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Chestfield Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 March 2017 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
Chestfield Dental Practice is a dental practice providing mostly private dental treatment, with a small NHS provision for treatment options for patients. The practice is located in Chestfield in Whitstable, Kent. There is roadside parking in the area.

The practice has two treatment rooms, both of which are on the ground floor.

The practice provides dental services to both adults and children. The practice provides mostly NHS treatment (85%). Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment. Patients also have the option of private treatment options such as cosmetic dentistry.

The practice's opening hours are – Monday, Tuesday: and Friday 9am to 5.30pm and Wednesday and Thursday 9am to 7pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the local dental out of hour's service or the NHS 111 service.

The principal dentist/owner is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'.

Summary of findings

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 practice has three dentists; two qualified dental nurses, two trainee dental nurses and a practice manager who is registered as a dental nurse with the General Dental Council.

We provided CQC comment cards prior to our inspection for patients to share their experiences with us. We collected 38 completed comment cards and all of the responses were positive We also reviewed feedback that practice had received through the NHS Friends and family test (FFT).

Our key findings were:

• The practice was visibly clean and tidy.

• Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.

• Patients at the practice gave positive feedback about their experiences at the practice.

• The practice was well equipped.

• Dentists identified the different treatment options, and discussed these with patients.

• Patients' confidentiality was maintained.

• The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilising dental instruments. Some improvements were however required in the monitoring processes as theses had not been conducted on a regular basis.

• The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the current arrangements for appropriate governance for the safe running of the service by establishing systems to identify and minimise any potential or perceived risks.
- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and, ensuring that improvements are made as a result.
- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures and dip slide results to evidence that dental water line disinfection has been successful.
- Review the records related to the management of regulated activities giving due regard to current legislation and guidance.
- Review auditing of clinical and non-clinical areas giving due regard to current guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role. Staff had been subject to a Disclosure and Barring Service (DBS) check before having contact with patients.

The practice was visibly clean and tidy and there were infection control procedures to ensure that patients were protected from potential risks. The infection control procedures followed the Department of Health guidance HTM 01-05 However the practice was not able to evidence that dental unit water lines were free from bacteria.

X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

No action

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

All patients were clinically assessed by a dentist before any treatment began.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, wisdom tooth removal and the non-prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

The practice made referrals to other dental professionals when it was appropriate to do so. There were clear procedures for making referrals in a timely manner.

Are services caring?

No action

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

Patient confidentiality was maintained and electronic dental care records were password protected.

Patients said staff were friendly, polite and professional. Feedback from patients identified that they felt they were always treated with dignity and respect by all staff.

Patients said they received good dental treatment and they were involved in discussions about their dental care.

Summary of findings

Patients said they were able to express their views and opinions.

Are services responsive to people's needs?

No action

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

Patients said they could get an appointment when they needed one and patients who were in pain or in need of urgent treatment would be seen the same day.

The practice had access for patients with restricted mobility via a ramp which would be used to help patients access the threshold. All patient areas were located on the ground floor.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the practice.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

No action

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

There was a management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice had policies for staff to refer to which were out of date and had not been reviewed since 2013.

The practice was carrying out audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided, improvements could be made to ensure these were undertaken at regular intervals.

Staff said the practice was a friendly place to work, and they could speak with the dentists if they had any concerns.

Chestfield Dental Practice

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 8 March 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

We also reviewed the information we held about the practice and asked the practice to send us their statement of purpose, a list of staff and any complaints which they had received in the last 12 months.

We reviewed policies, procedures and other documents, made observations and toured the building. We spoke with the principal dentist, two of the nurses and the practice manager. We received feedback from 38 patients about the dental services they had received.

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

Documentation we saw showed the last recorded accident had occurred in 2016 this being a minor injury to a member of staff. The records showed the staff had taken appropriate action to ensure this accident was dealt with appropriately. We were told by staff that there had been a power cut the day before our inspection. This event was written up and treated as significant. We were sent a copy of the event following our visit to demonstrate the practice had implemented a process for dealing with events and accidents and how they would reduce risk and learn.

The practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).

Staff said there had been no RIDDOR notifications made, although the practice was aware of how to make these on-line.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were received electronically by the practice manager who shared them with staff when appropriate.

Reliable safety systems and processes (including safeguarding)

The practice had a copy of the Kent multi-agency safeguarding procedures, and a link stored on the desktop of each of the practice computers which contained all of the local area teams and their contact details. The policies directed staff in how to respond to and escalate any safeguarding concerns. We spoke with staff who were aware of the safeguarding policies, they knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The relevant contact telephone numbers were available to all staff.

