

Dr Anne Budenberg

Bank House Dental Practice - Chester

Inspection Report

18 White Friars
Chester
CH1 1PW
Tel: 01244 326632
Website: www.annebudenberg.co.uk

Date of inspection visit: 22 March 2016
Date of publication: 25/07/2016

Overall summary

We carried out an announced comprehensive inspection on 22 March 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

Bank House Dental Practice is located close to the centre of Chester and comprises a reception and waiting room, six treatment rooms, all on the first floor, offices, storage and staff rooms. Parking is available outside the premises in the practice's private car park. The practice is accessible to patients with disabilities, impaired mobility but not to wheelchair users.

The practice provides general dental treatment to patients on an NHS or private basis. The practice opening times are Monday to Thursday 8.30am to 5.30pm, and Fridays 8.30am to 1.30pm. The practice is staffed by a principal dentist, a practice manager, an associate dentist, two hygienists, two receptionists, and six dental nurses. There are two other separately registered providers at this location and facilities and staff are shared between all three providers.

The practices' patients are predominantly of a middle aged to elderly demographic.

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

Summary of findings

Forty people provided feedback about the service. Every comment was positive about the staff and the service. New and long-standing patients commented that they found the staff welcoming, friendly, and caring and that the practice was excellent in every respect. They said that they were always given good explanations about dental treatment and dentists listened to them and took time with them.

Our key findings were:

- The practice recorded and analysed significant events and incidents and acted on safety alerts.
- Staff had received safeguarding training and knew the process to follow to raise any concerns.
- There were sufficient numbers of suitably qualified and skilled staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies, and emergency medicines and equipment were available.
- Premises and equipment were clean, secure and well maintained.
- Infection control procedures were in place and the practice followed current guidance.
- Patients' needs were assessed, and care and treatment were delivered, in accordance with current legislation, standards and guidance.
- Patients received explanations about their care, proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Staff were supported to deliver effective care, and opportunities for training and learning were available.
- We observed that patients were treated with kindness, dignity and respect, and their confidentiality was maintained.
- The appointment system met the needs of patients, and emergency appointments were available.
- Services were planned and delivered to meet the needs of patients and reasonable adjustments were made to enable patients to receive their care and treatment.
- Staff were supervised, felt involved and worked as a team.
- Governance arrangements were in place for the smooth running of the practice and for the delivery of high quality person centred care.
- The practice gathered the views of patients and took into account patient feedback but there was no formal system in place to obtain feedback regularly.

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

- Review the current legionella risk assessment having due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. The provider informed us after the inspection that a review is in progress.
- Review the systems and processes in place to comply with Regulations 4 to 20 of the HSCA 2008 (Regulated Activities) Regulations 2014, specifically in relation to seeking and acting on feedback from service users on the services provided, to allow continual evaluation and improvement of the service.

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 effective systems and processes in place to ensure that care and treatment were carried out safely, for example, there were systems in place for infection prevention and control, management of medical emergencies, dental radiography, and investigating and learning from incidents and complaints.

Staff had received training in safeguarding adults and children and knew how to recognise the signs of abuse and who to report them to.

Staff were appropriately recruited, suitably trained and skilled, and there were sufficient numbers of staff. We saw evidence of inductions for new staff and regular appraisals.

The practice had identified and assessed risks and put measures in place to reduce risks. Staff were aware of how to minimise risks.

We found the equipment used in the practice, including medical emergency and radiography equipment, was well maintained and tested at regular intervals. The practice had emergency medicines and equipment available, including an automated external defibrillator and staff were trained in dealing with medical emergencies.

There were systems in place to reduce and minimise the risk and spread of infection and the premises and equipment were clean, secure and properly maintained. The practice was cleaned regularly and there was a cleaning schedule in place. Staff had received training in infection prevention and control. There was guidance for staff on effective decontamination of dental instruments which staff were following.

We saw evidence that the practice was following current legislation and guidance in relation to X-rays which demonstrated the practice was protecting patients and staff from unnecessary exposure to radiation.

Are services effective?

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

Current guidelines were followed in the delivery of dental care and treatment for patients.

Patients received an assessment of their dental needs which included assessing and recording their medical history. Explanations were given to patients in a way they understood and risks, benefits, options and costs were fully explained and consented to. The practice kept detailed dental records and monitored any changes in the patients' oral health. The practice provided regular oral health advice and guidance to patients.

