John Carter and Partners

Richmond Road Dental Practice

Inspection Report

Richmond Road Dental Practice
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Overall summary

We carried out an announced comprehensive inspection on 5 August 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Richmond Road Dental Practice is located in Kingston, in the London Borough of Kingston. The premises are in a residential property, with the practice located on the ground floor only. The practice consists of two treatment rooms, a waiting area and reception and a staff kitchen. There are also toilet facilities shared between staff and patients.

The practice provides NHS and private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns, bridges, orthodontics, implants, dentures and oral hygiene.

The staff structure of the practice is comprised of the principal dentist who is also the practice manager, two associate dentists, three dental nurses and a receptionist who assists with administrative duties.

The practice is open 8am-5pm Monday to Thursday and 8am-1pm on Fridays.

Summary of findings

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

We spoke with four patients on the day of our inspection and received 43 completed CQC comment cards. Patients we spoke with, and those who completed CQC comment cards, were very 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:

- The practice had good decontamination procedures for dental equipment and thorough checks of the decontamination equipment were carried out.
- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients were very positive about their care; they felt listened to, involved in their care and found practice staff helpful and friendly.
- From reviewing comments cards and speaking to patients, all patients felt they received an excellent and efficient service.
- The practice provided a responsive service; patients were able to access emergency appointments on the day they needed them.
- The practice had a stable leadership structure and staff told us they were well supported by the management team.
- The practice routinely completed a range of risk assessments to identify health and safety risks and provided regular servicing for most equipment, although some equipment and medicines checks were not always recorded.
- We found that the governance arrangements including management of some risks and learning and improving from incidents and accidents were not assured.

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

- Establish effective systems to record and monitor all medicines, emergency equipment, refrigerator thermometer temperatures and water temperatures.
- Ensure the systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors are robust and adequately documented.
- Ensure that practice policies are updated at regular intervals and updates are documented.
- Review the practice's protocols for use of two dental chairs in one treatment room and ensure all reasonable efforts are made to make sure that discussions about care and treatment cannot be overheard and, that risks of aerosol contamination are minimised.
- Ensure all audits have documented learning points and the resulting improvements can be demonstrated.

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 a number of risk assessments in place for health and safety that had been completed by the principal dentist, but these did not always indicate that they had been regularly updated. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had systems in place for the management of infection control, medical emergencies and dental radiography.

However, there were some areas where the practice should make improvements. Some equipment, including emergency equipment, dental materials, water and refrigerator temperatures were not adequately checked and recorded.

Although the practice reported staff accidents, systems for reporting and learning from incidents were not fully in place.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE) and The Department of Health (DH). 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.

There were systems in place for recording written consent for treatments, with detailed, tailored proposed treatment plans provided to patients undergoing more complex procedures. The practice maintained appropriate dental care records and details were updated at each appointment where needed. The practice worked well with specialist colleagues and timely referrals were made.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

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

We received highly positive feedback from speaking to patients, from NHS Friends and Family Test results and through comment cards, that they were treated with dignity and respect. Patients reported a positive and caring attitude amongst the clinical and administrative staff.

Dental care records were stored securely in the practice. Confidentiality was maintained most of the time; however there were instances where the practice utilised two dental chairs in one treatment room such as for management of urgent situations. The principal dentist assured us that detailed treatments and assessments were not undertaken in such circumstances and the practice always obtained consent from both patients where they had to use two dental chairs at the same time.

Are services responsive to people's needs?

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

Summary of findings

Patients had good access to appointments, including emergency appointments, which were available on the same day. Staff were able to provide a very flexible service to meet the needs of patients. The needs of people with disabilities had been considered in terms of accessing the service; however the toilet facilities were not wheelchair accessible.

There was a clear complaints procedure and the practice had not received any complaints in the previous 12 months.

Are services well-led?

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

Some governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings. We found that the outcomes of risk assessments or audits had been reviewed and acted on in a timely manner. However there were some areas where the practice should make improvements. Risk assessments, incident reporting, audits and staff meetings were not always being used effectively to monitor and improve the quality of care.

Richmond Road Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 5 August 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist Specialist Advisor.

We reviewed information received from the provider prior to the inspection. This included the practice's statement of purpose and complaints received over the previous 12 months.