One of the dentists was the identified lead for safeguarding in the practice. They had received training to level two in child protection to support them in fulfilling that role. We saw evidence that all staff had attended a training course. In addition all staff had completed on-line refresher training in safeguarding during 2016. The practice had policies for safeguarding vulnerable adults and children, though improvements could be made to review and update them.

There were guidelines to guide staff in the use and handling of chemicals in the practice. The policy identified the risks associated with the Control of Substances Hazardous to Health (COSHH). There were risk assessments which identified the steps to take to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. The manufacturers' product data sheets were available to staff in the COSHH file.

We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. The principal dentist said that only dentists handled sharp instruments such as needles. The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely, though it needed updating.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were located in accordance with the guidance which states sharps bins should not be located on the floor, and should be out of reach of small children.

Discussions with dentists and a check of patients' dental care records identified that dentists were using rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society recommend that dentists should be using rubber dams. 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 and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

Medical emergencies

The dental practice was equipped to deal with any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the emergency medicines and found they were all in date and stored appropriately. We saw the practice had a designated member of staff who was responsible for checking and recording expiry dates of medicines, and replacing when necessary.

Are services safe?

There was an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed the AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff had completed basic life support and resuscitation training. Additional emergency equipment available at the practice included: airways to support breathing, manual resuscitation equipment (a bag valve mask) and portable suction.

Staff recruitment

We looked at the staff recruitment files for staff members and noted that safe recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). 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. We found that all members of staff had received a DBS check. The practice had access to occupational health facilities. We saw records which demonstrated staff had received inoculations against Hepatitis B. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections such as Hepatitis B. We noted that some of the clinical staff did not have information regarding their Hepatitis B status. We received this information following our inspection.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which was dated 2013. We noted that the practice had completed environmental risk assessments in 2014. We discussed this with the practice manager who said they would conduct one following our inspection.

Records showed that the fire extinguishers had last been serviced in December 2016. The practice had completed a fire evacuation drill in May 2016. A fire risk assessment had been carried out in December 2016 by the practice, though improvements could be made to include the garage where some of the dental equipment and clinical waste was stored.

Infection control

We saw how instruments were being cleaned and sterilised at the practice, with a dental nurse demonstrating the decontamination process. We saw the procedures were as outlined in the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices'

We saw that dental nurses had set responsibilities for cleaning and infection control in each individual treatment room.

The practice had a clinical waste contract with a recognised company. We saw that clinical waste was collected regularly. The waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam and teeth that had been removed. Amalgam is a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury. There were also spillage kits for bodily fluids which were in date.

There was a decontamination room where dental instruments were cleaned and sterilised. There was a clear flow from dirty to clean areas to reduce the risk of cross contamination and infection. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

The practice had an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. After cleaning the dental instruments were rinsed but did not always examine instruments using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments). The practice had two autoclaves, which were designed to sterilise instruments. At the completion of the sterilising process, all instruments were dried, and stored in pouches which were dated with the date they would require re-processing if they had not been used.

Are services safe?

We checked the records to demonstrate that equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. The records demonstrated the equipment was in good working order and being effectively maintained.

We used an illuminated magnifying glass to check a random sample of dental instruments that had been cleaned and sterilised. We found the instruments to be clean and undamaged.

Records showed that regular six monthly infection control audits had been completed. The most recent audit had been completed in December 2016. We saw that infection control audits were as recommended by HTM 01-05, being completed on a six monthly basis as per the guidance.

The practice had a risk assessment for dealing with the risks posed by Legionella. This had been conducted recently in January 2017. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The assessment had identified actions, such as, regular monitoring of hot and cold water temperatures at each water outlet. Staff told us that they did not conduct temperature monitoring as recommended, but would implement a system and record book immediately. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance. We noted that dip slides, used to evidence and in addition to HTM 01-05 guidance; that the flushing of the dental unit water lines was effective had failed. We spoke with the practice manager about this who assured us that they would investigate why the dip slides had failed and try a different disinfection product and conduct the test again.

Equipment and medicines

The practice kept records to demonstrate that equipment such as the autoclaves, compressor and X-ray units had been maintained and serviced in line with the manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in August 2015.

The practice had all of the medicines needed for an emergency situation, as recommended by the British National Formulary (BNF). Medicines were stored securely and appropriately and there were sufficient stocks available for use. The practice held a small dispensary of medicines, such as antibiotics. We saw that the medicines had been procured, stored, dispensed and disposed of in line with the Human Medicines Regulations 2012.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

The pressure vessel checks on the compressor which produced the compressed air for the dental drills and hand pieces had been completed on 10 May 2016.

