Mr. Gordon Smith

Gordon Smith Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 July 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

Gordon Smith Dental Practice is a dental practice providing general dental services on a NHS and private basis. The service is provided by two dentists. They are supported by three dental nurses, a practice manager and a receptionist. The practice manager was also a qualified dental nurse.

The practice is located on a busy road close to local amenities and several bus routes. There are nearby car parking facilities. The premises consist of a waiting room, a reception area, two treatment rooms and accessible toilet facilities on the ground floor. The first floor comprises of a staff room/kitchen/office area and a storage room. Opening hours are from 9am to 5pm from Monday to Thursday and 9am to 1pm on Fridays.

The provider is registered with the Care Quality Commission (CQC) as an individual. 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.

Forty-six patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff were friendly and polite.

Summary of findings

Our key findings were:

- The practice appeared clean and tidy on the day of our visit. Many patients commented that this was also their experience.
- Feedback from patients described the service as friendly, kind and caring. Patients were able to make routine and emergency appointments when needed.
- The practice carried out effective infection control procedures in line with current guidance.
- The practice had systems to monitor and manage risks to patients, staff and visitors. This included infection prevention and control, health and safety, safeguarding, safe staff recruitment and the management of medical emergencies.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines and current legislation.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competency and ensure all staff are aware of their responsibilities.
- Review the practice's protocols for completion of dental 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 of various aspects of the service, such as radiography and dental care records at regular intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.
- Consider replacing the flooring in one treatment room with a smooth impervious covering with coving as part of their future refurbishment programme.

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?

No action

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

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. Flooring in the treatment rooms required sealing to the walls and the provider arranged for this shortly after our visit.

Staff told us they felt confident about reporting accidents and incidents. Staff we spoke with were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Are services effective?

No action

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP) for one dentist but the other dentist's record keeping required improvement.

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

No action

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

Summary of findings

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. Patients described staff as friendly and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding.

Staff told us that a lot of the patients had visited the practice for many years (even decades) and had formed excellent professional relationships with them.

Are services responsive to people's needs?

No action ✓

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

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Patients were able to contact staff when the practice was closed and arrangements were subsequently made for these patients requiring emergency dental care.

The practice had an effective complaints process.

The practice offered access for patients with limited mobility and were aiming to fit a ramp at the front of the practice to accommodate wheelchair users.

Are services well-led?

No action ✓

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

There was a clearly defined management structure in place and staff we spoke with felt supported in their own particular roles.

There were some systems in place to monitor the quality of the service including infection control audits. The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

The practice regularly carried out audits in infection control to help improve the quality of service. These audits did not have documented learning points with action plans. The practice aimed to complete audits in dental care record keeping and X-rays.

Gordon Smith Dental Practice

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 inspected Gordon Smith Dental Practice on 21 July 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice and we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the provider, the practice manager, two dental nurses and the receptionist. We also reviewed CQC comment cards which patients had completed and spoke with patients. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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 arrangements for staff to report accidents and incidents. The last accident was recorded in November 2014. The last incident was recorded in June 2012. We discussed events with the practice manager and were told that no significant incidents had taken place since then. We were told that learning was shared by discussing with staff individually and in staff meetings too. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

All staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We saw evidence that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The provider was responsible for obtaining information from relevant alerts and forwarding this information to the rest of the team. These were discussed with staff during briefings which took place each morning. The provider also described the practice's arrangements for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for local safeguarding teams and these were clearly displayed in the staff room. The provider was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. We saw evidence that staff had attended a course on safeguarding children and vulnerable adults in April 2015. However, this was not a GDC verifiable course and no certificates were provided.

Within 24 hours, the provider emailed us with evidence that they had booked training on the safeguarding of children and vulnerable adults at an appropriate level that is required for dental professionals.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. Rubber dam kits were available at the practice but only one of the dentists regularly used them when carrying out root canal treatment. If a rubber dam was not used, one dentist did not use alternative measures to protect the airway. Within 24 hours, the provider emailed us with an action plan for the other dentist. This plan included the implementation of rubber dam wherever possible. It also included details of alternative precautions that must be utilised if rubber dam was not used.

