Hilsea Dental Care Limited

Hilsea Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 20 September 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

Hilsea Dental Care provides both private and NHS treatment to patients of all ages. The practice is part of the corporate provider brand Southern Dental Limited. The practice is based in a converted domestic dwelling in Portsmouth, south Hampshire.

The practice has three dental treatment rooms of which all are based on the ground floor and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users, prams and patients with limited mobility.

The practice employs three dentists, two hygienists, two dental nurses, two receptionists and a practice manager who is also a registered dental nurse.

The practice's opening hours are Monday between 8am and 8pm, Tuesday and Friday between 9am and 5pm, Wednesday and Thursday between 9am and 8pm and Saturday between 9am and 1pm.

There are arrangements in place to ensure patients receive urgent medical assistance when the practice is closed. This is provided by an out-of-hours service.

There was no registered manager at the time of our inspection at this location. We were told that the current Practice Manager was registered with CQC at another location nearby and was going through the CQC registration process to become the registered manager of both locations.

Summary of findings

A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We obtained the views of five patients on the day of our inspection.

Our key findings were:

- Leadership was provided by a newly appointed enthusiastic and hardworking practice manager.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The internal aspects of the practice appeared clean and maintained. We did note issues with some aspects of the outside of the practice.
- There appeared to be sufficient equipment for staff to undertake their duties, and equipment was well maintained. Although improvements could be made to the efficient storage arrangements for dental instruments.
- Infection control procedures generally followed published guidance although there were areas that could be improved. This included protocols around manual cleaning, recording of validation cycles of the automated washer disinfector and the storage of environmental cleaning equipment.
- The practice had effective processes in place for safeguarding adults and children living in vulnerable circumstances.
- There was a process in place for the reporting and shared learning when untoward incidents occurred in the practice.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access treatment and urgent and emergency care when required.
- Staff received training appropriate to their roles and were supported in their continued professional development (CPD) by the company.
- Staff we spoke with felt well supported by the practice manager and were committed to providing a quality service to their patients.
- We were told of issues with the company head office responding in a timely way to issues raised by the staff. This included shortages of staff and instruments and because of this staff were not always happy in their work.
- Information from five completed Care Quality Commission (CQC) comment cards gave us a mostly positive picture of a friendly, caring, professional practice.

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

- Review the availability of a hearing loop for patients who wear hearing aids.
- Consider providing the hygienist with the support of an appropriately trained member of the dental team.
- Review the contents of the annual infection control statement in relation to infection prevention control required under The Health and Social Care Act 2008: Code of Practice about the prevention and control of infections.
- Review the storage of processed instruments to make the process of identifying the numbers of instruments required for each clinical session more efficient. Specifically, the practice could consider placing examination packs in one storage box, filling instrument packs in another, dental hand pieces in another and so on.
- Consider discontinuing using the present staff toilet and reverting to using the patient toilet for both staff and patients.
- Consider the provision of a non-foot operated waste bin and mirror for disabled patients in the patient toilet.
- Review the protocols with respect to the manual scrubbing of instruments and the subsequent loading of instruments in the ultrasonic cleaning bath.
- Review the availability of a thermometer for ensuring that the temperature of the water used for manual scrubbing is below the recommended temperature of 45 degrees for this procedure.

Summary of findings

- Review the training of nurses in respect of recording the daily validation cycles of the automated washer disinfector.
- Review the safety arrangements of the window blinds in the practice; this should include carrying out a suitable risk assessment of the pull cords.
- Review the checking procedures of the emergency lighting system.
- Review the cleanliness of the external environment of the practice, including the use of the neighbour's domestic waste bin at the front of the practice and the removal of animal excrement from the back garden area.
- Consider the provision of an external name plate providing details of the dentists working at the practice including their General Dental Council (GDC) registration number in accordance with GDC guidance March 2012.
- Review the recording of the details of the subjects discussed during the staff meetings to capture the standing items which are part of the practice's policy.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). Although we did find that improvements could be made in the way infection control processes were carried out which included manual cleaning protocols, instrument storage and the storage of cleaning equipment. We found that all the equipment used in the dental practice was properly maintained.

The practice took its responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw dental care records which reflected this.

We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals on the day of our inspection. The staff received professional training and development appropriate to their roles and learning needs.

Are services caring?

No action

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

We obtained the views of five patients on the day of our visit. These provided a generally positive view of the service the practice provided.

The majority of patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and dentists were good at explaining the treatment that was proposed.

Are services responsive to people's needs?

