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The London Dental Studio

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 02 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 providing well-led care in accordance with the relevant regulations.

Background

London Dental Studio is located in the London Borough of Westminster. The premises are situated in a two-storey building in a high-street location. There are five treatment rooms, a decontamination room, two X-ray rooms, two reception areas and patient toilets. These are distributed across the ground, first and second floors of the building.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges. The practice also offers specialist services such as implants, orthodontics and conscious sedation.

The staff structure of the practice consists of two principal dentists, three associate dentists, one hygienist, five dental nurses, a practice manager and five receptionists. There is also an endodontist and a specialist orthodontist.

The practice opening hours are Monday to Friday from 9.00am to 6.00pm. The practice is also open from 9.00am to 5.00pm on Saturdays.

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

The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Summary of findings

Thirty people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- There were effective arrangements in place for managing medical emergencies.
- Equipment, such as the air compressor, fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the staff team.
- There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. However, we identified some areas where improvements were required.

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

- Review the systems for checking and monitoring equipment to ensure that all equipment is well maintained.
- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review the protocols and procedures for use of X-ray equipment giving due regard to Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment.
- Review the practice's protocols for completion of dental care records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the practice's audit protocols, such as those for radiography, conscious sedation and dental care records, to help monitor and improve the quality of service. The practice should check audits, where applicable have documented learning points and the resulting improvements can be demonstrated.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

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 systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

We found the equipment used in the practice was generally well maintained and checked for effectiveness. However, the ultrasonic baths had not been serviced in the recommended time frame. We also noted that the recommendations from a recent X-ray service report had not been followed up. The practice acted promptly to resolve these concerns. The practice manager confirmed with us via email, after the inspection, that the ultrasonic baths would not be in use until the servicing had been completed. They also confirmed that they had contacted their Radiation Protection Advisor (RPA) for further advice regarding the X-ray equipment.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting all of the training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

Are services caring?

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

The practice provided clear, written information for patients which supported them to make decisions about their care and treatment. Patient coordinators supported patients throughout their treatment and provided them with additional information about different treatment options and the risks and benefits of different treatments. This supported people to be involved in making their own choices and decisions about their dental care.

We received positive feedback from patients. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all.

Summary of findings

The needs of people in the local area had been considered and staff spoke a range of languages. The practice was wheelchair accessible as one of the treatment rooms situated on the ground floor, although a disabled toilet was not available. The practice had not carried out a formal disability discrimination audit to identify what further reasonable adjustments could be made to the premises to accommodate the needs of patients.

There was a complaints policy in place. There had been three complaints recorded in the past year. These had been investigated and responded to in line with the practice policy.

Patient feedback, through the use of an annual patient satisfaction survey and the NHS 'Friends and Family Test', was used to improve the quality of the service provided

Are services well-led?

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

The practice had clinical governance and risk management structures in place. However, the systems currently in place could be improved. For example, a formal incident reporting policy was not in place. We also noted that significant events and complaints were not systematically reviewed to identify improvements that could be made, and there was no system in place to review and share learning from these events to prevent a recurrence.

A system of audits was used to monitor and improve performance. However, the audit process had not always been used successfully to monitor and improve the quality of the service. For example, the X-ray audit was not comprehensive as it was not specific to each operator. The audit of dental care record keeping had not been successfully followed up in order to improve quality. Finally, we noted that an audit for conscious sedation carried out at the practice had not been carried out.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with each other. They were confident in the abilities of the principal dentists to address any issues as they arose.

The London Dental Studio

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 02 June 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with five members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. One of the dental nurses demonstrated how they carried out decontamination procedures of dental instruments.

Thirty people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

Staff understood the process for accident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was an accidents reporting book; there had been five accidents recorded within the past year. Staff could describe the actions taken at the time, but there was no further system in place for discussing or sharing advice regarding the prevention of future accidents.

There was also no policy or other system in place for reporting and learning from incidents or significant events. We discussed this with the principal dentist and practice manager. We noted one incident that had occurred in the past year that was reported to the police. The staff were able to describe the actions they took at the time to remedy the problems.

