Mr. Miraj Patel

Dental Sense

Inspection Report

378 Malden Road
Worcester Park
Surrey
KT4 7NL
Tel: 020 8337 3496
Website: www.dentalsense.co.uk

Date of inspection visit: 25 February 2016
Date of publication: 04/04/2016

Overall summary

We carried out an announced comprehensive inspection on 25 February 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

Dental Sense is located in the London Borough of Kingston-upon-Thames. The premises are situated on the ground floor of a building in a high-street location. There are three treatment rooms, a decontamination room, X-ray room, staff room, reception and waiting areas, and a patient toilet.

The practice provides private and NHS services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges and implants.

The staff structure of the practice consists of a principal dentist, four associate dentists, three hygienists, a dental nurse, two trainee dental nurses and a practice manager.

The practice opening hours are on Monday from 9.00am to 5.00pm, Tuesday from 9.00am to 6.00pm, Wednesday from 9.00am to 5.00pm, Thursday from 9.00am to 7.00pm, Friday from 9.00am to 4.00pm and Saturday from 9.00am to 2.00pm.

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.

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

Summary of findings

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

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were systems in place to reduce and minimise the risk and spread of infection. However, further improvements could be made to ensure that the practice fully complied with guidance issued by the Department of Health.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances. However, we did not see evidence that all staff had undergone relevant safeguarding training.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced. However, the ultrasonic bath had not had all of the recommended periodic checks. We also found that some items of equipment used in environmental cleaning were not stored safely.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- There were governance arrangements but the use of audits and risk assessments, as methods for driving improvements in the quality of the service, could be strengthened.

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

- Review the practice's infection control procedures and protocols giving due regard to 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'.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review staff training to ensure that all of the staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review the practice's policy and the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure a risk assessment is undertaken and the products are stored securely .
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review the storage of medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the use of risk assessments to monitor and mitigate the various risks arising from undertaking of the regulated activities.

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 policies and protocols related to the safe running of the service. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. Staff recruitment was effective and the necessary checks of professional registration, and other background checks had been completed.

There were some areas where improvements could be made to safety systems. For example, improvements could be made to infection control protocols and to the checking and storing of equipment.

There were safeguarding policies in place which staff members understood. However, we were not shown evidence that appropriate training in safeguarding for staff who would be in contact with vulnerable adults and children had been completed by all staff.

Are services effective?

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

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

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

Are services caring?

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

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

Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. Patients were invited to provide feedback through the NHS 'Friends and Family Test'. The needs of people with disabilities had been considered and there was wheelchair access to the waiting room and treatment rooms on the ground floor. Staff described effective strategies for supporting patients with some hearing or visual impairments.

Summary of findings

There was a complaints policy in place. Three complaints had been received in the past year. These had been investigated and dealt with in line with the practice policy.

Are services well-led?

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

The principal dentist had worked to improve staff engagement in the running of the practice. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the principal dentist to address any issues as they arose. The practice sought and acted on feedback from its patients and staff.

The practice had clinical governance and risk management structures in place. However, improvements could be made to ensure audits were used to effectively monitor and improve performance. Improvements could also be made to better identify, monitor and mitigate risks arising from undertaking of the regulated activities.

Dental Sense

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 25 February 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

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

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents and accidents. Staff understood the process for accident reporting, including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Two accidents involving members of staff had been recorded in the past year. There was a practice protocol, which staff had followed in these instances. The accidents had been appropriately investigated. Actions taken at the time and any lessons that could be learnt to prevent a recurrence were noted and discussed at the next available staff meeting.

The principal dentist was aware of the Duty of Candour and there was a relevant policy in place for staff to refer to. The principal dentist told us they were committed to operating in an open and transparent manner; they would always inform patients when they were affected by something that went wrong, give an apology, and inform them of any actions taken as a result. The provider knew when and how to notify CQC of incidents which cause harm. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Reliable safety systems and processes (including safeguarding)

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

The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns was displayed on noticeboards throughout the practice and a copy held in a file with the safeguarding policy.

There was evidence in some of the staff files showing that they had been trained in safeguarding adults and children to an appropriate level. However, not all of the staff had completed this training at the time of the inspection. We raised this issue with the principal dentist. They sent us evidence two days after the inspection showing that two more of the associate dentists had now completed relevant training. We, however, did not see evidence confirming that all of staff had completed safeguarding training.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. Following administration of a local anaesthetic to a patient, needles were resheathed using a single-handed scooping technique. Used needles were disposed of by the dentist in the sharps bins located inside the treatment rooms. The staff we spoke with demonstrated a clear understanding of the practice protocol with respect to handling sharps and needle stick injuries. There was also a written protocol for staff to follow in the event that they sustained a sharps injury. However, improvements could be made by ensuring that a written risk assessment was available, in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, as regards the resheathing of needles.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. Rubber dams should be used when endodontic treatment is being provided. On the occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids. However, the practice did not have portable suction, scissors, different sizes of face masks for adults and children, or different sizes of self-inflating bags in line with the Resuscitation Council UK guidelines. We also noted that although there was an in-date oxygen cylinder, this was stored next to an expired cylinder which could lead to confusion during an emergency scenario. The practice manager assured us that

Are services safe?

this cylinder would now be disposed of appropriately. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

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

Staff recruitment

The staff structure of the practice consists of a principal dentist, four associate dentists, three hygienists, a dental nurse, two trainee dental nurses and a practice manager.