Radiography (X-rays)

The practice had a Radiation Protection file which contained all of the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays are small images taken inside the mouth).

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out. The local rules are bespoke operating procedures for the area where X-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each X-ray set on the premises. The local rules set out the dimensions of the controlled area. This is a set parameter around the dental chair/patient and the lowest dose possible. Applying the local rules to each X-ray taken means that X-rays are carried out safely with doses of radiation kept as low as reasonably practicable.

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being the principal dentist. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for expert advice regarding the machinery and radiation safety. The Ionising Radiation Regulations 1999 (IRR 99) requires that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) to be appointed and identified in the local rules.

Records showed the X-ray equipment had last been inspected in February 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years to ensure it is safe

Are services safe?

and working correctly. Documents in the practice showed the Health and Safety Executive (HSE) had been informed that radiographs were being taken on the premises. This was a requirement of the Ionising Radiation (Medical Exposure) Regulations 2000.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic and paper dental care records for each patient. They contained information about the patients' assessments, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental professionals. The dental care records showed a thorough examination had been completed, and identified risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form at each visit. Following the patient's first visit the information was transferred into the electronic records and updated at each following visit. This allowed dentists to check the patient's medical history before treatment began. The patients' medical histories included any health conditions, medicines being taken and whether the patient might be pregnant or had any allergies.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of the timescales for recalling patients; prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart); and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had a variety of information for patients in the waiting room. There were leaflets in reception and posters about treatments and giving health education information to patients.

Discussions with dentists identified that patients were assessed on an individual basis to check their risk of dental decay. This resulted in patients, if necessary being offered fluoride application varnish and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This had been produced to support dental teams in improving patients' oral and general health.

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, dentists had particularly highlighted the risk of dental disease and oral cancer.

Information on display in the reception area gave patients information and advice on stopping smoking. This included contact details for other agencies who could be of assistance.

Staffing

The practice had three dentists; two qualified dental nurses, two trainee dental nurses, and a practice manager who is registered with the General dental Council as a dental nurse. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We looked at staff training records held in staff files and these identified that clinical staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training certificates showed how many hours training staff had undertaken together with which training courses were attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. The practice manager kept records to monitor the number of hours each dental professional had completed each year. Examples of training completed included: radiography (X-rays), infection control, and medical emergencies.

Records at the practice showed that appraisals had been completed for staff. We saw that they had developed an appraisal system which they conducted annually.

Working with other services

The practice made referrals to other dental professionals based on risks or if a patient required treatment that was not offered at the practice. The practice had a policy for making referrals to other services which had been reviewed in June 2015. The policy identified when and how to make referrals and had a section on making urgent referrals for patients who had suspected oral cancer. This was to the

Are services effective?

(for example, treatment is effective)

maxillofacial department at the local hospital Staff demonstrated these were sent electronically through immediately to the hospital where the referral had been made. These referrals were tracked through a log at reception, and we saw evidence that referrals had been made promptly. Patients were given details of any referral made on their behalf.

Consent to care and treatment

The practice had a consent policy which was dated 2013. The policy made reference to the different aspects of consent. The policy held information regarding adults who lacked capacity and this made reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. Staff at the practice had completed training in the MCA in January 2017. Staff could, when questioned describe how the MCA would affect their work and patients and how they would implement it.

Consent was recorded in the practice using the standard NHS FP17 form and on private treatment plans. This form recorded both consent and provided a treatment plan. The dentists discussed the treatment plan with the patients and explained the treatment process. This allowed the patient to give their informed consent. A hard copy of the consent form was retained by both the practice and the patient.

Discussions with dentists identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. However, staff said it was unusual for children to come to the practice unaccompanied by either a parent or guardian.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The reception desk was located close to the waiting room. Staff said they were aware of the need for confidentiality and if it were necessary there were areas of the practice where private discussions could be carried out, such as the back office or an unused treatment room. Staff said that patients' individual treatment was discussed in the treatment room not at reception.

Patients said staff were always friendly, polite and professional. Feedback from patients identified that they felt they were always treated with dignity and respect by staff.

We observed staff members throughout the day to see how staff spoke with patients. We saw that staff were professional, polite, and welcoming.

We saw that patient confidentiality was maintained at the practice. We asked two patients about confidentiality. Neither patient had any concerns about their confidentiality being breached. Computer screens could not be overlooked by patients standing at the reception desk. We saw that patients' dental care records were password protected and held securely.

Involvement in decisions about care and treatment

We obtained the views of 38 patients via our CQC comment cards. Feedback from patients was positive with patients saying they were happy with the dental service they received. Patients commented positively about the staff and said the facilities were clean and comfortable. Patients said they felt involved in their treatment. Patients said they were encouraged to ask questions and talk with staff about their treatment.

