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Thames Street Dental Surgery

Inspection Report

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Date of inspection visit: 08 September 2016
Date of publication: 06/10/2016

Overall summary

We carried out an announced comprehensive inspection on 8 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

The Thames Street Dental Surgery is located in the London Borough of Kingston-upon-Thames. The premises are situated in a high-street location. There is one treatment room, a decontamination room, a reception room, a waiting room, a patient toilet, and a staff kitchen. These are distributed across the first and second floors of the building.

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

The staff structure of the practice consists of a principal dentist, a dental nurse and a receptionist.

The practice opening hours are from 9.00am to 1.00pm on Monday, Wednesday and Friday, and from 9.00am to 6.00pm on Tuesdays and Thursdays.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual registered person. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

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

Eighteen 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 effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- There were effective arrangements in place for managing medical emergencies.
- Equipment, such as the autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced. The air compressor was booked for a service in the week following the inspection.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- 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 some governance arrangements in place and infection control audits were effective in improving the quality and safety of the services. However, further improvements could be made to governance arrangements through the use of a wider range of policies, structured audits and risk assessments.

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

- 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 practice's protocols for the use of rubber dam for root canal treatment taking into account guidelines issued by the British Endodontic Society.
- Review the practice's safeguarding training; ensuring it covers both children and adults and all staff are trained to an appropriate level for their role and aware of their responsibilities.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- Review the practice's use of audit protocols for various aspects of the service, such as radiography and dental care records, to help improve the quality of service. The practice should check that where applicable audits have documented learning points and the resulting improvements can be demonstrated.
- Review the practice's use of risk assessment processes, for example, in relation to fire or general health and safety, with a view to identifying and further reducing the risks to patients and staff.

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 systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. We found the equipment used in the practice was well maintained and checked for effectiveness.

Further improvements could be made through the implementation of a formal system for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

No action ✓

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 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 told us they were well-supported and supervised by the principal dentist. Staff engaged in continuous professional development (CPD) and were meeting all of the training requirements of the General Dental Council (GDC). The only exception was that the principal dentist needed to renew their safeguarding training at the time of the inspection. They confirmed that this had been completed two days after the inspection.

No action ✓

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.

No action ✓

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.

No action ✓

Summary of findings

The culture of the practice promoted equality of access for all. The practice was not wheelchair accessible as the treatment room was situated on the second floor. However, the practice had made reasonable adjustments to the building to support people with limited mobility and redirected patients, who needed full wheelchair access, to other local practices.

There was a complaints policy in place; no complaints had been received in the past year.

Are services well-led?

No action

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

The practice had clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. However, further improvements were needed in relation to the use of risk assessments and audits to monitor and improve performance. The principal dentist was responsive to our feedback in this area and implemented changes immediately after the inspection.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist or practice manager. They were confident in the abilities of the principal dentist and practice manager to address any issues as they arose.

Thames Street Dental Surgery

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 08 September 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 three 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.

Eighteen 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 a system in place for reporting and learning from accidents. There was an accidents reporting book. Staff understood the process for accident reporting, including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). No accidents had been recorded in the past 12 months.

The practice did not have a formal incident reporting policy in place at the time of the inspection. We discussed this with the principal dentist. They assured us that no significant adverse events had occurred within the past year. Staff confirmed that they would always discuss any concerns as they arose. The principal dentist told us that a formal reporting policy would now be implemented.

Staff were aware of the Duty of Candour and had reviewed the requirements in a recent staff meeting. Staff told us they were committed to operating in an open and transparent manner; they would always inform patients if anything had gone wrong and offer an apology in relation to this. . 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 practice had a well-designed safeguarding policy which referred to national guidance. The principal dentist was the named practice lead for child and adult safeguarding. Information about the local authority contacts for safeguarding concerns was displayed in different areas around the practice.

Staff 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. There was evidence in staff records showing that staff had been trained in safeguarding adults and children to an appropriate level. However, the safeguarding training for the principal dentist had not been renewed since 2011. The principal dentist sent us evidence, two days after the inspection, confirming that they had now renewed their training.

The practice had carried implemented some 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 not resheathed using the hands but instead a needle guard was used. Improvements could be made by putting in place a current, written risk assessment, in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries. There had not been any needle stick accidents in the past year.

We noted that the practice did not use 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 dam 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 patients' dental care records giving details as to how the patient's safety was assured).

We discussed this with the principal dentist. The dentist described what alternative precautions were taken to protect the patient's airway during the treatment. The dentist used a system of cotton wool rolls and gauze to protect the patient's airway during treatment. They also used rotary instruments that were attached to a handpiece, thus minimising the risk that files or reamers could unintentionally fall into the mouth. However, there was no written risk assessment in the dental care records to explain why rubber dam could not be used and to describe the alternative risk-reduction processes that were in place.

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 and portable suction, in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening

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irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). We noted that the airways equipment had gone past their use by date and needed replacing. The principal dentist confirmed that these items would be promptly replaced.

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 emergency oxygen in a location known to all staff.

Staff received annual training in using the emergency equipment.

Staff recruitment

The staff structure of the practice consists of a principal dentist, a dental nurse and a receptionist.

All of the staff had worked at the practice for over thirty years and no new staff had been recruited.

We reviewed the staff records and found that the practice kept evidence of each member of staff's registration with the General Dental Council. We also noted that it was practice policy to periodically carry out a Disclosure and Barring Service (DBS) check for all members of staff prior. (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). Improvements could be made by putting in place a formal recruitment policy and protocol.

Monitoring health & safety and responding to risks

There were some arrangements in place to deal with foreseeable emergencies and reduce the risks to staff and patients associated with the running of the practice.

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. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

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 manager via email. These were disseminated at staff meetings, where appropriate.

The practice kept contact information related to emergency services and local suppliers behind the reception desk. Staff were aware of the location of this information.

There were documents showing that fire extinguishers had been recently serviced. The practice had not carried out a formal fire risk assessment at the time of the inspection. The principal dentist sent us evidence after the inspection demonstrating that this had now been completed.

The practice also did not have a formal health and safety policy in place, and there was no associated practice-wide risk assessment to monitor and reduce exposure to hazards. The principal dentist told us that such documents would now be completed.

Infection control

There were effective 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. The practice had carried out practice-wide infection control audits every three months and found high standards throughout the practice.

We asked the dental nurse to demonstrate the end-to-end process of infection control procedures at the practice. The protocols showed that the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse 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.

Clear zoning demarked clean from dirty areas in the treatment room. We also 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 practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had not been kept of the outcome of these checks on a monthly basis, but the dental nurse confirmed that this would now be done.

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

The practice used a decontamination rooms for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment room 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 well-defined 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 autoclave. 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 and cycle number.

We saw that there were systems in place to ensure that the autoclaves were working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

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 within 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. There was a cleaning schedule for staff to follow which described daily, weekly and monthly tasks.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively 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.)

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the fire equipment and X-ray equipment had all been inspected and serviced. The principal dentist showed us that the air compressor had a service booked for the week after the inspection.

Portable appliance testing (PAT) had been completed in accordance with good practice guidance in April 2016. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The practice stored a single small prescriptions pad for NHS treatment and the dentist correctly wrote out private prescriptions. A small number of medicines, such a amoxycycillin, were dispensed by the practice. These were correctly labelled and a log book was kept in relation to any items that were dispensed.

The expiry dates of medicines, oxygen and equipment were monitored using weekly and monthly check sheets which enabled the staff to replace out-of-date drugs and equipment promptly.

Radiography (X-rays)

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000

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(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 set along with the three-yearly maintenance logs and a copy of the local rules.

We saw evidence in the staff records which showed they had completed radiography and radiation protection training. However, the principal dentist had only recently started recording the justification for taking the X-ray in patients' notes, together with a quality grading. A systematic audit of X-ray quality had not been carried out in the past year. We discussed this with the principal dentist, who subsequently undertook a retrospective audit of X-ray quality on the day of the inspection.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The principal dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. They described to us how they carried out their assessments. 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 discussed with 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 was 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 discussions with their patients, where appropriate, around effective tooth brushing, smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting areas. 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 the staff records and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and radiography and radiation protection training. The principal dentist needed to renew their safeguarding training at the time of the inspection. They confirmed that this had been completed two days after the inspection.

The dental nurse and receptionist told us that they were well supported by the principal dentist. They felt confident in raising concerns, discussing performance and training needs. They had not been engaged in a formal appraisal process, but felt this was unnecessary in light of the team's long standing working relationship over a period of thirty years.

Working with other services

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 implants and more complicated extractions.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was

Are services effective?

(for example, treatment is effective)

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 with the principal dentist and dental nurse 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.

The principal dentist was 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). They 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. 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 room was situated away from the main waiting room and reception room. We saw that the treatment room door was 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 training in information governance. Patients' dental care records were stored in a paper format in locked filing cabinets.

Involvement in decisions about care and treatment

The practice displayed information in the reception room which gave details of the NHS and private dental charges or fees.

Staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, 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. The dentist decided on the length of time needed for their patient's consultation and treatment. 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 reception room and waiting room displayed a variety of information including opening hours, practice policy documents. The practice had a website which reinforced this information.

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. There was an equality and diversity policy which staff were following.

Staff spoke a range of different languages, which supported some patients to access the service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired.

The practice was not wheelchair accessible as the treatment room was on the second floor of the building. The principal dentist told us that they had explored access options at the time they took over the practice from the previous provider. They had made some adjustments, including installing hand rails at various locations around the practice. However, they had not been able to make any further, reasonable adjustments to the fabric of the building due to the restricted site and agreement with the freeholder. They had a system in place for referring patients with limited mobility to an alternative, wheelchair accessible practice in the local area.

Access to the service

The practice opening hours are from 9.00am to 1.00pm on Monday, Wednesday and Friday, and from 9.00am to 6.00pm on Tuesdays and Thursdays.

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 dentists in the event of needing emergency treatment.

We asked the reception staff about access to the service in an emergency or outside of normal opening hours. Calls from patients were redirected to a member of staff's mobile phone so that they could assess the urgency of need. The principal dentist then contacted the patient directly to discuss their concerns. The dentist saw the patient on the same day, if necessary, or gave further information on how to access out-of-hours 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 reception room. The staff we spoke with were aware of the contents of the complaints policy. No complaints had been received in the past year.

Patients were invited to give feedback through the use of the NHS 'Friends and Family Test'. We reviewed the most recent results. These showed that patients were likely to recommend the practice to other people.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were some relevant policies and procedures in place. Staff were aware of these and acted in line with them. They told us that they held regular, team meetings to discuss any concerns related to protocols or individual patients. These were arranged as and when they were needed.

Records related to patient care and treatments were kept accurately and staff records were generally well maintained.

However, we noted some examples where improvements were required to ensure the systems in place were used effectively. For example, there were limited arrangements for identifying, recording and managing risks through the use of risk assessment processes. At the time of the inspection, the practice did not have a health and safety policy in place and there was no practice-wide risk assessment to monitor and reduce the risks associated with running a dental practice. There was also no fire or sharps risk assessment in place. The principal dentist was responsive to our feedback in these areas and carried out these assessments, where possible, on the same day as the inspection.

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. Staff told us they were well supported by the principal dentist in relation to career and training goals.

Learning and improvement

At the time of the inspection, the practice did not have a structured plan in place to audit quality and safety. The exception to this was audits of infection control, which were carried out on a quarterly basis. However, other audits, for example, in relation to the quality of X-rays or dental care recording keeping, had not been carried out. We brought this to the attention of the provider and were assured a structured audit plan to ensure completed audit cycles would be established.

The principal dentist sent us evidence, one day after the inspection, showing that these audits had now been completed. These identified action points for improvement and opportunities for shared learning across the dental staff team.

Staff told us they were supported to pursue development opportunities. 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 General Dental Council (GDC).

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. All of the responses received indicated that patients were likely to recommend the practice to others.

However, we noted that the opportunities for private patients to provide feedback were limited. The principal dentist told us they would explore options for obtaining more formal feedback, for example, through the use of a suggestions box, comments book or patient survey.

The staff we spoke with told us the principal dentist was open to feedback regarding the quality of the care.