During our inspection visit, we reviewed policy documents, staff records and dental care records. We spoke with five members of staff, which included the principal dentist, two associate dentists, two dental nurses and the receptionist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We reviewed the practice's decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

Forty seven people provided feedback about the service. Patients we spoke with and those who completed CQC comment cards were very positive about the care they received from the practice. They were highly complementary 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

The practice had a system in place to report and record accidents in the practice. The records we reviewed showed appropriately recorded incidents relating to staff injuries, for example a needle stick injury. The staff were aware of the need to report incidents as per the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR) though they'd never had to do so.

There had been no reported clinical or non-clinical significant events or incidents in the last year. The practice had a significant event analysis policy in place; however this had not been used as staff told us that no significant events had happened. We were told that if an accident occurred they would be discussed in the monthly staff meeting, however hand-written records of staff meetings were limited. It was not evident that learning from incidents was taking place in order to improve the quality and safety of care.

We were told that if incidents arose where people who use services were affected, the practice would inform them where something had gone wrong, give an apology and inform patients of any actions taken as a result. There had not been any instances where service users had been affected.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults, which had been updated yearly. This included contact details for the local authority safeguarding team. This information was easily accessible to staff in a central folder.

The principal dentist and the associate dentist were the safeguarding leads for the protection of vulnerable children and adults. All staff had completed safeguarding training for adults and children to level two and the principal dentist had completed safeguarding children's training to level three, due to the practice's frequent contact with children. Staff were able to describe potential signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager, however they had never had to do so. A whistleblowing policy for the practice was available.

Most dental care records were handwritten, and x-rays were stored with the patients' records.

During procedures such as root canal surgery and fillings, the practice often used rubber dams although file holders were used routinely as an alternative measure. (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.)

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. The practice had comprehensive policies and procedures for the safe handling of sharps and guidance for the management of a sharps injury; however a sharps risk assessment hadn't been undertaken and not all dental nurses were familiar with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We noted that dental nurses disposed of needles in sharps containers after the dentists had removed these from syringes and we were told that needle guards were utilised by all staff as a means of prevention.

Medical emergencies

The practice had some arrangements in place to deal with medical emergencies. All staff had received annual training in emergency resuscitation and basic life support. Staff were aware of the practice protocols for responding to an emergency and we saw the medical emergencies procedure which was displayed in the practice.

The practice had a range of emergency equipment in accordance with guidance issued by the Resuscitation Council UK, however we noted that some items such as a self-inflating oxygen bag and a full range of airway pieces were not available at the time of inspection. The practice stocked a range of relevant emergency medicines, although some medicines did not fully align to the recommended guidance. Shortly after the inspection, the full range of emergency medicines and equipment were made available.

Are services safe?

Oxygen and an automated external defibrillator (AED) were available in the practice. (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). However we found that the oxygen cylinder had expired and required replacement. We also found that the defibrillator pads had expired and the practice did not stock defibrillator pads for children. Shortly following the inspection, the practice told us that the oxygen cylinder had been replaced and new sets of defibrillator pads were available for both adults and children.

The medicines were checked monthly and these checks were recorded, however the oxygen was checked annually and checks for the defibrillator and emergency equipment were not recorded. The practice agreed to commence all checks weekly and record these.

Staff recruitment

The practice staffing consisted of a principal dentist who was the director, two associate dentists, three dental nurses and a receptionist. All staff who were employed by the practice had a range of information in their personnel files including updated criminal records checks, evidence of professional registration and identification.

The practice had a recruitment policy in place, which needed updating as it did not mention all the recruitment checks such as those for criminal records that were required for new staff. The practice had recruited one new permanent clinical staff member in 2015 and we found that they had completed identity checks, disclosure and barring service (DBS) checks and were in the process of obtaining references although the staff member had been working at the practice for some months. There was an induction programme for new staff and staff were directed to the practice manual to facilitate the process.

Monitoring health & safety and responding to risks

The practice had a range of health and safety risk assessments and policies in place that were updated annually by the principal dentist, however it was not always recorded if they were updated or not. Policies included a general health and safety policy, a range of infection control policies and procedures, fire safety, mercury handling and waste management. A health and safety risk assessment was carried out by the principal dentist every year, the most recent being in 2015 and we saw that health and safety training had been received by staff in 2012. The practice had also completed a disability assessment audit some years ago, and they reported as a result of this they had provided a portable ramp to enable wheelchair access into the practice.

The principal dentist completed a fire risk assessment annually, however these were not recorded with the most up to date review. The practice reported they had annual fire drills with all staff present, to go over the practice procedure and we saw updated escape plans in situ. Staff did not receive specific fire training apart from during the fire drills. The practice risk assessment indicated that the premises did not need a fire alarm, however they had two extinguishers which were checked annually by the principal dentist.