The practice had recruited new staff during the past two years; this included an associate dentist, and trainee dental nurses. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We saw evidence in staff recruitment records that these checks had been carried out.

We also noted that some members of staff had been recruited through the use of a specialist agency. We were shown the terms of agreement with this agency which included assurances that all of the relevant checks and documents were obtained by the agency.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. Where staff had been recruited through an employment agency, we were shown evidence in relation to the assessments carried out by agency, which included obtaining a DBS check. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Monitoring health & safety and responding to risks

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

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted some discrepancies in the COSHH file between the products listed and those in actual use. We discussed this issue with the practice manager who assured us that a review and update of the file would be carried out.

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

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

Infection control

There were systems in place to reduce the risk and spread of infection within the practice. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. Staff files showed that staff regularly attended training courses in infection control.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available,

Are services safe?

including wall-mounted liquid soap, hand gels and paper towels in the treatment rooms, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the dental nurse to describe to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

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

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The principal dentist described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by one of the principal dentists in August 2015. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with the Department of Health 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)' guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a system of zoning from dirty through to clean.

Instruments were manually cleaned prior to inspection under a light magnification device. Items were then placed in an ultrasonic bath. Following this, the instruments were placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We noted that the dental nurse demonstrated an incorrect pouching procedure for instruments used during implants. These items were being pouched in the 'clean' zone prior to sterilisation in a vacuum cycle in the autoclave. These items should be pouched in the 'dirty' zone. The dental nurse also did not check the temperature of the water during manual cleaning in line with HTM 01-05 advice.

We saw that there were systems in place to ensure that the autoclave was working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the records were kept of the essential daily validation checks of the sterilisation cycles. However, the ultrasonic bath had not been tested in line with the recommendations in HTM 01-05. Ultrasonic activity ('foil') tests were being completed every 2-3 months, but other tests, such as the protein residue test, were not being carried out.

We noted that the practice had carried out practice-wide infection control audits every six months. There had also been an audit by an external agency in August 2015. This had identified a range of issues including the lack of an organised schedule of daily, weekly and quarterly testing for the steriliser and ultrasonic bath. We found that the practice had not fully acted on this advice as the testing for the ultrasonic bath was still not being carried out at the time of our inspection.

There was a daily checklist system for the dental nursing staff to complete to indicate that they were following the correct procedures for the carrying out of decontamination procedures, including the monitoring of the equipment. We found that these were all completed and up to date. However, the check list itself was not fit for purpose as it referred to a system not currently in use at the practice. For example, the checklist referred to the use of a washer disinfector, although no such equipment was installed at the practice. The dental nurses had also ticked boxes to indicate they had carried out a daily helix test on the autoclave, although the principal dentist told us that in fact this test was carried out only intermittently when a vacuum cycle was needed for sterilising implant instruments.

Are services safe?

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location outside the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Environmental cleaning was carried out using cleaning equipment in accordance with the national colour-coding scheme. However equipment that was used for cleaning the premises was not stored suitably in line with current guidelines.

Clinical staff had been required to produce evidence to show that they had been vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections). However, the practice had not checked staff members' immunisation status to confirm the vaccination had been effective. The practice subsequently sent us confirmation by email that such checks had been completed.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Certificates for pressure equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) had been completed in accordance with current guidance in August 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

We noted that one item, glucagon, which can be needed for use during a medical emergency, had been stored in a fridge in line with the manufacturer's guidance. The practice had not monitored the temperature of the fridge daily to ensure that this item was stored at the correct temperature.

Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray sets along with the three-yearly maintenance logs and a copy of the local rules.

We also saw evidence that staff had completed radiography and radiation protection training. Audits on X-ray quality had been undertaken within the past year.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The clinical staff carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with the principal dentist and an associate dentist. They described to us how they carried out their assessment. They told us that all of the dentists had recently met and agreed a standardised procedure for carrying out an assessment; this approach had been supported by the development of a computerised-assessment tool.

The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

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

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The principal dentist and associate dentist told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. They were aware of the need to discuss a general preventive agenda with their patients and referred to the advice supplied in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. (This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and dietary advice in relation to the maintenance of good oral health. The dentists also carried out examinations to check for the early signs of oral cancer.

There were three hygienists working at the practice. Where required, the dentists referred patients to the hygienists to further address oral hygiene concerns.

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

Staffing

Staff told us they received appropriate professional development and training. We checked a range of staff files and saw that this was the case. The training covered all of the mandatory and recommended requirements for registration issued by the General Dental Council. This included responding to emergencies, infection control and radiology and radiation protection training. However, we did not find evidence confirming that all staff had received training, to an appropriate level, in safeguarding vulnerable adults and children in line with published guidance.