No action

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

The service was aware of the needs of the local population and took these into account in how the practice was run.

Summary of findings

Patients could access treatment and urgent and emergency care when required. The practice provided patients with access to telephone interpreter services when required.

The practice had three ground floor treatment rooms and level access into the building for patients with mobility difficulties and families with prams and pushchairs.

Are services well-led?

No action

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

Leadership was provided by an enthusiastic and hardworking practice manager. The staff we spoke with had an open approach to their work and shared a commitment to continually improving the service they provided.

The practice had clinical governance and risk management structures in place.

We saw evidence of systems to identify staff learning needs which included an appraisal system for dental nurses and a programme of clinical audit. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council.

Staff told us that they felt well supported and could raise any concerns with the practice manager. However, the staff stated that there were issues with the company head office in responding in a timely way to issues raised by the them and because of this they were not always happy in their work.

Hilsea Dental Care

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 20 September 2016.

Our inspection was carried out by a lead inspector and a dental specialist adviser.

During our inspection visit, we reviewed policy documents and staff training and recruitment records. We obtained the views of six members of staff.

We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We obtained the views of five patients on the day of our inspection.

Patients gave positive feedback about their experience 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 practice had systems and processes which underpinned RIDDOR 2013 (reporting of injuries, diseases and dangerous occurrences regulations). The practice had an incident reporting system in place when something went wrong; this system also included the reporting of minor injuries to patients and staff.

Records showed that one such accident, a needle stick injury, occurred during 2015-16. On the day of our visit because the practice manager was new we were unable to establish if this particular incident was managed in accordance with the practices accident reporting policy. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Agency (MHRA). Where relevant, these alerts were shared with all members of staff by the practice managers.

Reliable safety systems and processes (including safeguarding)

The practice had in place systems to ensure that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus helping to protect staff from blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked a dentist how they treated the use of instruments used during root canal treatment. They explained that these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained that root canal treatment was carried out where practically possible using a rubber dam. 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.

The practice manager acted as the point of referral should members of staff encounter a child or adult safeguarding issue. A policy and protocol was in place for staff to refer to in relation to children and adults who may be the victim of abuse or neglect. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was available in the practice that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date and stored in a central location known to all staff.

The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies.

Staff recruitment

All of the dentists, dental hygienist and dental nurses had current registration with the General Dental Council, the dental professionals' regulatory body. The practice had a recruitment policy that detailed the checks required to be

undertaken before a person started work. For example, proof of identity, a full employment history, evidence of relevant qualifications, adequate medical indemnity cover, immunisation status and references.

We looked at six staff recruitment files and records confirmed they had been recruited in accordance with the practice's recruitment policy. The systems and processes we saw were in line with the information required by regulations.

We saw that all staff had received appropriate checks from the Disclosure and Baring Service (DBS). These are checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice maintained a comprehensive system of policies and risk assessments which included radiation, fire safety, general health and safety and those pertaining to all the equipment used in the practice. We noted that emergency lighting checks did not cover every lighting unit in the practice. We spoke with the practice manager who assured us this would be addressed immediately after our inspection.

The practice had in place a well maintained Control of Substances Hazardous to Health (COSHH) file. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

The windows in the patient area were dressed with vertical blinds which had pull cords. The pull cords were not attached to the wall securely.

Infection control

There were systems in place to reduce the risk and spread of infection within the practice; although there were areas that could be improved. The practice had in place an infection control policy that was regularly reviewed. It was observed that the practice carried out an audit of infection control processes during January and May 2016. We reviewed the practice's annual infection control statement in relation to infection prevention control required under The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections'. We noted the statement did not include details of staff training and policy reviews.

We saw that the three dental treatment rooms, waiting area, reception and toilet were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

The drawers of two treatment rooms were inspected and these were clean, ordered and free from clutter. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The practice had a separate decontamination room for instrument cleaning, sterilisation and the packaging and storage of processed instruments. We observed a trainee dental nurse carrying out the initial cleaning process which involved manual scrubbing and the use of an ultrasonic cleaning bath. A staff toilet was positioned next to this room. We found that the door to the toilet did not automatically close when not in use.

We noted that certain steps in the process could be improved to ensure that the process followed published guidelines. This included the scrubbing and rinsing of instruments in immersed water rather than under a running tap. We noted that a thermometer was not used to check that the water was below the recommended temperature of 45 degrees. We also noted that when instruments were placed in the ultrasonic cleaning bath this tended to be so that the bath was overfilled with instruments. We pointed out these findings to the practice manager who stated they would arrange further supervisory training as soon as practically possible. Instruments were then placed in an automated washer disinfector.

Following this process instruments were inspected using an illuminated magnifier and then placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated

with an expiry date in accordance with current guidelines. We noted that the way in which instruments were stored was not conducive to efficiency. A variety of instruments were stored in a single box allocated for each surgery making it difficult to assess accurately the quantities of available instruments by staff during a clinical session. As a result, one member of staff reported that this led to a shortage of instruments. We pointed this out to the practice manager. A possible solution included placing examination packs in one storage box, filling instrument packs in another, dental hand pieces in another and so on so that the dental nurses could maintain the flow of instruments during a clinical session in a more efficient way. It would also highlight if additional instruments were needed to be purchased by the practice.

We were shown the systems in place to ensure that the autoclaves and automated washer disinfector used in the decontamination process were working effectively. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date. We did note that the data sheets for the washer disinfector were not always kept up to date. We pointed this out to the practice manager who arranged for this to be rectified as soon as practically possible. All recommended tests utilised as part of the validation of the ultra-sonic cleaning bath were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

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); they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in January 2016. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags were properly maintained in accordance with current guidelines. We noted that municipal waste was not stored in the most appropriate way. The next door neighbour's rubbish bin was found to be in use by the practice and was overflowing with cardboard material which could present a fire hazard to the practice.

The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. We found animal excrement in the back garden area near to the clinical waste bin.

We saw that storage of cleaning equipment was not stored in accordance with current national guidelines. Would found that the colour coded mops were stored with the mop heads in contact with one another. We pointed this out to the practice manager who has since sent us photographic evidence to show that this issue has been resolved.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in June 2016 and other equipment such as the washer disinfector used in the decontamination processes had been serviced in August 2016. The practice compressor had been serviced according to the Pressure Regulations in June 2016. We did note however that the compressor was not stored securely in a shed adjacent to the practice. We pointed this out to the practice manager who has since sent us photographic evidence to show that this issue has been resolved.

The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in August 2016. Portable appliance testing (PAT) had been carried out in May 2015 and was due to be carried out again in 2020.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We observed that the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

We noted that there was no ventilation in one treatment room which was not conducive to staff or patient comfort.

Are services safe?

This was also the case with the decontamination room in respect of staff comfort. We were assured this was being dealt with and we have since been provided with written evidence to confirm works are under way.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level.

We were shown that a radiological audit for each dentist had been carried out in June 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff where appropriate had received training for core radiological knowledge under IRMER 2000 Regulations.

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 recognised general professional guidelines. One dentist we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing 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 then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient 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 the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records that were shown to us by the dentists demonstrated 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 using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

Health promotion & prevention

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice appointed two dental hygienists to work alongside the dentists in delivering preventative dental care. This service was only available on a private basis; an option that was given to all NHS patients.

A dentist explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth in children who were particularly vulnerable to dental decay).

We spoke to the dental hygienist who described the advice that they gave which included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'.

Dental care records we observed demonstrated that the dentists had given oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council. We noted that the external name plate which detailed names of the dentists working at the practice did not include their General Dental Council (GDC) registration number in accordance with GDC guidance March 2012.

We asked five patients if they felt there were enough staff working at the practice. Three patients said yes, one was not sure and one said no. Staff we spoke with told us they felt supported by the dentist and practice manager but only four staff told us they felt there was enough staff at the practice. They told us they felt they had acquired the necessary skills to carry out their role and were encouraged to progress.

The practice employed three dentists, two hygienists, two dental nurses, two receptionists and a practice manager who is also a registered dental nurse.

There was a structured induction programme in place for new members of staff.

Are services effective?

(for example, treatment is effective)

The dental hygienist did not work with chair side support. We pointed this out to the practice manager and referred them to the guidance set out in the General Dental Council's guide 'Standards for the Dental Team' specifically standard 6.2.2 working with other members of the dental team.

Working with other services

A practice manager explained how the dentists worked with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and orthodontic providers.

Consent to care and treatment

A dentist we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentist explained how 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.

The dentist went on to explain how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They added they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists.

Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy. Patients' clinical records were stored mainly in paper form. Computers which contained patient confidential information were password protected and regularly backed up to secure storage; with paper records stored in lockable metal filing cabinets.

Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. Staff were aware of the importance of providing patients with privacy and maintaining confidentiality.