There were effective 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 that were associated with hazardous substances had been identified and actions were described to minimise these risks. This folder was updated annually.

The practice had a business continuity plan in place, however this was not dated. The plan contained details of actions in response to staff absence, and a variety of catastrophes. A buddying system was evident with a local dental practice in the event of any incident affecting the business.

The practice had good measures in place in response to Medicines and Healthcare products Regulatory Agency (MHRA) alerts. If there were any medicines alerts, we were told these were sent through to the receptionist and principal dentist. We saw numerous examples of alerts related to COSHH information and medical devices, which were signed by staff and the principal dentist indicating whether action was required.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy that had been recently updated, with detailed infection control procedures which included the decontamination of dental instruments, hand hygiene, use of personal protective equipment, the segregation and disposal of clinical waste,

Are services safe?

sharps safety and dealing with spillages. The principal dentist was the infection control lead. Staff had completed regular infection control training online, and we saw evidence of this.

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)'. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between surgeries and the decontamination areas which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. Decontamination was carried out in both the dental surgeries, and each surgery had a designated decontamination area with clearly marked 'dirty' and 'clean' areas. Dental nurses wore appropriate personal protective equipment, such as heavy duty gloves and eye protection. Both surgeries had dedicated sinks for cleaning used dental instruments and for hand washing, and a removable bowl for rinsing of instruments.

Following manual cleaning, equipment was placed in the non-vacuum autoclave which was in one of the treatment rooms, and then checked with an illuminated magnifier for any debris during the cleaning stages. If any debris was noted, the items would be re-cleaned and placed back in the autoclave. We asked the practice about this system and they reported it was due to the layout of the practice and potential health and safety hazards of having the illuminated magnifier near the sink, so they preferred to use the autoclave twice, if required, so that there was less risk of decontamination by moving equipment around the decontamination area.

Following sterilisation in the autoclave, items were pouched and date stamped. The date stamps indicated an expiry date, identifying how long they could be stored for before the sterilisation became ineffective. All sterilised dental instruments we checked were in date. The practice had a robust system of daily logs used by the dental nurses, for the daily checking of the autoclave. There were also testing strips attached to the log books.

Clinical areas and decontamination rooms were clean and free of clutter. The practice had sealed floors and work surfaces. Practice staff led on the cleaning of the surgery, with clinical areas being cleaned by dental nurses and all staff had responsibilities for different areas of the whole practice. The practice was cleaned daily, with some areas thoroughly cleaned weekly such as switches, door handles and ceilings. The practice took into account national guidance on colour coding equipment, to prevent the risk of cross-infection. A cleaning schedule was in place and we were told a cleaning audit was completed monthly. The principal dentist carried out an annual cleaning audit, which was last completed in February 2015.

We saw adequate hand washing facilities including hand soap and paper towels by all hand washing sinks. Sufficient stocks of personal protective equipment (PPE) including gloves and eye protection were available for staff.

There had been regular, annual infection control audits which had more recently been completed six-monthly. The last audit was completed in April 2015, with an additional audit completed by NHS England where the practice had met essential criteria, but had an action plan in place following this audit to meet best practice guidance. Actions we saw were to install a washer-disinfector and replace current radiators with easy-clean radiators, however these action points were still pending.

The practice had an on-going contract with two clinical waste companies. We saw a record of waste consignment notices for the last few years. This included the collection of clinical waste including amalgam and safe disposal of sharps. We were shown a secure, locked area outside of the practice where waste was stored. A waste audit was carried out in 2014. We saw that all staff, including the receptionist, had Hepatitis B immunization records in their files. All staff were required to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Practice staff followed recommended guidelines to assure dental water line safety. The practice had also carried out a risk assessment of the dental water lines in 2010 and the practice was identified as low risk as water was not stored on the premises. The principal dentist completed the Legionella risk assessment bi-annually and no issues were identified. The last documented assessment was in 2009, however the dentist assured us this had been regularly re-reviewed.

Are services safe?

(Legionella is a bacterium found in the environment which can contaminate water systems in buildings.) The practice undertook monthly water temperature tests monthly as indicated by the risk assessment.

Equipment and medicines

We found that most of the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor and autoclave had all been serviced. We saw the recent pressure vessel certificate dated September 2014. Portable appliance testing (PAT) was completed in May 2015 in accordance with good practice guidance. (PAT is the name of a process during which electrical appliances are routinely checked for safety.) The four dental chairs were serviced annually, however evidence confirming the last testing date was not available during the inspection.