We discussed the investigation of incidents and accidents with a range of staff. They told us that they were committed to operating in an open and transparent manner. Patients would be told if they were affected by something that went wrong; they would offer an apology to patients, and inform them of any actions that were taken as a result. Improvements could, however, be made to ensure staff were aware of the Duty of Candour requirements. [Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

The practice manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns was readily available for staff. There was evidence in staff records showing that staff had been trained in safeguarding adults and children to an appropriate level.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. Following administration of a local anaesthetic to a patient, needles were not resheathed using the hands. The clinicians either used a rubber needle guard or a 'safer sharps' system where the injection device had an in-built needle retraction structure, which was in line with current guidelines. The staff we spoke with demonstrated a clear understanding of the practice protocol with respect to handling sharps and needle stick injuries.

We noted that there had been two sharps injuries recorded in the past year. We discussed the actions taken to prevent a recurrence of these accidents with the practice manager. We noted that the staff members involved had taken appropriate steps to follow-up on any safety concerns. However, the practice had not reviewed these incidents more systematically to identify what actions could be taken to prevent a recurrence and share learning points with staff throughout the practice.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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. Rubber dam should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in patients' dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

Are services safe?

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

Staff recruitment

The staff structure of the practice consists of two principal dentists, three associate dentists, one hygienist, five dental nurses, a practice manager and five receptionists. There is also an endodontist and a specialist orthodontist.

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

The majority of the staff had worked at the practice for many years. However, the practice had recruited two members of the reception staff within the past year. We saw that all relevant documents had been obtained prior to employment for these members of staff.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS checks 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).

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice by post. These were disseminated at staff meetings, where appropriate.

There was an arrangement in place to direct patients to another local practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts for services in the local area were kept up to date in a business continuity plan. This could be used for reference purposes in the event that a maintenance problem occurred at the premises.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. One of the dental nurses was the infection control lead. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The practice had carried out practice-wide infection control audits every six months and found high standards throughout the practice.

We observed that the premises appeared clean and tidy. Clear zoning demarcated clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment rooms, decontamination room and toilets. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked one of the dental nurses to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, and dental chair were suitably decontaminated.

Are services safe?

This included the treatment of the dental water lines. Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in February 2016. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. Instruments were cleaned in an ultrasonic bath and inspected under an illuminated magnifier to check for any remaining debris. Following this, the instruments were placed in an autoclave (steriliser).

When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date. However, we noted that separate, sterilised instrument trays, or single-use instrument trays, were not in use for each patient in line with HTM 01-05 guidance. Instead the practice re-used trays wiped them down and covered them with new paper between uses. We raised this concern with the practice manager, who told us that a new protocol, in line with the guidance, would now be established.

We saw that there were systems in place to ensure that the autoclave and ultrasonic baths were working effectively. These included, for example, the automatic control test, steam penetration test, ultrasonic activity ('foil') test and protein residue test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of dental 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. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location inside the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example portable appliance testing (PAT) for all electrical appliances had been carried out in November 2015.

A Pressure Vessel Certificate for the dental compressor and autoclaves had been issued in accordance with the Pressure Systems Safety Regulations 2000.

However, we found that there were two ultrasonic baths in use at the practice which had not been serviced or inspected by an engineer within the past year. The practice manager and one of the principal dentists confirmed with us, on the day of the inspection, that these baths would not be used until such a service had been carried out. A system of manual cleaning would be implemented as an alternative in the interim.

Are services safe?

The practice had a newly installed CBCT scanner (cone beam computed tomography) in April 2016. All of the other X-ray machines had been serviced in December 2015.

The medicines used in intravenous conscious sedation, (e.g. Midazolam and the reversal agent Flumazenil) were stored appropriately and were in date. The batch number and expiry dates of Midazolam along with the amounts used were recorded during each episode of conscious sedation and a log book was kept. Conscious sedation are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation.

Some medicines, such as antibiotics, were occasionally dispensed to patients by their dentist. Whole boxes were supplied with a relevant information leaflet included. However we noted that these boxes were not always correctly labelled with the name and address of the supplying dentist, in line with the Human Medicines Regulations 2012.

The practice stored glucagon, for use in medical emergencies, in a fridge. The practice had monitored the temperature of the fridge on a weekly, but not daily basis. We discussed this with the practice manager. They confirmed with that they would use the reduced expiry dates for glucagon, in line with the manufacturer's guidance for when the product had not been stored in a fridge.

We also noted that a bodily fluid spill kit for use in emergencies, as well as bandages, were out of date, according to the manufacturer's labelling, and needed replacing. The practice manager assured us these would be promptly replaced.

Radiography (X-rays)

The practice had an X-ray room containing an OPG (or orthopantomogram) [An OPG (or orthopantomogram) is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these]. There was a second X-ray room where it was also possible to take CBCT scans (cone beam computed tomography).