The treatment provided for patient focused on the needs of the individual. Patients were referred to other services where necessary, in a timely manner.

Patients were provided with a written treatment plan which detailed the treatments considered and agreed together with the fees involved.

Qualified staff were registered with their professional body, the General Dental Council. Staff received training and support and were supported in meeting the requirements of their professional body. Staff were offered a variety of training and development opportunities.

Summary of findings

Are services caring?

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

Patients commented that staff were caring, kind and friendly. They told us that they were treated with respect and that they were happy with the care and treatment given.

Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Patient feedback on CQC comment cards confirmed that staff were professional and understanding and made them feel at ease.

The practice had separate rooms available if patients wished to speak in private.

We found that treatment was clearly explained and patients were provided with information regarding their treatment and oral health. Patients were given time to decide before treatment was commenced. Patients commented that the staff were informative and that information given to them about options for treatment was good.

Are services responsive to people's needs?

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

Patients had access to appointments to suit their preferences, and emergency appointments were available on the same day. Patients could request appointments by telephone or in person. The practice opening hours and out of hours appointment information was provided at the entrance to the practice and in the patient leaflet.

The practice captured social and lifestyle information on the medical history forms completed by patients which helped the dentists to identify patients' specific needs and direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via a flagging system on the dental care records.

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users. Staff had access to interpreter services where patients required these.

The practice had a complaints policy in place which was displayed in the waiting room and outlined in the practice leaflet.

Are services well-led?

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

The provider had effective systems and processes in place for monitoring and improving services.

The practice had a management structure in place. Staff we spoke to were aware of their roles and responsibilities within the practice. Staff reported that the managers were approachable and helpful, and took account of their views.

The practice had a culture of evaluation and improvement and the provider encouraged openness and honesty.

There was a range of policies and risk assessments in place at the practice. Protocols and procedures were in place to guide staff in undertaking tasks. Policies, procedures and protocols were regularly reviewed and audited for their effectiveness.

The practice used a variety of means to monitor quality and safety at the practice and to ensure continuous improvement, for example learning from complaints, carrying out audits.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete, accurate and securely stored. Patient information was handled confidentially.

Summary of findings

The practice held regular staff meetings and these were used to share information to inform and improve future practice and gave everybody an opportunity to openly share information and discuss any concerns or issues.

The practice had a limited system to seek the views of patients.

Bank House Dental Practice – Chester

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.

The inspection took place on 22 March 2016 and was led by a CQC Inspector assisted by a dental specialist adviser.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included details of complaints they had received in the last 12 months, their latest statement of purpose, and details of their staff members including their qualifications and proof of registration with their professional body. We also reviewed information we held about the practice.

During the inspection we spoke to the managers, dentists, dental nurses and receptionists. We reviewed policies, procedures and other documents and observed procedures. We reviewed 37 CQC comment cards which we had sent prior to the inspection for patients to complete about the services provided at the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The provider had procedures in place to report significant events and incidents, however there had been no recent significant events. We discussed examples of what could constitute a significant event in a dental practice and were assured that should one occur, it would be reported and analysed and improvements would be put in place to prevent re-occurrence.

Staff had a good understanding of the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 and were aware of how and when to report. The practice had procedures in place to record and investigate accidents, and we saw examples of these in the accident book.

Staff had an understanding of their responsibilities under the Duty of Candour. Duty of Candour means relevant people are told when a notifiable safety incident occurs and in accordance with the statutory duty are given an apology and informed of any actions taken as a result. The provider knew when and how to notify CQC of incidents which could cause harm.

The practice received alerts from the Medicines and Healthcare products Regulatory Agency and Department of Health. These alerts identify problems or concerns relating to a medicine or piece of medical or dental equipment, or detail protocols to follow, for example, in the event of an outbreak of pandemic influenza. The practice manager brought relevant alerts to the attention of the clinicians. The principal dentist was able to discuss several recent alerts.

Reliable safety systems and processes (including safeguarding)

We saw evidence that the practice had systems, processes and practices in place to keep people safe from abuse.

The practice had a whistleblowing policy in place and staff were encouraged to bring safety issues and concerns to the attention of the managers.

The practice had a policy for safeguarding children and vulnerable adults. Staff we spoke to understood the policy. The principal dentist was the lead for safeguarding and provided advice and support to staff on safeguarding and

oversaw procedures. We saw that safeguarding procedures were reviewed annually. Local safeguarding authority's contact details for reporting concerns and suspected abuse were displayed for easy access. Staff were trained to the appropriate level in safeguarding and were aware of how to identify abuse and follow up on concerns. Staff described to us examples of concerns which had been reported. The provider had a policy for staff to follow up children who failed to attend for dental appointments. Clinicians were assisted at all times by a dental nurse.

We observed that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Dental care records were stored securely. Records contained a medical history which was completed or updated by the patient and reviewed by the clinician prior to the commencement of dental treatment and at regular intervals of care. The clinical records we saw were well structured and contained sufficient detail to demonstrate what treatment had been prescribed and completed, what was due to be carried out next and details of alternatives.

We saw evidence of how the practice followed and implemented recognised dental treatment guidance and current practice to keep patients safe, for example, the dentists told us that a rubber dam was routinely used in all root canal treatments. This was documented in the dental records we reviewed where root canal treatment had been undertaken. A rubber dam is a thin, rectangular sheet used in dentistry to isolate the operative site from the rest of the mouth. We also established the practice's policy and protocols for the use of endodontic equipment and found the dentists were adhering to recognised guidance.

Medical emergencies

The provider had procedures in place for staff to follow in the event of a medical emergency. All staff had received basic life support training as a team and this was updated annually. Staff described to us how they would deal with a variety of medical emergencies.

The practice had emergency medicines and equipment available in accordance with the Resuscitation Council UK and British National Formulary guidelines. Staff had access to an automated external defibrillator (AED) on the premises, in accordance with Resuscitation Council UK guidance and the General Dental Council standards for the dental team. [An AED is a portable electronic device that

Are services safe?

analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. We saw records to show that the medicines and equipment were checked regularly. All medicines were within their expiry date.

The practice stored emergency medicines and equipment centrally in the practice and staff were able to tell us where they were located.

Staff recruitment

The provider used the skill mix of staff in a variety of clinical roles, for example, dentists, a dental hygienist, and dental nurses with enhanced skills to deliver care in the best possible way for patients.

The practice had reviewed staff training requirements in conscious sedation as set out by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015'. We saw that the dental nurse was qualified in dental sedation nursing and was a member of the Society for the Advancement of Anaesthesia in Dentistry.

The practice had a recruitment policy and a recruitment procedure in place, which reflected the requirements of current legislation. The practice maintained recruitment records for each member of staff. We reviewed a number of these records and saw most of the prescribed information was present, for example, evidence of qualifications, evidence of registration with their professional body, the General Dental Council, where required, evidence of indemnity cover and evidence that Disclosure and Barring checks had been carried out where appropriate.

The practice had an induction programme in place. The most recently recruited members of staff confirmed to us that they had received an induction when they started work at the practice. The induction pack was comprehensive and included policies, protocols and assessments.

Staff we spoke to were aware of their own competencies and skills.

Monitoring health and safety and responding to risks

The provider had systems in place to assess, monitor and mitigate risks, with a view to keeping staff and patients safe.

The practice had an overarching health and safety policy in place, underpinned by several specific policies and risk specific assessments. A range of other policies, procedures, protocols and risk assessments were in place to inform and guide staff in the performance of their duties and to manage risks at the practice. Policies, procedures and risk assessments were regularly and consistently reviewed.

We saw evidence of a control of substances hazardous to health risk assessment and associated procedures. Staff maintained a file containing details of products used at the practice, for example, chemicals for dental treatment, and details to inform staff what action to take in the event of a chemical spillage, accidental swallowing or contact with the skin. Measures were identified to reduce risks, for example, the use of personal protective equipment for staff and patients and the secure storage of chemicals.

We saw evidence that the practice had carried out a sharps risk assessment and measures had been implemented to mitigate the risks associated with the use of sharps, for example, the provider had implemented a sharps policy identifying responsibility for the dismantling and disposal of sharps. The provider had implemented a safer sharps system to dispose of used needles. The policy also included procedures to follow in the event of a sharps injury. These procedures were displayed in the treatment rooms for quick reference. Staff were fully familiar with the procedures and able to describe the action they would take should they sustain an injury. We observed that sharps bins were suitably located in the clinical areas.

