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Acorn Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 June 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 not providing well-led care in accordance with the relevant regulation.

Background

Acorn Dental operates from a converted domestic dwelling and provides NHS and private dentistry for both adults and children. The practice is situated in Slough, Berkshire.

The practice has two dental treatment rooms which are based on the ground floor. The practice has a separate decontamination room used for cleaning, sterilising and packing dental instruments.

The practice employs two dentists, a hygienist, two dental nurses, of which one is the practice manager, two trainee dental nurses and one receptionist.Appointments are available Monday to Friday between 8am and 5pm. Emergency dental treatment is available between 8am and 10pm seven days a week (by appointment after 5pm).

There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours service. If patients call the practice when it is closed, an answerphone message gives the telephone number patients should ring depending on their symptoms.

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

Summary of findings

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

During our inspection we reviewed 41 CQC comment cards completed by patients and obtained the view of 14 patients on the day of our inspection.

The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- The practice ethos was to achieve high quality patient centred care.
- The practice owner provided effective clinical support and supervision for dentists working in the practice.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures followed published guidance.
- There were processes in place for safeguarding adults and children living in vulnerable circumstances.
- Patients could access treatment and urgent and emergency care when required.
- There were areas where the provider should improve access for disabled patients and patients with mobility difficulties.
- The practice maintained a system of policies and procedures; however there were shortfalls within the system. This included files containing policies and procedures from several different compliance systems which led to confusion with respect to operating practice policies, procedures and protocols.
- Staff recruitment files were not always complete.
- Fire safety control measures were not effective.
- Most staff received training appropriate to their roles and were supported in their continued professional development (CPD) but there were shortfalls in the recording system for training.
- Staff we spoke with were committed to providing a quality service to their patients.
- Information from 41 completed Care Quality Commission (CQC) comment cards gave us a completely positive picture of a friendly, professional service.
- The practice had a system of clinical and non-clinical audit in place.

We identified regulations that were not being met and the provider must:

- Ensure the practice's recruitment policy and procedures are suitable and the recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Ensure that a system for collating the records of training of relevant staff members is established.

You can see full details of the regulations not being met at the end of this report.

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

- Provide an annual statement in relation to infection prevention and control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance is prepared.
- Review the timing of the visual checking of electrical appliances between formal portable appliance testing.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and

Summary of findings

Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as Public Health England (PHE).

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 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 properly maintained. Staff were aware of the importance of identifying, investigating and learning from patient safety incidents. Staff were aware of their responsibilities regarding safeguarding children and vulnerable adults.

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 focused 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. This included treatment under conscious sedation. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff generally received professional training and development appropriate to their roles and learning needs. Staff where appropriate were registered with the General Dental Council (GDC).

Are services caring?

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

We collected 41 completed Care Quality Commission patient comment cards and obtained the views of a further 14 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.

Are services responsive to people's needs?

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

Patients could access treatment and urgent and emergency care when required. The practice provided patients with information in language they could understand and had access to telephone interpreter services when required. There were areas where the provider should improve access for disabled patients and patients with mobility difficulties. For example, addressing the high threshold at the entrance of the practice and filling in the gap in the path at the rear emergency exit, the addition of a hearing loop for hearing aid users, a grab rail in the patient toilet and a disabled person's parking space at the front of the building.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Although the practice owner provided effective clinical support, mentoring and supervision to other dentists leading to good patient outcomes, there were shortfalls in the clinical governance systems and processes underpinning the clinical care.

Summary of findings

These shortfalls related to managing fire safety risks and the systems that mitigated further risks to patients and the tenants on the first floor of the building in the event of a fire. These included: lack of regular testing of fire alarms and emergency lighting. We also noted that the signage relating to fire exists did not conform to current fire regulations and fire drills were not timed.

Other areas of concern were the organisation of policies and procedures from several different compliance systems which led to confusion with respect to operating practice policies, procedures and protocols. This led to shortfalls in the maintenance of staff training records and risk assessment in relation to Legionella. We also found shortfalls in relation to staff recruitment files, specifically the failure to obtain satisfactory written references.

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

Acorn Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 16 June 2016. The inspection was carried out by a CQC inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff recruitment and training records. We spoke with six 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 computer system that supported the patient dental care records. We reviewed CQC comment cards completed by patients and obtained the views of 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

The practice had an incident reporting system in place for RIDDOR (The reporting of injuries diseases and dangerous occurrences regulations) and a system for the reporting of minor injuries to patients and staff. The practice reported that there had been no serious incidents that required formal reporting during 2016 or that required investigation. The practice manager explained that incidents would be discussed during staff meetings to facilitate shared learning should they occur.