The practice had a system for raising concerns. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Staff we spoke with were aware of the duty of candour regulation and there was a policy present. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were not aware of 'never events' and the practice did not have written processes to follow to prevent these happening. For example, there was no written process to make sure they did not extract the wrong tooth. However, staff told us they worked in accordance with these protocols.

The practice had processes in place for the safe use of needles and other sharp instruments.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies and were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an automated external defibrillator

Are services safe?

(AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in this area. All equipment and medicines were stored in a secure area.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented weekly checks of the emergency oxygen, medicines and the AED and we reviewed records dating back to 2013. The emergency medicines were all in date and stored securely.

All staff we spoke with were aware of the location of this equipment and equipment and medicines were stored in purposely designed storage containers.

Staff recruitment

The practice carried out appropriate processes for the safe recruitment of staff. We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of employment contracts, staff identity verification and all had two written references. Where relevant, the files contained copies of staff's dental indemnity and General dental Council (GDC) registration certificates. Some of the staff files contained curricula vitae.

There were also Disclosure and Barring Service (DBS) checks present for all staff files we reviewed. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults.

The practice had a system in place to monitor the professional registration of its clinical staff members. GDC certificates were displayed in the staff room for all GDC registered staff.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that the fire extinguishers had been serviced in September 2015. We saw evidence that the fire alarms and emergency lights were checked monthly. Fire drills took place annually. Fire safety signs were clearly displayed. Fire risk assessments were carried out internally by the practice manager on an annual basis.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them. This was reviewed annually and, also, each time a new substance was used by the practice.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice mostly followed the guidance about 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)'. However, some improvements were required. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff. Clinical staff had undertaken training in infection control in April 2016.

We observed the treatment rooms to be visually clean and hygienic. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were clean and free from clutter. Dental chairs were covered in non-porous material which aided effective cleaning. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable. HTM 01-05 advises that flooring should be coved to the wall to prevent the accumulation of dirt where the floor meets the wall. We inspected both treatment rooms and found that the flooring was not coved. Within 24 hours, the provider informed us that a carpenter had been booked to visit the practice within three working days to assess the work required and the aim was to complete all necessary work within a fortnight. Also, one of the treatment rooms had tiles on the floor. HTM 01-05 states that the flooring in clinical areas should be

impervious and easily cleanable. The floor appeared visibly clean on the day of our visit; however, the provider should consider replacing the tiles with a smooth impervious covering as part of any future refurbishment plans.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Decontamination procedures were carried out in the treatment rooms and there was no separate decontamination room. HTM 01-05 recognises that a separate decontamination room is not always achievable due to physical limitations on space. In accordance with HTM 01-05 guidance, staff described a dirty-to-clean workflow system in the treatment rooms. There was signage to clearly demarcate the clean and dirty zones.

Sharps bins were appropriately located and out of the reach of children. We observed waste was separated into safe and lockable containers for regular disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. There appeared to be sufficient instruments available and staff confirmed this with us. Staff we spoke with were aware of disposable items that were intended for single use only.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly (or even more frequently) basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument – this included all the necessary information and was easily accessible. Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

The practice manager informed us that environmental cleaning of all clinical and non-clinical areas were carried out daily by an external cleaner. The practice had a dedicated area for the storage of their cleaning equipment. Cleaning logs were seen for all areas.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every four months in line with current guidance. Action plans were not documented and there was no written analysis of the results. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings. This was discussed with the practice manager and they told us they would begin writing up action plans for all future audits.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in June 2016. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range. This was in accordance with the recommendations as per the risk assessment. The risk assessment from June 2016 also recommended water quality testing. Staff had ordered and received water testing kits and were planning to carry out these tests in the immediate future.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels and autoclaves.

Are services safe?

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirms that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in November 2015.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The prescription number was recorded in the patients' dental care records. The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked.

There was a separate fridge for the storage of dental materials. The temperature was monitored and recorded weekly.

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records and corroborated what they told us by viewing a sample of records.

Stock rotation of all dental materials was carried out on a regular basis by the dental nurse and all materials we viewed were within their expiry date. A system was also in place for ensuring that all processed packaged instruments were within their expiry date.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

The X-ray equipment in the treatment rooms was fitted with a part called a rectangular collimator which is good practice as it reduces the radiation dose to the patient.