The practice was well stocked with single use equipment, however there was no structured system for the re-ordering and monitoring of stock and dental materials kept in the refrigerator. We found one out-of-date dental material, which expired in 2014. There were no checks carried out for the monitoring of the refrigerator temperature.

All prescriptions were handwritten. Prescription pads were stored in a locked cupboard in one of the dental surgeries. Private and NHS prescriptions were available and the practice stored some medicines to sell within the practice. We saw the practice had a dispensing medicines policy with details regarding each medicine that they stocked. We saw a comprehensive log of any prescription provided and batch number of the medicine sold, and the practice had a robust system for checking stock and expiry dates. These medicines were stored safely and could not be accessed inappropriately by patients.

Batch numbers for local anaesthetics were mostly recorded in the clinical notes from records we saw. The practice did not use intravenous sedation, however they used inhalation sedation on some occasions. (These 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). The practice had a contract with an external company, who were in charge of replenishing the stocks of nitrous oxide and maintaining the cylinders.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of x-ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in each treatment room that housed an x-ray machine as well as in the file. An external radiation protection advisor (RPA) gave support to the practice and the principal dentist was the radiation protection supervisor (RPS). The folder contained an inventory of equipment with evidence of a track record of maintenance logs for the four machines and the Health and Safety Executive (HSE) notification certificate. Not all the critical examination packs were available to view on the day of inspection, although we were told the practice did have these for all their x-ray machines. We saw certificates confirming that annual x-ray safety checks had been carried out over the previous few years.

All clinical staff had completed radiation training with evidence of certificates in the radiation protection file and staff certificate files. We saw radiography audits had been undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed a sample of dental care records and discussed patient care with two dentists and two dental nurses. We found that the dentists regularly assessed patients' gum health, and soft tissues (including lips, tongue and palate) were regularly examined. Dentists took x-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). They also recorded the justification, grading, findings and quality assurance of images taken in most cases.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool in adults. The practice had not completed these checks for children above the age of seven. (The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) If scores were indicative of advanced gum disease, dentists carried out a full charting.

The dentists were aware of and complied with National Institute for Health and Care Excellence (NICE) guidance in relation to deciding appropriate intervals for recalling patients and antibiotic prophylaxis.

Records showed thorough and detailed dental care records, including medical histories and clear records that patients were involved in care decisions, with documented price discussions.

Health promotion & prevention

The practice promoted maintenance of good oral health. Although not all staff were aware of the Department of Health Delivering Better oral Health Toolkit, from the discussions and dental care records that we saw, the guidance was being followed. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.) Staff told us they discussed oral health with their patients, for example, effective tooth brushing, oral hygiene, prevention of gum disease and dietary advice. Dentists and dental nurses identified patients' smoking status and discussed smoking cessation; we were told that a number of patients had successfully quit smoking following this repeated advice.

Dentists also carried out examinations to check for the early signs of oral cancer. Prescription of high fluoride toothpastes were evident in patient records and they provided all children with fluoride varnish applications every six months and those who were high risk every 3 months. Children over six were provided with fluoride fissure sealants where indicated.

We observed that the practice provided targeted health promotion materials, by issuing these and discussing them directly with patients during consultations. There were some health promotion materials displayed in the waiting area, in relation to dietary advice.

Staffing

The practice benefited from employing a range of experienced staff who had worked at the practice for a number of years. Each dentist had a dental nurse that normally worked with them, to ensure continuity of care; however where needed dental nurses would assist other dentists. There was a weekly rotation arrangement to ensure a mix of experience between the nursing and dental staff. The practice had an agreement with a local dental surgery to provide dental cover in times of short staffing. Opportunistic advice could be sought from peers where needed. A temporary dental nurse was used when the receptionist was on annual leave, as one of the dental nurses covered the reception duties.

Staff told us they received appropriate professional development and training from the practice and were given time to attend courses. We reviewed some staff files and saw evidence of training certificates. The training covered the mandatory requirements for registration issued by the General Dental Council (GDC). The practice ensured they had up to date details of registration with the GDC for all dental staff and had a log of all CPD activities undertaken by practice staff.

Working with other services

Are services effective?

(for example, treatment is effective)

Most referrals were to other specialist colleagues for orthodontic and periodontal treatment that could not be done in-house, plus referrals were occasionally made to secondary care for complex cases requiring oral surgery, as most cases could be dealt with in the practice.

All referral letters we viewed were comprehensive to ensure enough information was provided. Patients were routinely given a copy of their referral letter.