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. However, the file did not contain a full list of operators, or a schematic for each piece of X-ray equipment. The critical exam and acceptance test documents were also not available. Copies of the local rules were available and displayed in each treatment room and X-ray room.

We noted that the engineer's report in relation to the servicing of the X-ray equipment carried out in December 2015 had identified three machines delivering higher than expected dosages. The engineer had certified the machines as being 'in working order', but recommended that further advice should be sought from the Radiation Protection Advisor (RPA). The practice had not followed up on this recommendation at the time of the inspection. The practice manager confirmed with us via email, after the inspection, that they had contacted their RPA for further advice on this matter.

We checked staff training records for all of the personnel taking X-rays. We noted that all relevant staff had completed some radiography and radiation protection training. All of the staff taking X-rays had been booked to renew their training in June 2016.

There had been an audit on X-ray quality for both of the principal dentists in 2016. However, the performance of the other five operators had not been audited. We checked a random sample of dental care records for each of the dentists. We found that the notes did not always consistently record the justification and grading of X-rays. We discussed the X-ray audit protocol with one of the principal dentists and practice manager. They told us that an audit for each operator would now be carried out with a view to identifying areas for improvement.

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 and General Dental Council (GDC) guidelines. One of the principal dentists described to us how they carried out their assessments. The assessment began with the patient completing a medical history questionnaire covering 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 made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's 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 details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were generally recorded appropriately. We saw details of the condition of the gums were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

However, the quality of information in the dental care records was variable across dentists. For example, some records did not include the details related to the assessment of soft tissues or discussions of the risks and benefits of different treatment options. X-ray justification was also not consistently noted. There had been an audit of dental care records for each dentist within the past year, but this had not been successfully followed up to improve the quality of record keeping.

We also checked a sample of dental care records for patients who had undergone intravenous sedation. We found that patients had important checks prior to sedation; this included a medical history, height, weight and blood pressure. During the sedation procedure, checks were also carried out at regular intervals and a record of these checks was kept. These checks included pulse, blood pressure and the oxygen saturation of the blood. The processes carried out were in line with current good practice guidelines demonstrating that sedation was carried out in a safe and effective way.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. One of the principal dentists told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussions with their patients, where appropriate, around smoking cessation, sensible alcohol use and dietary advice. The dentists also carried out examinations to check for the early signs of oral cancer.

There was a hygienist working at the practice. Where required, the dentists referred patients to a hygienist to further address oral hygiene concerns.

We observed that there were health promotion materials displayed in the waiting area and treatment room. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition

Staffing

Staff told us they received appropriate professional development and training. We checked seven staff records and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, infection control and radiography and radiation protection training. Staff had also completed safeguarding training to an appropriately high level.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they recently been engaged in an appraisal process to review their performance and identify their training and development needs. They commented that

Are services effective?

(for example, treatment is effective)

they were well supported by the principal dentists and practice manager. The practice manager demonstrated that the appraisal process was underway by showing us some preliminary survey data they had collected for each staff member with a view to providing a tailored appraisal meeting.

The practice had reviewed the staff training requirement in conscious sedation as set out in The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015. Staff had already attended some additional training within the past three months and the practice was continuing to review its position in relation to the new guidance.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

Staff explained how they worked with other services, when required. The dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complicated extractions. The practice also accepted referrals from other practices, for example, for implants and for CBCT scans.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

The practice also ensured that all necessary documentation was forwarded to referring dentists who made use of the CBCT scanner or implant services. However, we noted that service level agreements had not been set up for the use of the X-ray equipment between referring practices and this provider for CBCT scanning.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to one of the principal dentists about their understanding of consent. They explained that 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 had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

All of the staff we spoke with were aware of the Mental Capacity Act 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 for themselves).

The principal dentist we spoke with could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The feedback we received from patients was positive and referred to the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. Patients who felt they were nervous about dental treatment indicated that their dentist was calm, worked with them, listened to their concerns, and gave them reassurance throughout the processes of the dental treatments.

Staff were aware of the importance of protecting patients' privacy and dignity. For example, the treatment room doors were closed at all times when patients were having treatment.

Staff understood the importance of data protection and confidentiality and had received training in information governance. They were careful not to discuss issues concerning individual patients in the reception area.

Patients' dental care records were stored in a paper format. The records were stored in locked filing cabinets and were not left unattended in the reception area.