We saw evidence that the dentists were up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

We were told that staff had completed an X-ray audit just before our visit and this was the first X-ray audit in a long time. They had not had the opportunity to analyse the results or conduct an action plan yet. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. The practice manager told us they would be carrying out more regular audits.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date electronic dental care records. They contained information about the patient's current dental needs and past treatment. The provider carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

We spoke with the provider about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were documented in all of the records we viewed. This should be updated and recorded for each patient every time they attend.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentist told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the provider was recording the BPE for all adults (age 18 and above) but not for children. The guidelines recommend that all children above 7 years old have their BPE checked and documented. Discussions with staff confirmed that patients with gum disease were appropriately managed and in line with current guidelines by the provider. The other dentist was not routinely recording the BPE in patients' dental care records. Within 24 hours, the provider emailed us with an action plan detailing the recording of BPE for all patients age 7 and above.

We discussed the dental care record keeping with staff at the practice. In view of some of the shortfalls identified, the practice manager agreed that a record keeping audit was required to encourage improvement. The previous audit in record keeping was in 2012. Within 24 hours, the provider emailed us with an action plan for the practice. The other dentist accepted that the clinical records needed to include more detail and would ensure that this would be actioned with immediate effect.

Health promotion & prevention

The provider told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. However, both dentists were not routinely recording this in the patients' dental care records. There were oral health promotion leaflets and posters available in the practice to support patients in looking after their health. Examples included information on smoking, diet and gum disease.

The practice was aware of the provision of preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive oral hygiene advice. However, not all aspects of the guidance was being followed such as topical fluoride applications on young children. Within 24 hours, the provider emailed us with an action plan detailing this.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This included areas such as fire safety and medical emergencies

Staff told us they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating

Are services effective?

(for example, treatment is effective)

dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC.

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. Some of the dental nurses worked on a part-time basis and had the flexibility to work additional hours when required. Therefore, the practice did not utilise locum dental nurses as their own staff were able to increase their hours.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us that senior staff were readily available to speak with at all times for support and advice.

We were told that the dental nurses were encouraged to carry out further training. The practice manager was also a qualified dental nurse and had undertaken further training which enabled her to take dental X-rays.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist dental services for complex oral surgery. We viewed three referral letters and noted they were comprehensive to ensure the specialist services had all the relevant information required.

Staff understood the procedure for urgent referrals, for example, patients with suspected oral cancer.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began.

Staff members we spoke with had some understanding of the Mental Capacity Act 2005 (MCA). 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. We were told that none of the patients at the patients lacked the capacity to consent. However, staff agreed they would arrange some MCA training to further their limited knowledge on this particular topic. Within 24 hours, the provider emailed us to state they had arranged an urgent staff meeting to discuss the principles of the MCA.

Staff members we spoke with were not familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Written treatment plans were available for all adult patients but not for children. This was discussed with staff and we were told that written treatment plans will be given to the parent(s)/guardian(s) accompanying children with immediate effect. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Forty-six patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was overwhelmingly positive about the care they received from the practice. They described staff as friendly, caring, thorough and professional. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive, reassuring and understanding. Several patients commented that they had recommended this practice to their friends and family. Many patients used our comment cards to express their gratitude for the kindness that they always received at the practice.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. We were told that all staff had individual passwords for the computers where confidential patient information was stored. There was a room available for patients to have private discussions with staff. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

We were told that the practice appropriately supported children and anxious patients using various methods. This removed the need for the dentists to refer nervous patients to external dental practices for sedation or general anaesthetic. Conscious sedation involves 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. Patients had the option of being referred but we were told that most nervous patients were treated in-house. Methods used by the practice included booking loner appointments for anxious patients so they had ample time to discuss their concerns with staff. The dentist would plan treatment so that simplest procedures were carried out initially. Patients also had the option of seeing a male or female dentist.

The computer system at the practice had a feature that enabled nervous patients to be identified quickly by all staff. This would enable staff to adopt their approach, if deemed appropriate and necessary.