We noted that the practice did not have a robust system in place to receive national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA). We noted that the last safety alert received by the practice was an alert pertaining to dental X-ray sets in 2013. We pointed this out to the practice manager who assured us a system would be put into place as soon as practically possible.

Reliable safety systems and processes (including safeguarding)

We spoke to a dental nurse 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 safer 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 several systems to prevent inoculation injuries, these included a rubber protective device used by the dentist to cover the contaminated needle following administration of a local anaesthetic and the use of a single use local anaesthetic syringe. Dentists were 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 also asked the practice owner how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. In those situations where rubber dam was not used, a special root canal hand piece was used to mitigate the risk of patients swallowing or inhaling a root canal file. This was confirmed by another dentist we spoke with. 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 followed as far as possible appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice owner acted as the safeguarding lead and was the point of referral should members of staff encounter a child or 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 not all staff had received continuing professional development in child and adult safeguarding. 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. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines.

The emergency medicines and oxygen we saw were all in date and although the emergency kit was stored in a central location known to all staff. We noted that the site was vulnerable to unauthorised access by members of the general public and drew this to the attention of the practice owner. 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.

Are services safe?

Staff recruitment

All the dentists and dental nurses who worked at the practice had current registrations with the General Dental Council. The practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. For example, employment checks included two references.

We looked at recruitment files for three staff employed since the provider registered with CQC and found the registered provider had not fully undertaken all the required checks to comply with Schedule 3 of the Health and Social Care Act 2008 (amended 2014). Checks required included proof of identity, a full employment history, evidence of relevant qualifications and employment checks including references.

All three staff had satisfactory information about any physical or mental health conditions which could be relevant to their roles. Two staff had gaps in their employment histories but there was no evidence to confirm these gaps had been investigated. No staff had evidence to confirm that references were undertaken for their previous employment. We spoke with the practice manager about this who undertook to implement a monitoring system as soon as practically possible.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. We noted shortfalls with respect to managing fire safety risks and the systems that mitigated further risks to patients and the tenants on the first floor of the building in the event of a fire. These included; lack of regular testing of fire alarms and emergency lighting. We also noted that the signage relating to fire exists did not conform to current fire regulations and fire drills were not timed. Following our inspection, the practice owner provided evidence to confirm that a fire risk assessment was to be undertaken by a specialist company on 27 June 2016.

The practice had a business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The practice had in place 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. However, we found cleaning fluids under COSHH regulations were not stored securely in the decontamination area. We pointed this out to staff and these were immediately moved to a secure area in the practice.

Following our inspection, the practice owner provided evidence to confirm that a health and safety audit was to be undertaken by a specialist company on 27 June 2016.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice although the decontamination area used by the practice should be reassessed to reduce the risk of unauthorised access by members of the general public. We pointed this out to the provider who had arranged for the facility to be sited in a currently unused room at the rear of the building following our inspection. We have since been provided with photographic evidence to confirm this has been addressed.

The practice had an 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 control in dental practices) Essential Quality Requirements for infection control were being met. It was observed that audit of infection control processes carried out in March 2016 confirmed compliance with HTM 01 05 guidelines.

We saw that the two dental treatment rooms, waiting area, reception and toilet were visibly clean. 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 and bare below the elbow working was observed.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

A dental nurse 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.

Are services safe?

The dental unit 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 general measures were in place to manage the water systems safely in the building. We did not see that a Legionella risk assessment had been carried out by a competent person in recent times. We pointed this out to the practice owner who assured us that this would be arranged as soon as practically possible. Following our inspection, the practice owner provided evidence to confirm that a Legionella risk assessment was to be undertaken by a specialist company on 27 June 2016.

The dental nurse we spoke with 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 system of manual scrubbing and ultrasonic baths for the initial cleaning process, following inspection with an illuminated magnifier the instruments were 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 autoclave used in the decontamination process was 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. We also noted that the essential validation checks for the ultrasonic baths, including protein residue and foil tests, were carried out and the results recorded.

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 and was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice and clinical waste was stored in a locked facility adjacent to the practice prior to collection. Waste consignment notices were available for inspection.

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.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in February 2016. The practice X-ray machines had been serviced and calibrated as specified under current national regulations in June 2016.