The provider also ensured that clinical staff had received a vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was identified. The provider ensured effectiveness was identified prior to staff being employed. People who are likely to come into contact with blood products and are at increased risk of injuries from sharp instruments should receive these vaccinations to minimise the risks of acquiring blood borne infections.

We saw that a fire risk assessment had been carried out. The provider had arrangements in place to manage and mitigate the risks associated with fire, for example, safety signage was displayed, fire-fighting equipment was available and fire drills were carried out annually.

Are services safe?

We saw evidence to demonstrate that the provider had implemented a business continuity plan which detailed arrangements to be able to respond to and manage, disruptions and developments.

Infection control

The practice had an overarching infection control policy in place underpinned by policies and procedures which detailed decontamination and cleaning tasks. Procedures were displayed in appropriate areas such as the decontamination room and treatment rooms for staff to refer to.

The practice undertook infection control audits regularly. We saw that the audits had clearly identified actions and that these had been carried out.

We observed that there were adequate hand washing facilities available in the treatment rooms, the decontamination room, and in the toilet facilities. Hand washing protocols were displayed appropriately near hand washing sinks.

We observed the decontamination process and found it to be in accordance with the Department of Health's guidance, Health Technical Memorandum 01-05 Decontamination in primary care dental practices, (HTM 01-05). The practice had a dedicated decontamination room which was accessible to staff only. The decontamination room and treatment rooms had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff used sealed boxes to transfer used instruments from the treatment rooms to the decontamination room. Staff followed a process of cleaning, inspecting, sterilising, packaging and storing of instruments to minimise the risk of infection. Packaged instruments were dated with an expiry date in accordance with HTM 01-05 guidance. Staff wore appropriate personal protective equipment during the decontamination process.

We observed that instruments were stored in drawers in the treatment rooms. We looked at the packaged instruments in the treatment rooms and found that packages were sealed and marked with an expiry date which was within the recommendations of the Department of Health.

Staff showed us the systems in place to ensure the decontamination process was tested and decontamination equipment was checked, tested and maintained in accordance with the manufacturer's instructions and HTM 01-05, and we saw records of these checks and tests.

Staff changing facilities were available and staff wore their uniforms inside the practice only.

The practice had had a Legionella risk assessment carried out in 2012 to determine if there were any risks associated with the premises; however we did not see evidence of a review since. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The provider informed us after the inspection that a review is in progress. The plumbing system had been upgraded in 2014 to reduce potential risks. We saw records of checks and testing on water outlet temperatures, which assisted in monitoring the risk from Legionella. The dental water lines and suction unit were cleaned and disinfected daily, in accordance with guidance to prevent the growth and spread of Legionella bacteria.

The treatment rooms had sufficient supplies of personal protective equipment for staff and patients.

The practice had an environmental cleaning policy and procedures in place. Cleaning was the responsibility of two cleaners but the dental nurses were responsible for the cleaning of the clinical areas. The practice had a cleaning schedule in place identifying tasks to be completed, daily and weekly. The practice used a colour coding system to assist with cleaning risk identification in accordance with National specifications for cleanliness : primary medical and dental practices, issued by the National Patient Safety Agency. We observed that the practice was clean and treatment rooms and the decontamination room were clean and uncluttered. We observed that the floor mops were not stored suitably in accordance with current guidance.

The segregation and disposal of dental waste was in accordance with current guidelines laid down by the Department of Health in the Health Technical Memorandum 07-01 Safe management of healthcare waste. The practice had arrangements for all types of dental waste to be removed from the premises by a contractor. Spillage kits were available for contaminated spillages. We observed that clinical waste awaiting collection was stored securely.

Are services safe?

Equipment and medicines

We saw evidence that the provider had systems, processes and practices in place to protect people from the unsafe use of materials, medicines and equipment used in the practice.

The practice was meeting the standards set out in the guidance published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015 and had achieved the standard outlined in this guidance. The practice had previously adhered to the guidelines published by the Standing Dental Advisory Committee: conscious sedation in the provision of dental care. Report of an expert group on sedation for dentistry, Department of Health 2003.

The practice offered intra-venous sedation for patients who were nervous about having dental treatment, and patients who required complex dental work. We found that the practice had put into place robust governance systems and processes in relation to the provision of sedation.

We looked at the systems and processes the practice had implemented to support sedation. We saw that these included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions, and staff training.

We found that patients were appropriately assessed for sedation. We saw evidence in the dental care records to show that all patients undergoing sedation had the recommended checks carried out prior to sedation. The records demonstrated that during the sedation procedure patients were monitored at regular intervals.

Staff responsible for stock control showed us the recording system for the prescribing, storage, stock control and recording of medicines, including those used in the provision of sedation.

Staff showed us contracts for the maintenance of equipment, and recent test certificates for

the decontamination equipment, the air compressor, X-ray machines. The practice carried out annual current portable appliance testing, (PAT). PAT is the name of a process under which electrical appliances are routinely checked for safety.

We saw records to demonstrate that fire detection and fire-fighting equipment, for example, emergency lighting and extinguishers were regularly tested.

We saw that the practice was storing NHS prescription pads securely and in accordance with current guidance and operated a system for checking deliveries of blank NHS prescription pads. Private prescriptions were printed out when required following assessment of the patient.

Radiography (X-rays)

The practice maintained a radiation protection file which contained the required information.

The provider had appointed a Radiation Protection Advisor and a Radiation Protection Supervisor.

We saw that the Health and Safety Executive had been notified of the use of X-ray equipment on the premises.

We saw a critical examination pack for the X-ray machines. Routine testing and servicing of the X-ray machines had been carried out in accordance with the current recommended maximum interval of three years.

We observed that local rules were displayed in areas where X-rays were carried out. These included specific working instructions for staff using the X-ray equipment.

We saw evidence of regular auditing of the quality of the X-ray images which demonstrated the practice was acting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and patients and staff were protected from unnecessary exposure to radiation.

Dental care records confirmed that X-rays were justified, reported on and quality assured in accordance with IR(ME)R, current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines.

We saw evidence of recent radiology training for relevant staff in accordance with IR(ME)R requirements.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with current National Institute for Health and Care Excellence guidelines, Faculty of General Dental Practice, (FGDP), guidelines, the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' and General Dental Council guidelines. The dentists described to us how examinations and assessments were carried out. Patients completed a medical history form which included detailing health conditions, medicines being taken and allergies, as well as details of their dental and social history. The dentists then carried out a detailed examination. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the examination the diagnosis was discussed with the patient and treatment options and costs explained. Follow-up appointments were scheduled to individual requirements.

Details of the treatments carried out were documented and details of medicines used in the dental treatments were recorded. This would enable a specific batch of a medicine to be traced to the patient in the event of a safety recall or alert in relation to a medicine.

We checked dental care records to confirm what was described to us and found that the records were complete, clear and contained sufficient detail about each patient's dental treatment. The dental care records adhered to current guidance. We saw patients' signed treatment plans containing details of treatments and costs. Patients confirmed in CQC comment cards that dentists were clear about treatment and alternative options and treatment plans were excellent.

We saw evidence that the clinicians used current National Institute for Health and Care Excellence Dental checks: intervals between oral health reviews, guidelines to assess each patient's risks and needs and to determine how frequently to recall them.

Health promotion and prevention

The practice adhered closely to 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 used by dental teams for the prevention of dental disease in primary and secondary care settings. Tailored preventive dental advice and information was given to the patients in order to improve health outcomes for them. This included dietary advice and advice on general dental hygiene procedures. Where appropriate fluoride treatments were prescribed. Adults and children attending the practice were advised during their consultation of steps to take to maintain good oral health. Tooth brushing techniques were explained to them in a way they understood. The dental care records we observed confirmed this. Information in leaflet form was available in the waiting room in relation to improving oral health and lifestyles, for example, smoking cessation.

Staffing

We observed that staff had the skills, knowledge and experience to deliver effective care and treatment.

We saw that the practice used a variety of training methods to deliver training to staff, for example lunch and learn sessions, courses and online learning. We saw that training included the mandatory topics, health and safety issues and a variety of generic and role specific topics.

The practice manager attended quarterly meetings with local dental practice managers. We were told the meetings were used for peer review and sharing best practice.

The manager told us that new staff and trainees undertook a programme of training and supervision before being allowed to carry out any duties at the practice unsupervised.

We saw evidence to demonstrate that the principal dentist had undertaken postgraduate training.

We saw that the provider carried out staff appraisals annually. We saw that the principal dentist was appraised by the postgraduate deanery. We noted the appraisals were a two way process with actions identified. Staff confirmed appraisals were used to identify training needs and that the practice supported them to undertake further study. Staff we spoke to were aware of their own abilities and competencies and confirmed all their colleagues were supportive.