The practice offered mostly private treatment and the costs were clearly displayed in leaflets and posters in the practice. We saw that NHS and private fees were displayed in the waiting area.

We spoke with one dentist about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence in the patient care records of how the treatment options and costs were explained and recorded before treatment started. All patients were given a written copy of the treatment plan which included the costs.

Where it was necessary dentists gave patients information about preventing dental decay and gum disease. We saw examples in patients' dental care records. Dentists had discussed the risks associated with smoking and diet, and this was recorded in patients' dental care records. The practice had a member of staff trained to deliver smoking cessation advice and posters in the waiting room gave additional information.

Patients' follow-up appointments were in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There was street parking available in close proximity to the practice. The practice had two treatment rooms, both of which were on the ground floor.

The practice had separate staff and patient areas, to assist with confidentiality and security. We saw there was a sufficient supply of instruments to meet the needs of the practice.

Patients commented they had not had a problem getting an appointment, both routine and in an emergency. Patients also said they found reception staff were always helpful, friendly and approachable. Staff said that when patients were in pain or where treatment was urgent the practice had made efforts to see the patient the same day.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The practice scheduled emergency slots for patients who were in pain or who required urgent treatment. In addition there was a sit and wait system for patients who were unable to get an emergency appointment but who were in pain or who required emergency treatment. Staff said that generally the practice ran to time, and waiting times were kept to a minimum.

Tackling inequity and promoting equality.

The practice was on the ground floor, with a step into the waiting area. This included two treatment rooms. The practice had a removable ramp which would allow patients using wheelchair or with restricted mobility to access treatment at the practice.

The practice had a ground floor toilet large enough for the use of patients with mobility problems.

Improvements could be made to ensure the practice had access to an interpreter for patients whose first language was not English. Staff said they had never had to use an interpreter.

Access to the service

The practice's opening hours are – Monday, Tuesday: and Friday 9am to 5.30pm and Wednesday and Thursday 9am to 7pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message for access to the local out of hour's dental service or by telephoning the 111 NHS service.

Concerns & complaints

The practice had a complaints procedure. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction. Information about how to complain was on display in the practice leaflet.

From information received before the inspection we saw that there had been two complaints received in the 12 months prior to our inspection. There was an analysis and actions identified to address these complaints. Staff we spoke with were all able to explain the complaints process to us and how they would help a patient to complain if they feel that they needed to.

Are services well-led?

Our findings

Governance arrangements

The practice manager identified that all of policies were out of date and required updating.

We spoke with staff who said they understood their roles and could speak with either a dentist or the practice manager if they had any concerns. Staff said they understood the management structure at the practice. We spoke with two members of staff who said the practice was a good place to work, but sometimes they did not feel supported as part of the team.

We looked at a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

Chestfield Dental Practice had a practice manager in post. Staff told us that the practice manager was easy to contact either by telephone or email when not on the premises. We noted that the practice manager had been absent recently and that some duties had not been completed as a result. We discussed this with the practice manager who stated that duties would be delegated and shared in the future so that none were missed.

The practice had conducted staff meetings and we looked at the meeting minutes for the last year. Topics discussed included, Mental Capacity Act, medical emergencies , dermatitis and significant events.

Staff at the practice said there was a close team and they were able to express their views during daily chats. Staff said dentists were approachable and were available to discuss any concerns.

Discussions with different members of staff showed there was a good understanding of how the practice worked. Staff could explain when asked how the duty of candour affected their work and how they would inform patients if anything went wrong. Staff told us that they had not had to apply the duty of candour to their work so far; but would when necessary.

Copies of the General Dental Council's nine principles were displayed in the waiting room. This gave patients an insight into the standards they could expect from their dental practice.

Staff could demonstrate what they would do if they felt that they needed to raise any concerns if they had any issues with a colleagues' conduct or clinical practice. They told us how they would do this was both internally and with identified external agencies. Improvements could be made to ensure practice staff also had access to a whistleblowing policy.

Learning and improvement

We saw that the practice was carrying out some audits throughout the year.

Examples of audits included a radiography (X-rays) audit and infection prevention and control audit; which was undertaken at six-monthly intervals as per national guidance.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period.

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

The practice had recently implemented a patient satisfaction survey, and were in the process of collating the data collected. We looked at the format for the survey and saw that it covered appointments, waiting times, information given and comfort at the practice. It also gave the opportunity for patients to suggest improvements.

The NHS Choices website: www.nhs.uk there were no patient reviews recorded in the year up to this inspection.