Mr. Russell Greenwood

Green Street Green Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 May 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

Green Street Green Dental Practice is located in the London Borough of Bromley. The premises are situated in a parade of shops in a high street location. There are two treatment rooms, a reception area and a patient toilet on the ground floor.

The practice provides 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 practice also offers a full range of treatments including implants and Specialist root canal treatment and Specialist periodontal treatment.

The staff structure of the practice consists of a principal dentist, who specialises in prosthodontics, an associate periodontist, an associate endodontist, an associate dentist, four hygienists, three dental nurses, a newly appointed practice manager, a finance administrator and three receptionists.

Summary of findings

The practice opening hours are on Monday, Tuesday, Thursday and Friday from 8.00am to 6.00pm, Wednesday from 8.00am to 8.00pm, and Saturday from 8.00am to 2.00pm.

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

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

Fifty-one 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 was a policy in place for the recording and investigating of incidents. However, we found that this had not always been effectively followed by all staff to support shared learning.
- There were arrangements in place for managing medical emergencies. However, some of the equipment needed for responding to medical emergencies needing renewing or replacing at the time of the inspection.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- 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.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review the system for recording and investigating incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the current Legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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. However, some additional items were required for the medical emergencies kit in line with guidance issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team. .

We also noted that improvements needed to be made to the systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

The principal dentist and practice manager responded promptly to our feedback on these topics and sent us confirmation via email, after the inspection, that these issues were being addressed.

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 engaged in continuous professional development (CPD) and were working towards meeting all of the training requirements of the General Dental Council (GDC). Staff appraisals had been planned for June 2016 in order to provide staff with an opportunity to discuss their role and identify additional training needs.

Are services caring?

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

The practice provided clear, written information for patients which supported them to make decisions about their care and treatment. The dental care records demonstrated that staff provided people with explanations about the risks and benefits of different treatments. This supported people to be involved in making their own choices and decisions about their dental care.

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

Are services responsive to people's needs?

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

Summary of findings

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. The practice was wheelchair accessible with the treatment rooms situated on the ground floor.

There was a complaints policy in place. Two complaints had been received within the past year. These had been recorded and appropriately investigated. Patient feedback, through the use of feedback forms collected in the waiting area, was used to monitor the quality of the service provided.

Are services well-led?

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. A system of audits was used to monitor and improve performance. There were some areas where risk management processes could be improved. This included protocols in relation to investigation of incidents as well as the monitoring of Legionella risk. The practice manager and principal dentist assured us that these issues would be addressed promptly.

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

Green Street Green 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 19 May 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

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

Fifty-one 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

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was an accidents reporting book. Two accidents had occurred within the past year and been appropriately recorded and followed up.

There was also a patient safety policy in place for reporting and learning from incidents. No incidents had been recorded in the past year. We noted that there was a separate sharps injury reporting protocol and record book. One sharps injury had been recorded in the past year. We found that this incident had not been followed up in line with the protocol. We discussed this with the practice manager and principal dentist. They subsequently confirmed with us via email that this incident had now been appropriately followed up. The practice manager had also put in place an opportunity for shared learning to prevent a recurrence. They had added the discussion of the event, and wider incident reporting protocols, to the agenda for the next staff meeting.

Staff were aware of the Duty of Candour requirements. They had been asked to read the Duty of Candour regulation and associated guidance and sign a record sheet to confirm that they had done so. [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 manager was the named practice lead for child and adult safeguarding. We discussed safeguarding with a range of different staff. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns was readily available for staff. There was evidence in the staff records that we checked which showed that staff had received training in safeguarding adults and children.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of sharps injuries. Following administration of a local anaesthetic to a patient, needles were not resheathed using the hands and a rubber needle guard was used instead, which was in line with current guidelines. The staff we spoke with demonstrated a clear understanding of the practice protocol with respect to handling sharps and needle stick injuries. However, at the time of the inspection, the practice did not have a written risk assessment, in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The practice manager sent evidence via email, after the inspection, that such a risk assessment had been conducted and a written protocol was now in place.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. Rubber 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 the patient's dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED) and an oxygen cylinder, in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The equipment was being regularly checked for effectiveness. However, we found that some of the equipment, such as the oropharyngeal airways, were past their use by date and needed replacing. The practice manager sent us evidence via email, after the inspection, that these items had been ordered.