Although portable appliance testing (PAT) had been carried out in November 2012, we found that no additional assessments of electrical appliances had been carried out during the intervening period.

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

The practice dispensed their own medicines as part of a patient's dental treatment. These medicines included a range of antibiotics. The dispensing procedures were in accordance with current dispensing regulations and medicines were stored according to manufacturer's instructions. We saw that the practice had a logging system to account for the medicines dispensed to prevent inappropriate prescribing or loss of these medicines. Although the sedative medicine midazolam was stored in the lockable treatment room where sedation was carried out, the storage arrangements as per the safe custody requirements for schedule 3 controlled drugs were not in place. We informed the practice owner of this who then arranged for the medicines to be stored securely. The practice owner also arranged for the sedative reversal agent and the other medicines dispensed to be stored securely

Radiography (X-rays)

We were shown a radiation protection file that contained documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). Included in this file were the

Are services safe?

names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. We also saw a copy of the local rules.

We saw that a radiological audit had been carried out in February 2016. 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 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 confirmed all 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 two dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists 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 and treatment options explained in detail.

Where relevant, preventative dental information was given in order 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 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.

The practice owner carried out intra-venous sedation at the practice for patients who were very nervous of dental treatment and required complex dental treatment such as the provision of dental implants. We found that the provider had put into place governance systems to underpin the provision of conscious sedation.

The governance systems supporting sedation included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We spoke to the practice owner who described the typical patient journey for a patient undergoing intra-venous conscious sedation. They explained that all patients undergoing sedation would have important checks made prior to sedation; this included a detailed medical history, BMI, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system.

The practice owner also explained that during the sedation procedure important checks would be recorded at regular intervals which included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. At the end of treatment patients would be monitored by the dentist until they were completely recovered. The practice owner explained that they would be responsible for the discharge of the patient. They also explained that the patient and their carer would be given verbal and written instructions on post-operative home care and emergency contact details should this be necessary.

Patient treatment records we saw showed that all of the parameters described in the patient journey for intra-venous sedation were recorded accurately and appropriately.

Health promotion & prevention

The practice focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this, the practice appointed a dental hygienist to work alongside of the dentists in delivering preventative dental care. Both dentists we spoke with explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth) in the mouths of children who were particularly vulnerable to dental decay.

Other preventative advice included tooth brushing techniques explained to patients in a way they understood

Are services effective?

(for example, treatment is effective)

and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that 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 of the patients we asked told us they felt there was enough staff working at the practice. Staff we spoke with told us the staffing levels were suitable for the size of the service. All the staff we spoke with told us they felt supported by the practice manager and owner. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed two dentists, a hygienist, two dental nurses, of which one is the practice manager, two trainee dental nurses and one receptionist. There was a structured induction programme in place for new members of staff.All clinical staff had current registration with their professional body, the General Dental Council. All but two clinical staff had dental indemnity in place. We raised this with the practice owner who immediately arranged insurance and presented certificates to confirm cover was in place.

Working with other services

Dentists were able to 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 oral surgery or special care dentistry. We were told the practice did not always need to refer many patients to other centres because of the diverse range of clinical skills possessed by the dentists working at the practice. This supported patients to be seen by the right person at the right time.

Consent to care and treatment

We spoke with the dentists about how they implemented the principles of informed consent; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs, where appropriate, were discussed with each patient and then documented in a written treatment plan.

The practice owner described how they used photography prior, during and at the end of dental treatment. These photographs captured the condition of teeth requiring treatment, the appearance of the gums and of the soft tissues which strengthened the consent process. Photographs provided a means of patient education as well as preventing medico-legal problems in cases where patients could dispute the dentist's findings and treatment outcomes.

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. The orthodontists went onto 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 went on to say 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 principles of the Mental Capacity Act 2005.

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 at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage.

We noted that paper records were not stored under secure conditions and could be accessed by unauthorised persons. We pointed this out to the practice owner who told us that arrangements would be made to make these storage arrangements secure as soon as practically possible after our inspection visit. We have since been provided photographic evidence to confirm records are stored securely.

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

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. We collected 41 completed CQC patient comment cards and obtained the views of 14 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 also commented that treatment was explained clearly and the staff were caring and put them at ease. During the inspection, we observed staff who were polite and helpful towards patients and that 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. Private treatment costs were discussed with the patients in the treatment room following their consultation the dentists we spoke with paid particular 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 private treatment.