All qualified dental care professionals are required to be registered with the General Dental Council, (GDC), in order to practice dentistry. To be included on the register dental

Are services effective?

(for example, treatment is effective)

care professionals must be appropriately qualified and meet the GDC requirements relating to continuing professional development, (CPD). We saw evidence that the qualified dental care professionals were registered with the GDC.

The GDC highly recommends certain core subjects for CPD, such as cardio pulmonary resuscitation, (CPR), safeguarding, infection control and radiology. Checks to ensure dental care professionals were up to date with their CPD were carried out by the practice. We reviewed a sample of staff records and found these contained a variety of CPD, including the core GDC subjects, and a wide range of other subjects demonstrating that they were meeting the requirements of their professional registration.

Working with other services

The practice had effective arrangements in place for referrals. Clinicians were aware of their own competencies and knew when to refer patients requiring treatment outwith these. Clinicians referred patients to a variety of secondary care and specialist options where required. Information was shared appropriately when patients were referred to other health care providers. Urgent referrals were made in line with current guidelines. We saw that referrals were logged and tracked.

We saw examples of internal referrals for example, to the hygienist, and these followed recognised guidelines.

Consent to care and treatment

The clinicians described how they obtained valid informed consent from patients by explaining their findings to them and keeping records of the discussions. Patients were given a treatment plan after consultations and assessments, and prior to commencing dental treatment. The patient's dental

care records were updated with the proposed treatment once this was finalised and agreed with the patient. The signed treatment plan and consent form were retained in the patients' dental care records. The plan and discussions with the clinicians made it clear that a patient could withdraw consent at any time and that they had received an explanation of the type of treatment, including the alternative options, risks, benefits and costs.

The clinicians described to us how they obtained verbal consent at each subsequent treatment appointment. We saw this confirmed this in the dental care records.

Treatment costs were displayed in the reception area. Information on dental treatments was available in the waiting room to assist patients with treatment choices.

The dentists explained that they would not normally provide treatment to patients on their examination appointment unless they were in pain or their presenting condition dictated otherwise. Dentists told us they allowed patients time to think about the treatment options presented to them.

The clinicians told us they would generally only see children under 16 who were accompanied by a parent or guardian to ensure consent was obtained before treatment was undertaken. Clinicians demonstrated a good understanding of Gillick competency. (Gillick competency is a term used in medical law to decide whether a child of 16 years or under is able to consent to their own treatment).

The Mental Capacity Act 2005, (MCA), provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Staff we spoke to had a good understanding and application of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback given by patients on CQC comment cards demonstrated that patients felt they were always treated with kindness and respect, and staff were friendly, caring and helpful. The practice had a separate room available should patients wish to speak in private. Treatment rooms were situated away from the main waiting area and we saw that the doors were closed at all times when patients were with the clinicians. Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Several patients confirmed in CQC comment cards that staff put them at ease.

Involvement in decisions about care and treatment

The dentists discussed treatment options with patients and allowed time for patients to decide before treatment was commenced. We saw this documented in the dental care records. CQC comment cards we reviewed told us treatments were always explained in a language patients could understand. Patients commented that the dentists' listening skills were excellent. Patients confirmed that treatment options, risks and benefits were discussed with them and that they were provided with helpful information to assist them in making an informed choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw evidence that services were planned and delivered to meet the needs of people. The practice premises provided a spacious and comfortable environment. The provider had a rolling programme of maintenance and improvement in place.

We saw that the practice tailored appointment lengths to patients' individual needs and patients could choose from morning or afternoon appointments.

The practice captured social and lifestyle information on the medical history forms completed by patients. This enabled clinicians to identify any specific needs of patients and direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records which helped them treat patients individually.

The provider had a system in place to gather the views of patients via the use of a suggestions box in the waiting room. Staff told us that patients were always able to provide verbal feedback but this was not captured and analysed by the practice. The provider had not carried out any formal structured feedback since 2008.

Tackling inequity and promoting equality

The provider had taken into account the needs of different groups of people, for example, people with disabilities, impaired mobility, and wheelchair users and had carried out a Disability Discrimination Act audit.

The practice was located on the first floor of a listed building. Parking was available outside the premises in the practice's private car park. The practice was accessible to people with disabilities and impaired mobility but not to wheelchair users. The provider had considered installing a lift but was unable to obtain permission to do so; however was considering the possibility of installing a chair lift. The

provider had an agreement with a practice nearby to provide dental treatment for wheelchair users, and included information in the practice leaflet about access and arrangements for wheelchair users.