Consent to care and treatment

The practice ensured signed, valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. The practice had a standard form which detailed the treatment, clear costings and the patient signature. Notes of these discussions were recorded in the dental care records and a copy of the signed consent form was kept by both the patient and the dental practice. We also saw comprehensive consent forms for complex procedures, were they were tailored to individual patients, clearly setting out all possible options and potential consequences of the procedures.

We saw evidence that dental staff had an understanding of the requirements of the Mental Capacity Act 2005 (MCA). Staff could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We received 43 CQC comments cards and found that 100% of feedback was highly positive about the practice. Patients felt that the service provided exceptional care, staff were patient-friendly and highly professional. The patients we spoke with all commented positively on their experience at the practice with the dentists, dental nurses and reception staff and felt it was a very efficient service. The majority of patients who provided feedback had been with the dental practice for more than 10 years and some patients travelled some distance to continue receiving dental care at the practice after moving away.

Patients who reported some anxiety about visiting the dentist commented that the dental staff were good about providing them with reassurance by clearly explaining procedures. Staff always called patients following complex dental work in order to reduce any anxieties and to ensure patients were recovering suitably after their procedures. Staff told us that where children had anxieties relating to treatment, they would ensure the child knew what to expect and provided reassurance at each stage of the procedure. Parents reported they were pleased with the level of care their children received. Children were provided with stickers and balloons after their appointments. We saw that the practice had received seven compliment letters over the past seven months. NHS Friends and Family Test data for the previous three months showed that 100% of respondents were extremely likely to recommend the practice.

We observed that clinical and administrative staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking to patients on the telephone.

Patients indicated they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Dental care records were stored securely.

We were shown how the practice had two dental chairs in each of the two treatment rooms and staff told us that they were able to use both dental chairs if needed so they could begin treatment for patients requiring urgent treatment. We noted that the dental chairs in one room could be separated by a partition if both chairs were being used, however in the other treatment room, the chairs were partitioned by a storage unit so conversations could still be heard. Dental staff explained that they always asked consent from both patients where they needed to use both chairs and did not discuss assessment and treatment details or perform lengthy procedures with two patients in one treatment room. Patients we spoke with and feedback from comments cards indicated no concerns about confidentiality and we noted there had been no complaints or incidents related to confidentiality.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the dental fees for the range of procedures that the practice offered. CQC comments cards and patients we spoke with indicated that all patients felt involved in their care and felt they were always given adequate information about their treatment and fees.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their proposed treatment plans where informed consent was required for complex procedures. There was a range of information leaflets in the waiting area which described the different types of dental treatments available and the practice website also detailed these treatments.

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' needs. Staff told us they had enough time to treat patients and that patients could always book to see the dentist of their choice. We found that the service was very flexible and was able to adapt to needs of the patients, to accommodate emergency appointments. We were also shown how the practice accommodated children of school age by providing before-school appointments from 8am daily.

The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled to receive treatment. We noted positive comments from patients who reported they had received timely emergency care from the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of the service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had access to a telephone translation service, but had not needed to use this.

The practice had policies in place for equal opportunities and equality and diversity. The practice had previously completed a disability assessment audit some years previously. They had identified that they needed to provide a portable ramp to allow access to the surgery for wheelchair users, which was now in place. We observed during the inspection that the practice did not have wheelchair accessible toilet facilities as the toilet was accessed via a step. The practice agreed to review the accessibility of the toilet facilities following the inspection.

All treatment rooms were wheelchair accessible and dental treatment chairs were seen to be adjustable to provide easy access for patients. Dental equipment could be adjusted if patients were unable to leave a wheelchair. The waiting room was large enough for wheelchairs and pushchairs.

We observed that the practice information leaflet was not suitable for patients with visual impairment, however the practice reported they would provide larger print copies for patients when required.

Access to the service

The practice was open 8am-5pm Monday to Thursday and 8am-1pm on Fridays. The practice displayed its opening hours on the premises and on the practice website. Patients were also given a practice information leaflet which included the practice contact details and opening hours.

Patients told us they were given text message reminders or phone calls the day before their appointments and staff felt this worked well to reduce failed attendances.

We asked dental and reception staff about access to the service in an emergency or outside of normal opening hours. The practice directed patients to the out-of-hours provider contracted by NHS England, which was based at a local hospital. The out-of-hours provider operated between 5pm-10pm on weekdays and 9am-10pm at weekends and bank holidays. The practice answer phone message and website gave details on how to access out-of-hours emergency treatment. We were also told that the practice occasionally saw emergency patients if the need arose at weekends, for patients who had undergone complex procedures. This provided continuity of care.