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. The practice waiting area displayed a wide variety of information including leaflets about the services the practice offered, how to make a complaint and information about maintaining good oral health. The practice website also contained useful information to patients such as details about different types of treatments which patients receive and how to provide feedback on the services provided.

Appointment diaries were not overbooked and that 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 took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The service was aware of the needs of the local population and generally took these into account in how the practice was run although improvements could be made. The practice provided patients with written information in language they could understand and had access to telephone interpreter services when required.

There were areas where the provider could improve access for disabled patients and patients who had mobility difficulties. For example, addressing the high threshold at the entrance of the practice and filling in the gap in the path at the rear emergency exit, the addition of a hearing loop for hearing aid users, a grab rail in the patient toilet and a disabled person's parking space at the front of the building.

Following our inspection, the practice owner provided evidence to confirm that a disability access audit was to be undertaken by a specialist company on 27 June 2016.

Access to the service

Acorn Dental Care offered appointments Monday to Friday between 8am and 5pm. Emergency dental treatment was available between 8am and 10pm seven days a week (by appointment after 5pm).

We asked 14 patients if they were satisfied with the practice's opening hours.All but one said they were whilst one said they were not sure when the practice was open.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed an answerphone message gave the telephone number patients should ring depending on their symptoms.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. For example, a complaint would be acknowledged within 3 days and a full response would be provided to the patient within 10 days. The practice listed two complaints received over the previous 12 months which records confirmed had been concluded satisfactorily.

Information for patients about how to make a complaint was seen in the patient leaflet and on display in the practice waiting room. We asked 14 patients if they knew how to make a complaint if they had an issue and nine said yes, three were not sure and two did not.

Are services well-led?

Our findings

Governance arrangements

The governance arrangements for this location consisted of the practice owner and the practice manager who were responsible for the day to day running of the practice. The practice maintained a system of policies and procedures, however there were shortfalls within the system. This included files containing policies and procedures from several different compliance systems which led to confusion with respect to practice operating policies, procedures and protocols. This was evident with respect to fire safety arrangements and maintaining satisfactory records. Many of the files contained protocols no longer in use and historical service agreements and certificates which added to the confusion. Following the inspection, we received evidence that the practice owner was engaging with a commercial company who specialise in dental clinical governance systems to improve the way the practice is managed.

We were told that staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. However evidence to confirm all relevant staff were up to date with their mandatory training and their Continuing Professional Development was not available during or after our inspection. For example fire safety, infection prevention and control and safeguarding children and vulnerable adults.

Pre-employment checks such as obtaining written references and obtaining full employment histories were not carried out during the recruitment process.

Leadership, openness and transparency

The practice ethos focused on providing high quality patient centred dental care in a relaxed and friendly environment. The comment cards we saw reflected this approach. 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. We found staff to be hard working, caring and committed to the work they did. Staff were happy with the practice facilities, felt 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, this was underpinned by an appraisal system and a programme of clinical audit. We observed that the dental nurses received an annual appraisal; these appraisals were carried out by the practice manager.

One dentist we spoke to explained how the practice owner provided clinical support, mentoring and supervision to them when patients presented with complex dental problems. This dentist also explained that the practice owner provided good quality materials and equipment wherever possible to enable the dentist to achieve optimum clinical outcomes for patients. With respect to clinical audit, we saw results of audits in relation to clinical record keeping, the quality of X-rays and infection control which demonstrated that good standards were being maintained.

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

The practice had gathered feedback from patients through the NHS Choices, 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 carried out its own survey of patients. January to March 2016's survey showed that 100% of patients, who responded, said they would recommend the practice to a friend. As a result of patient feedback the practice had introduced improvements suggested by patients. These included text appointment reminders and new chairs in the patient waiting area.

Staff told us that the practice manager and principal dentist were very approachable and they felt they could give their views about how things were done at the practice. Staff confirmed that they had practice meetings every month. Staff described the meetings as good with the opportunity to discuss successes, changes and improvements. Staff we spoke with said they felt listened to.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found the provider did not have effective systems in place to maintain securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.** **This was in breach of regulation 17 (1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • The provider was unable to demonstrate that relevant training had been undertaken by all relevant staff.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **We found the provider had not ensured persons employed for the purposes of carrying on a regulated activity were of good character and that all other information specified in Schedule 3 was available in relation to each such person employed.** **This was in breach of Regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • **Pre-employment checks missing included references and full employment history.**