We saw that patients were very complimentary and grateful to the practice for the dental care they received. We saw several cards addressed to the practice which thanked staff for their kindness and support.

Staff told us that a lot of the patients had visited the practice for many years (even decades) and had formed excellent professional relationships with them. Patients (or their family members) would often notify the practice if they became very unwell. In these situations, staff would ask family members if the patient concerned was happy for the provider and practice manager to visit them at home or at the hospital. Staff would also make donations to relevant charities.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment (where applicable) was discussed with them and this information was also provided to them in the form of a customised written treatment plan. All adult patients received written treatment plans.

NHS examination and treatment fees were displayed in the waiting room (but not private fees).

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as the treatment rooms were on the ground floor. There were toilet facilities available on the ground floor but these were not wheelchair-accessible. At the time of our inspection, there was no ramp access to the practice. We saw evidence that the provider had made enquiries to have a ramp fitted at the front of the practice and they aimed to have a ramp fitted in the near future to accommodate wheelchair users. In the meantime, staff would assist patients with limited mobility by helping them walk up the steps. Staff would also move their own car(s) for these patients so they could park directly outside the practice.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were not always seen on time but they felt the wait was not too long. We were told it was easy to make an appointment. Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We reviewed the appointment system and saw that dedicated emergency slots were available on a daily basis to accommodate patients requiring urgent treatment. Staff told us they would never turn away patients in pain and they would work into their lunch hour if required.

Patient feedback confirmed that the practice was providing a good service that met their needs. Courtesy calls were made to patients who had previously forgotten to attend an appointment to remind them of an upcoming appointment.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services. The practice did not have an audio loop system for patients who might have hearing impairments. However, the practice used various methods so that patients with hearing impairments could still access the services such as speaking slowly so that patients could lip read.

Staff shared examples of how they appropriately treated patients with physical and learning disabilities. Certain patients were booked at specific times of the day to suit their medical needs better, for example, in accordance with timing of medication. We were told that patients with mental health conditions and physical and learning disabilities were given longer appointments so that sufficient time was allocated to meet their dental needs.

The practice had access to an interpreting service for patients that were unable to speak fluent English but this had never been used. Several staff members spoke different languages relevant to patients such as Punjabi, Urdu and Hindi.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

Access to the service

Feedback from patients confirmed they could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment. There was information in the waiting room and the practice leaflet for patients about this service.

Opening hours were from 9am to 5pm from Monday to Thursday and 9am to 1pm on Fridays.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and clearly displayed. This included details of external organisations in the event that patients were dissatisfied with the practice's response.

No complaints had been received in the last 12 months. We reviewed older complaints and saw evidence that complaints received by the practice had been

Are services responsive to people's needs?

(for example, to feedback?)

appropriately recorded, analysed and investigated. There was a designated complaints lead and all verbal complaints were documented too. We found that complainants had been responded to in a professional manner.

Are services well-led?

Our findings

Governance arrangements

The provider was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments. The practice also had risk assessments for areas such as fire safety.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead, complaints lead and infection control lead.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The GDC requires all registrants to undertake CPD to maintain their professional registration.

Staff audited some areas of their practice as part of a system of continuous improvement and learning. These included audits of infection control. None of the audits we reviewed had been reported on and they lacked action plans. All audits should have documented learning points so that the resulting improvements can be demonstrated. Audits were also completed in areas such as workstation safety, X-rays and waste disposal.

Staff meetings took place on a quarterly basis. In addition to this, all staff participated in briefings which took place every morning. The minutes of the staff meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as confidentiality, infection control and safeguarding had been discussed in the last 12 months.

The practice manager told us that some staff had received recent appraisals. We reviewed a selection of staff files and saw that most staff had received appraisals in 2015. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. Examples included the refurbishment of the practice in response to suggestions made by patients. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. The results were collated monthly and displayed in the reception area so that patients were kept informed. Patient satisfaction surveys were available for patients to complete prior to the introduction of the NHS FFT. It was recommended that the satisfaction surveys were re-introduced so that patients undergoing private dental treatment only had the opportunity to leave their feedback. We were told that the practice welcomed verbal feedback at all times.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires.