staff had completed courses in line with their professional development plans.

We saw staff had undertaken training as a team to ensure they were kept up to date with essential training such as CPR and basic life support. In addition staff had access to an on-line training system. Staff told us they were allocated time within the working day to complete training. There was an appraisal system in place which was used to discuss training needs.

This was a small practice and staff told us they would discuss any issues or alerts informally but had regular staff meetings.

Staff records showed professional registration was up to date for all staff and they were all covered by personal indemnity insurance. The staff we spoke with told us they worked part time, were flexible and would cover each other's shifts if there was sickness or leave.

Working with other services

There was a system in place for referring patients for secondary care for specialist procedures such as; orthodontic treatment complex treatments for example

Are services effective?

(for example, treatment is effective)

oral cancers. There was a patient referral form which included urgent two week referrals where oral cancer was suspected. When the patient had received their treatment they would be discharged back to the practice for further follow-up and monitoring.

Consent to care and treatment

There was a policy relating to consent to guide staff in the different types of consent a patient could give. This included; implied verbal or written consent.

We reviewed a sample of dental care records and saw that consent was documented. The staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions. The Gillick competency test (used to help assess whether a child under 16 years of age has the maturity to make their own decisions and to understand the implications of those decisions) was discussed and staff showed that they understood how this test was applied.

The dentist we spoke with was aware of their responsibilities to ensure consent was obtained and recorded appropriately. We saw where verbal consent was given a record of the conversation was made in the dental care records.

We spoke with four patients who told us they had been given clear information about treatment options. The patients we spoke with confirmed that they fully understood and consented to treatment. Patients were given time to consider and make choices about which option they wanted.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed the 21 CQC comment cards patients had completed prior to the inspection and spoke with four patients who used the service. Patients were extremely positive about their experience and they commented that they were treated with care, respect and their dignity was maintained.

We observed staff speaking with patients on the telephone and found they were polite and worked with the patient to find a convenient day and time for their appointment. Staff were observed They were polite, greeting patients in appropriate and helpful manner.

The comment cards we reviewed showed that patients were extremely satisfied with the way they were treated by all of the staff. We spoke with four patients who commented that the staff treated them with respect, compassion and understanding.

We spoke with patients who told us the staff were very good with children. They commented that the dentist and dental nurses were understanding and where necessary allowed more time for treatments. All of the patients we spoke with said they were happy with the treatment they received and three said they would happily recommend the practice to friends and family.

There were data protection and confidentiality policies in place of which staff were aware. These covered disclosure of, and the secure handling of patient information. Patient's dental care records were maintained electronically; access to files was password protected and systems were regularly backed up to secure storage. Staff we spoke with were aware of the importance of respecting patients privacy and right to confidentiality.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area that gave details of NHS dental charges. We saw patients were asked to complete medical history forms and their general health was taken into consideration when decisions about treatment were made.

The patients we spoke with told us the dentist discussed the treatment options that were available to them. They told us they felt involved and were able to make and informed decision about which treatment they received. The dentist told us they would explain the planned procedures to patients using visual aids when necessary.

A treatment plan was developed following examination of and discussion with each patient. The patients we spoke with told us the dentist fully explained the plan of treatment that included the costs (if any) and were given time to consider the options before returning to have their treatment. We reviewed four dental care records and found the dentist had recorded the discussions about the treatment options available to the patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There was a practice leaflet that explained the range of services offered to patients. The practice did not provide treatment under sedation but patients who were anxious could be referred to another practice for treatment under conscious sedation.

New patients to the practice were asked to complete a medical questionnaire to enable the dentist to carry out an initial assessment and respond to their dental care needs.

On the day of our inspection appointments ran smoothly and patients were not kept waiting. If there were delays due to an emergency, patients would be informed of this when they booked in. Patients commented they had sufficient time during their appointment and were seen promptly. Staff told us that if appointments were running late they would keep patients informed to make sure they were able to wait.

There were vacant appointment slots each day to accommodate urgent or emergency appointments. The patients we spoke with told us they were able to get an appointment to fit in with their other commitments.

Tackling inequity and promoting equality

The practice took account of the Equality Act 2010 and had made reasonable adjustments for patients who have disabilities to access the practice. Ramped access was provided at the front of the building and a handrail had been fitted in the ground floor patient toilet. Due to the layout of the building this would not be suitable for wheelchair access.