All patients we spoke to and all CQC comments cards reviewed were positive about their experience of getting an appointment, including emergency appointments.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area and on the practice information leaflet. The practice reported that they had not received any complaints over the last 12 months. There was a complaints policy in place. We reviewed the complaints log book, which detailed three complaints from 2012 and 2013. The practice had recorded the date of complaint, acknowledgements and responses were sent, however there were no acknowledgement or response letters to view in the practice, as we were told that these had been sent to the dental protection service and not yet sent back.

Complaints were shared at practice meetings, although there was limited recorded information of what was discussed at meetings.

Are services well-led?

Our findings

Governance arrangements

The practice had a management structure in place. The principal dentist was the clinical lead and also the practice manager. The principal dentist was in day to day charge. When the principal dentist was not working, the associate dentist led in all clinical areas.

There were relevant policies and procedures, including a range of health and safety polices. The principal dentist reported that they reviewed and updated all practice policies and procedures annually, however we noted that some policies did not have dates recorded and it was not clear when they were last updated. Staff were aware of these policies and procedures and they were easily accessible to all staff in the reception area. We were told that during practice meetings staff were made aware of any changes to policies and procedures. We saw that some policies were signed by staff indicating they had read these.

Governance and monitoring of equipment and procedures was managed suitably though improvements were needed. For example, we found that the practice were not adequately monitoring and stock checking emergency equipment, dental materials in the refrigerator and refrigerator temperatures. All servicing of practice equipment had been undertaken, but the practice did not have assurances of the last testing dates for the dental chairs.

The practice had completed a range of risk assessments internally, in relation to health and safety, control of substances hazardous to health (COSHH) and legionella; however the date that these had been carried out and how frequently they were updated was not always indicated. We noted that although there had been one sharps injury in 2014, the practice had not completed a sharps risk assessment in order to assure sharps safety in the practice. The practice also assessed risk through scheduled audits including infection control and radiography. The practice were routinely utilising safety information to monitor risks through the use of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and business risks were identified with mitigating actions in the practice's business continuity plan.

Accidents were recorded, however the practice did not also record near misses, clinical or non-clinical incidents.

Staff were being supported to meet their continuing professional development (CPD) standards set by the General Dental Council, and staff records contained comprehensive information to confirm that dental staff had carried out mandatory CPD and other mandatory training in order to perform competently in their role. Records, including those related to patient care and treatment, as well as staff employment, were kept well-maintained. Most recruitment checks were being carried out in line with guidance.

Leadership, openness and transparency

Staff told us that the practice encouraged a team approach and they described a transparent culture which encouraged candour, openness and honesty where any issues were discussed and amended quickly. Staff said that they felt very comfortable about raising concerns with the principal dentist. Staff told us they really enjoyed their work and were well supported.

Staff knew who to report to depending on the issue raised, for example, the principal dentist was in day to day charge for safeguarding concerns, complaints and was also the infection control lead. The associate dentist was the lead clinician when the principal dentist was not working.

The principal dentist outlined the practice's mission statement for providing good care for patients. They shared with us their Statement of Purpose. We saw that the practice had provided a recent duty of candour policy and had a whistleblowing policy as well as a range other human resources policies to support staff.

The principal dentist engaged with staff on a monthly basis via a regular staff meeting and we saw minutes of these were kept. From minutes we saw, action points and areas for improvement identified from any incidents and safety information were not widely discussed or recorded.

Learning and improvement

We were told that clinical staff were up to date with their continuing professional development (CPD). 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). Staff told us that any training courses completed, CPD activities and new clinical guidance was discussed during practice meetings.

Are services well-led?

The practice did not currently engage staff in an appraisal process, however we saw a recent appraisal statement and evidence of an appraisal template that had been developed by the principal dentist and we were told that providing formal staff appraisals was an identified area of development for the practice. Staff reported they did have opportunistic discussions with the principal dentist, but these had not been recorded previously.

Appropriate audits were carried out, although improvements could be made in the documentation of the learning points from audits, as some were spot checks and not written up formally that would assist in identifying trends.

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

The practice had gathered feedback from patients previously, but reported they had only received positive comments. They had recently commenced the monthly NHS Friends and Family Test and we saw the results form the last three months which were all positive.

Staff feedback was gained where the need arose, as staff were happy to raise concerns opportunistically or during practice meetings.