Involvement in decisions about care and treatment

The practice displayed information on its website which gave details of the private dental charges or fees. This information was also displayed in the waiting area.

We spoke with a range of staff on the day of our inspection including one of the principal dentists, a hygienist, and a dental nurse. They told us they worked towards providing clear explanations about treatment and prevention strategies. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

The practice had also trained administrative staff to act as patient co-ordinators. The patient co-ordinators were invited to attend consultations and were subsequently available to discuss concerns and answer questions about treatment plans with patients. These members of staff had attended relevant clinical training courses to support their understanding of the treatment planning process. Patients commented positively about this service. They indicated that it promoted their understanding of the treatments provided and the sense of being well supported throughout the treatment process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including guides to different types of dental treatments. New patients were given a practice leaflet which included advice about appointments, opening hours and the types of services that were on offer. The practice had a website which reinforced this information.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. There was an equality and diversity policy which staff were following.

Staff spoke a range of different languages, which supported some patients to access the service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired.

The practice was wheelchair accessible with access to the treatment room on the ground floor, although there was no access to a disabled toilet. However, we noted that the practice had not carried out a formal disability discrimination audit to identify and consider what reasonable adjustments could be made to the premises to accommodate the needs of disabled patients.

Access to the service

The practice opening hours are Monday to Friday from 9.00am to 6.00pm. The practice is also open from 9.00am to 5.00pm on Saturdays.

We asked the one of the receptionists about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access NHS out of hours emergency treatment. Private patients also had direct access to one of the dentists via an 'on call' mobile phone system.

We were told that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards and through reviewing the results of the practice's survey confirmed that patients had good access to the clinical staff in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in a patient information folder and on a notice board in the waiting areas. Patients were directed to ask the staff at the reception desk for further information about how to complain.

We viewed a copy of the complaints policy and saw that it described how the practice handled formal and informal complaints from patients. There had been three complaints recorded in the past year. We saw that these had been investigated and responded to in line with the practice policy. Complaints had not been formally discussed at a staff meeting. However, the practice manager could demonstrate that action had been taken to improve protocols following discussions with staff. For example, security protocols and equipment had been reviewed following a complaint.

Patients were invited to give feedback through an annual patient satisfaction survey and through the NHS 'Friends and Family' test. We reviewed the information received from these two sources. The information collected demonstrated that patients were satisfied with their care.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

Records related to patient care and treatments were kept accurately and staff records were generally well maintained.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. We identified some areas where improvements were required. For example, in relation to managing the risks associated with the proper use and maintenance of equipment, such as the ultrasonic baths and X-ray machines, the practice had either not serviced equipment in a timely manner, or the outcome of the servicing had not been followed up without delay. The principal dentist and practice manager who we spoke with about these issues were responsive to our feedback and confirmed that they would act to remedy these issues.

There were regular staff meetings to discuss key governance issues. We reviewed minutes from meetings held in the past year and noted that topics such as staff training and infection control, were discussed. However, the agenda for the staff meetings had not allowed for a review of significant events, including any incidents, accidents or complaints, with a view to identifying areas for improvement and preventing a recurrence.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentists and the practice manager. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring and committed to their work and overall there was a strong sense that staff worked together as a team.

Staff were being engaged in an appraisal process, at the time of the inspection, to identifying their training needs and overall career goals.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control, clinical record keeping and X-ray quality. However, we found that the audit process had not always been used successfully to monitor and improve the quality of the service. For example, the X-ray audit was not comprehensive as it did not cover each clinician taking X-rays at the practice. Additionally, our check of the dental care records noted inconsistencies in quality which had not been addressed through the audit process. Finally, we noted that an audit of the conscious sedation procedures carried out at the practice had not been completed.

We found that all staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

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

The practice gathered feedback from patients through the use of their own patient satisfaction survey, as well as the NHS 'Friends and Family Test'. The majority of feedback had been positive.

We noted that the practice acted on feedback from patients where they could. For example, some patients had noted that waiting times could be long. Therefore the practice manager had carried out an audit of waiting times. The results highlighted that waiting times were long when complex treatments over ran. The practice manager had subsequently instigated a change in protocol whereby patients attending for complex treatments were invited to arrive 20 to 30 minutes earlier to begin preparation, including filling in of written forms, prior to the start of the appointment for treatment. They were continuing to monitor the system to evaluate if this led to any improvements

Staff told us that the principal dentists were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.