The ground floor reception and waiting room had level access. There was a treatment room and a waiting room on the ground floor and a second treatment room (used by the dental therapist) and waiting room were on the first floor.

The practice provided a service to patients from a range of different backgrounds, cultures and religions. Some of the staff spoke other languages and had access to a telephone translation service if needed.

Access to the service

The practice was open Monday to Wednesday from 9am to 5.30pm, Thursday from 9am to 7pm, Friday from 9am to 5pm and Saturday from 9am to 1pm.

Patients with emergencies were usually seen on the same day where possible or within 24 hours. There was an answer machine message providing out of hours contact numbers for patients needing emergency treatment when the practice was closed.

The practice provides dental services to a diverse community. We saw one of the dental nurses speaking on the telephone translating information to a patient who spoke English as a second language.

Concerns & complaints

A Care Quality Commission (CQC) comments box was sent to the practice two weeks before our visit. Twenty one patients completed a comment card and the feedback about the service provided was overwhelmingly positive.

In addition to the practice satisfaction survey they used the friends and family test questionnaire and there was a box for completed forms in the reception area. The results of the most recent survey was positive all patients who completed a form expressed satisfaction with the services provided.

There was a policy and procedure in place for responding to complaints this was available to patients in the practice leaflet. The complaint policy gave details of external agencies patients could contact such as the GDC. The patients we spoke with were aware how to make a complaint. They told us they had never had reason to complain and would speak to the dentist if they had any concerns. We looked at the complaint record and saw there had been no complaints made in the last 12 months.

Are services well-led?

Our findings

Governance arrangements

Practice policies were in place to support the safe running of the practice and were readily available to staff. These included health and safety, infection prevention control, confidentiality and record keeping. We found the policies were not dated. However, the dentist had taken over the practice two years ago and all the policies had been introduced at that time. We discussed the importance of dating these documents to demonstrate they were being reviewed on a regular basis and updated to reflect current guidance.

A Legionella risk assessment had been undertaken by a specialist contractor the week before our inspection (Legionella is a bacteria which can contaminate the water systems in buildings). At the time of the inspection the dentist had not received the completed risk assessment. Staff told us they carried out weekly testing in line with the practice protocol and monthly water temperature checks were carried out in line with current guidelines.

Staff we spoke with told us they were well supported and although there were no formal supervision meetings they worked alongside the dentist and received on the job support and guidance. Staff told us there was an open culture at the practice and they felt well supported by the dentist.

We reviewed the minutes of the team meetings held since January 2015 and saw topics such as; building work, new staff, cleaning procedures, sickness and the opening and closing procedures were discussed. We saw that the meetings were used for staff to learn, develop and be updated on practice issues. We saw documentary evidence to show that staff received an annual appraisal which was used as a forum to discuss training and development.

Fire safety equipment was available and in date fire exit signs were in place and there were signs above the fire extinguishers to identify the contents. There had been a fire risk assessment completed on 2 September 2015 by an external company with a number of recommendations made. We discussed this with the dentist who told us he was working through the recommendations to achieve full compliance.

Leadership, openness and transparency

The dentist had a clear vision for the practice which was to provide high quality dental care for their patients. The dentist told us if there was an incident or accident that affected a patient they would offer an apology and take all necessary steps to ensure there were no reoccurrences.

Staff told us there was a culture of openness and honesty and that the dentist was available for them to speak to at any time if they had any concerns. Staff within the practice told us they supported each other to carry out their roles.

Management lead through learning and improvement

We saw that audits were used to identify areas of improvement and develop the practice. Various audits had been carried out as part of on-going improvement including; six monthly infection control, dental care records and the quality of X-ray images.

Staff told us they had good access to training to ensure essential training was completed. They told us they were supported by the dentist to maintain their continuing professional development (CPD) which was a requirement of their registration with the General Dental Council (GDC).

We looked at staff training files and saw certificates that demonstrated staff had attended appropriate training for their role.

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

Patients who used the service were able to provide feedback about the service and patient feedback forms were available in reception. Feedback from the patient satisfaction survey was all very positive in particular about the recent improvements to the practice.

The practice also had a Friends and Family Test survey and feedback questionnaires were in the waiting area. This was to assess if patients would recommend the practice to their friends and family. All of the patient feedback was positive with comments about how attentive, helpful and pleasant the staff were.

Staff told us any comments patients made directly to them were feedback to the dentist for discussion at practice meetings. The staff reported increased job satisfaction since the refurbishment of the practice.