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

The practice held regular supervision and review meetings with each member of staff. This provided staff with an opportunity to discuss their current performance as well as their career aspirations. Notes from these meetings were kept in each staff member's training record.

Working with other services

Are services effective?

(for example, treatment is effective)

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

The principal dentist explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complicated extractions.

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

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the principal dentists about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal, written consent forms for specific treatments.

All of the staff we spoke with were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). Some of the staff, including both of the principal dentists, had completed formal training in relation to the MCA in 2016. The principal dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received, and the patients we spoke with, all made positive remarks about the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. Patients who felt they were nervous about dental treatment indicated that their dentist gave them reassurance throughout the processes of the dental treatments. We also observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that the doors were closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received in-house training in information governance. Patients' dental care records were stored electronically on computers. Staff were careful to ensure that computers were closed down when not in use and all computers were password protected.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area, and on their website, which gave details of the private and NHS dental charges or fees. There were a range of information leaflets in the waiting area and treatment rooms which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We reviewed a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. We spoke with one of the dental nurses, who also worked as a receptionist, about the process for booking appointments. They told us that there were different periods of time allocated for different treatments, but that individual dentists could also specify the length of appointment needed, depending on their knowledge of the patient and treatment plan. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

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

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff told us they supported people to access the service and encouraged people to tell them what additional support they might need. They could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment. There were a range of languages spoken in the local area; some of the staff were bilingual which supported people in accessing the service. The practice was wheelchair accessible. There was a level access at the main entrance. The treatment rooms were on the ground floor. The patient toilet was suitable for wheelchair users.

Access to the service

The practice opening hours are on Monday from 9.00am to 5.00pm, Tuesday from 9.00am to 6.00pm, Wednesday from 9.00am to 5.00pm, Thursday from 9.00am to 7.00pm, Friday from 9.00am to 4.00pm and Saturday from 9.00am to 2.00pm.

We asked one of the dental nurses and the principal dentist about access to the service in an emergency or outside of normal opening hours. They told us that any messages left on the answerphone were directed to one of the dentists so that they could call the patient back and determine their level of need. The dentist then either arranged to see the patient, or referred them to another service, depending on the outcome of their telephone assessment.

The reception staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the patient information leaflet available at the reception desk.

There had been one written complaint and two verbal complaints recorded in the past year. These had been responded to in line with the practice policy. The practice manager had carried out investigations and discussed learning points with relevant members of staff.

Patients were also invited to give feedback through the NHS 'Friends and Family Test'. We reviewed the responses to this survey for 2016. The information received demonstrated that patients were satisfied with the care they received.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Formal staff meetings were held approximately every month to discuss key governance issues such as infection control, responding to emergencies, and safeguarding vulnerable patients.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. However, there were some area where improvements could be made to further mitigate risks associated with running a dental practice. For example, the COSHH file had not been regularly updated, there was no written sharps protocol in relation to the resheathing of needles and some equipment in the medical emergencies kit was out of date or not present. We also were not shown evidence that all of the staff had received the relevant training in safeguarding vulnerable adults and children.

Staff were generally aware of the policies and procedures and acted in line with them. However, we noted some areas where the infection control protocol had not been accurately followed. This was in relation to the pouching of equipment used during implants, the testing of water temperature during manual cleaning, and the testing of equipment used in cleaning instruments. We also found that the dental nurses were completing a daily checklist for decontamination which described an incorrect protocol which did not relate to the practice's own equipment and systems.

Leadership, openness and transparency

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

We found staff to be hard working, caring and committed to their work and overall there was a strong sense that staff worked together as a team. The principal dentist told us that they had been working with an external consultant to develop staff engagement with the running of the practice, including the standardisation of dentistry protocols, and a process for wider, shared decision making. They met regularly with different groups of staff and actively encouraged feedback with a view to improving the service.

There was a system of yearly staff appraisals for the dental nurses to support staff in carrying out their roles to a high standard. Notes from these appraisals also demonstrated that they identified staff's training and career goals.

Learning and improvement

The principal dentist had a clear vision for the practice and could demonstrate a programme of ongoing improvements in terms of both staff recruitment and maintenance plans for the premises.

Staff were also being supported to meet their professional standards and complete continuing professional development (CPD) standards set by the General Dental Council (GDC). We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC.

The practice had a rolling programme of clinical audit and risk assessments in place. There were a range of audits including those for infection control, X-ray quality and dental care records. However, we found that improvements could be made to ensure the outcomes of these audits were consistently used to drive improvements in the quality of the service.

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

The practice gathered feedback from patients through the use of the NHS 'Friends and Family Test'. The majority of feedback had been positive and did not indicate any areas for improvement. Staff told us that the principal dentist was open to feedback regarding the quality of the care. The staff meetings also provided an appropriate forum for staff to give their feedback.