We obtained the views of five patients prior to the day of our visit and five patients on the day of our visit. These generally provided a positive view of the service the practice provided. The majority of patients commented that the dentists were good at treating them with care and concern and that treatment was explained clearly and the staff were caring and put them at ease. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the waiting area and on the practice website that detailed the costs of both NHS and private treatment.

The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable and estimates and treatment plans for private patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we looked at examples of information available to patients. We saw that the practice waiting area displayed a variety of information including the practice patient information file. This explained opening hours, emergency 'out of hours' contact details and arrangements and how to make a complaint. It also contained a selection of practice policies that would be of interest to patients. The practice web site also contained useful information to patients such as treatment costs and how to provide feedback to the practice.

We observed that the appointment diaries were not overbooked and that this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentist decided how long a patient's appointment needed to be and took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had made some reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that may hamper them from accessing services.

The practice used a translation service, which they arranged if it was clear that a patient had difficulty in understanding information about their treatment.

To improve access for patients who found steps a barrier, the practice had level access and all treatment rooms were on the ground floor. A wheelchair accessible toilet was available. We noted that a mirror and non-foot controlled waste bin was not available for wheel chair using patients. We also noted that a hearing loop for patients who used hearing aid was not available.

Access to the service

The practice's opening hours were Monday between 8am and 8pm, Tuesday and Friday between 9am and 5pm, Wednesday and Thursday between 9am and 8pm and Saturday between 9am and 1pm.

We asked five patients if they were satisfied with the hours the surgery was open; all but two patients said yes.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information booklet kept in the waiting area, NHS Choices website and on the telephone answering machine when the practice was closed.

Concerns & complaints

There was a complaints policy which provided staff with information about handling formal complaints from patients. Staff told us the practice team viewed complaints as a learning opportunity and discussed those received in order to improve the quality of service provided.

Information for patients about how to make a complaint was available in the practice's waiting room. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the practice investigation into their complaint. All the patients we asked told us they knew how to make a complaint if they had an issue.

We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

For example, a complaint would be acknowledged within three working days and a full response would be given in 14 days. We saw a complaints log which listed nine complaints received since April 2016 which records confirmed were being managed appropriately.

Are services well-led?

Our findings

Governance arrangements

The company had in place a system of policies, procedures and risk assessments covering all aspects of clinical governance in dental practice. The system of policies and procedures were held on the company intranet called the 'nerve centre,' this enabled all staff to access these policies as required. We saw that these policies and procedures including COSHH, fire and Legionella were maintained and up to date by the Head of Compliance on a regular basis.

Underpinning the governance arrangements for this location was a practice manager who was responsible for the day-to-day running of the practice. The corporate provider had in place a system of area managers and a governance lead manager who provided support to the practice manager. The practice had a clinical support manager who was a dentist who provided clinical advice and support to the other dentists and dental nurses working in the practice. The clinical support manager had appropriate support from an overall company clinical director.

Leadership, openness and transparency

The corporate provider had in place a system of managers who provided support and leadership to the practice manager. On the day of our visit the staff we spoke were hard working, caring towards the patients and committed to the work they did.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty within the location. Staff meetings took place regularly but did not follow the practice's policy for staff meeting format and missed standing items such as complaints and significant events.

Staff told us that they felt well supported and could raise any concerns with the practice manager. However, the staff stated there were issues with the company head office in responding in a timely way to issues raised by the them and because of this staff told us they were not always happy in their work.

Learning and improvement

We saw evidence of systems to identify staff learning needs; this included an appraisal system for dental nurses and a number of clinical audits. With respect to clinical audit, we saw results of audits in relation to clinical record keeping and the quality of X-rays which demonstrated that good standards were being maintained.

For example, we saw the record keeping audits for each dentist. These contained a detailed analysis of the findings by the Clinical Support manager. They would then provide useful hints and tips as to how the dentists could improve their standards. Each dentist was also given a red, amber or green rating of their records. The governance lead for the company explained that any dentist rated red would be invited to discuss the findings with the company Clinical Director who would then arrange for further training or support.

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

The practice gathered feedback from patients through surveys, compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area. Staff told us that most of the dentists were very approachable and they felt they could give their views about how things were done at the practice.

Results of the most recent practice survey, carried out in August 2016, indicated that 100% of patients, who responded, said they would recommend the practice to a family member or friend. However, the number of patients who completed this survey was very low. We spoke with the practice manager as we noted that feedback surveys were stored on the top of a filing cabinet and as they were not easily accessible to patients this could contribute to the low completion rate. We were assured future surveys would be promoted more effectively.