Toilet facilities were situated on the ground floor and were accessible to people with disabilities and impaired mobility.

Staff told us they offered interpretation services to patients whose first language was not English and to patients with impaired hearing.

The practice made provision for patients to arrange appointments by telephone or in person. Where patients failed to attend their dental appointments staff contacted them to re-arrange appointments where possible and to establish if the practice could assist by providing adjustments to enable patients to receive their treatment.

Access to the service

We saw evidence that patients could access care and treatment in a timely way. The practice opening hours and out of hours appointment information were displayed at the entrance to the practice and details of the practice opening times and out of hours information were provided in the practice leaflet. Emergency appointments were available daily.

Concerns and complaints

The practice had a complaints policy and procedure which was available in the waiting room and outlined in the practice leaflet; however details as to further steps people could take should they be dissatisfied with the practice's response to their complaint were not provided. Verbal complaints were not documented by the practice to monitor for trends but the provider was aware of recent issues. Patients commented in CQC comment cards that concerns were always dealt with promptly.

We saw evidence that the practice had investigated complaints thoroughly and responded appropriately. We saw evidence of openness and transparency in the practice's responses to complaints.

Are services well-led?

Our findings

Governance arrangements

The practice had a management structure in place. The practice manager had access to suitable supervision and support in order to undertake the role effectively, and there was clarity in relation to management and staff roles and responsibilities. Staff reported that the managers were approachable and helpful.

The provider had systems and processes in place for monitoring and improving the services provided for patients and these were operating effectively.

The provider had arrangements in place to ensure risks were identified, understood and managed, for example, the provider had carried out risk assessments and put in place reasonable measures in order to mitigate these risks. We saw that risk assessments and policies were regularly reviewed to ensure they were current and up to date with regulations and guidance.

The provider had arrangements in place to ensure that quality and performance were regularly considered and used a variety of means to monitor quality and performance, for example, through the analysis of significant events, learning from complaints and auditing. The practice had a structured rolling programme of auditing, and undertook a wide range of audits, for example, sterilisation procedures, dental care records and antibiotic prescribing. Analysis of the audits was used to improve the service.

The provider had a training plan in place which supported staff in meeting the requirements of their professional registration, and monitored dental professional's continuing professional development to ensure staff were meeting these requirements.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete and accurate. They were maintained on paper and electronically. Electronic records were backed up daily. We saw that computer records were secured by the use of individual passwords, and paper records were stored securely.

Leadership, openness and transparency

The practice had a culture of evaluation and improvement. We saw examples of continual evaluation and improvement in dental care record keeping and in relation to safer sharps systems.

We saw systems in place to support communication about the quality and safety of the service, for example, staff meetings.

The practice held monthly staff meetings. These meetings were scheduled in advance to maximise staff attendance. We saw recorded minutes of these. Items discussed included action taken, and learning identified, as a result of concerns, compliments and complaints. Meetings included regular agenda items and staff were encouraged to bring suggestions. The practice manager maintained a file in which documents for discussion at the next staff meeting were stored, for example, recently published research papers and new or updated guidelines. We saw that challenges to practices and protocols were welcomed from all staff.

The practice held daily informal management meetings to prepare for the day ahead.

Managers told us they operated an open door policy and staff told us they could speak to managers if they had any concerns.

Learning and improvement

The provider used quality assurance measures to encourage continuous improvement, for example, auditing. The practice had a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography. We saw evidence that actions resulting from auditing were carried out and scheduled re-auditing took place, which demonstrated that the process was functioning well and encouraging improvement. We saw evidence of discussion of audit findings and actions in staff meetings.

The provider gathered information on the quality of care and treatment from a suggestion box for patients but no formal system to obtain feedback from a range of sources was in place.

Staff confirmed that learning from complaints, incidents, audits and feedback were discussed at staff meetings to share learning to inform and improve future practice.

Are services well-led?

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

We saw evidence to show that staff were engaged and involved.

We were told staff could provide feedback to the managers at any time. Staff told us that suggestions for

improvements to the service were listened to and acted on, for example, staff had suggested improvements to the decontamination room and we saw that this had been acted on.

Staff told us they felt valued and involved.