Are services safe?

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 staff.

Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

Staff recruitment

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council. We checked a random sample of the staff records. We found that copies of the relevant documents had been obtained prior to employment.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Monitoring health & safety and responding to risks

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

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

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

The practice had a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). Relevant alerts were disseminated to all staff, when necessary.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. One of the principal dentists was the infection control lead. 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 six months and found high standards throughout the practice.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in both of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment rooms and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked one of the dental nurses to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated 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.

Are services safe?

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

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). The 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 in 2011 and had been reviewed again in 2015. However, the practice had not followed recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. The dental nurse assured us that such testing would now be carried out on a monthly basis.

The practice did not have space for a dedicated decontamination room for instrument processing. Instead, dirty instruments were cleaned in one of the treatment rooms in a dedicated area before being moved to the second treatment room for sterilising. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between the treatment rooms 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 cleaned in an ultrasonic bath prior to inspection under a light magnification device. Following this, the instruments were transported in lidded 'dirty' boxes and placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclave and ultrasonic bath were working effectively. These included, for example, the automatic control test, steam penetration test, ultrasonic activity ('foil') test and protein residue 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 outside the practice prior to collection by the contractor. Waste consignment notices were available for inspection. Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme.

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 been inspected and serviced. Pressure Vessel Certificate for the dental compressor and autoclave had been issued within the past year, in accordance with the Pressure Systems Safety Regulations 2000. The practices' ultrasonic cleaner had been newly installed within the past month.

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

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. However, this system had not identified the need to replace the oropharyngeal airways for the emergency kit. The practice manager sent us evidence to show that this equipment had been replaced.

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

Are services safe?

(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 also saw evidence that staff had completed radiography and radiation protection training. Audits on X-ray quality were undertaken at regular intervals.

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 and General Dental Council (GDC) guidelines. The principal dentist and the periodontist described to us how they carried out their assessments. (Periodontics is the specialty of dentistry concerned with gum health and the supporting structures of teeth, as well as diseases and conditions that affect them). The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

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

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

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around effective tooth brushing, smoking cessation, sensible alcohol use and diet in relation to maintaining healthy teeth. The dentists also carried out examinations to check for the early signs of oral cancer.

There was a periodontist and four hygienists working at the practice. The dentists could refer patients internally to the periodontist or hygienists and consulted with them for further advice and the setting up of treatment plans related to promoting good oral health.

We observed that there were health promotion materials displayed in the reception area and the practice printed its own leaflets related to oral health which were available to patients upon request, or provided directly by one of the dentists to their patients, where appropriate. 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

The staff structure of the practice consists of a principal dentist, who specialises in prosthodontics, an associate periodontist, an associate endodontist, an associate dentist, four hygienists, three dental nurses, a practice manager, a finance administrator and three receptionists.

Staff told us they received appropriate professional development and training. We checked the training records for seven members of staff 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, infection control, and radiography and radiation protection training.

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

The practice manager told us they had recently engaged staff in discussions with a view to carrying out a formal appraisal in June 2016. We reviewed the records kept for these discussions and saw that appraisal forms had been prepared. Staff had also been engaged in one to one supervision sessions with the lead dental nurse on a monthly basis.

Working with other services

Are services effective?

(for example, treatment is effective)

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

The principal dentist and periodontist explained how they worked with other services, when required. A large proportion of patients seen by the practice had been referred to them for specialist treatment by other dentists. The periodontist told us that they worked with dentists who referred patients to the practice. They made visits to other dental practices and spent time explaining their role and the type of treatments on offer.

The practice was also able to make in-house referrals to dentists with other specialisms in the same practice. They were able to draw up a comprehensive treatment plan to meet a range of dental care needs. They held joint reviews for complex cases to ensure patients' needs were met.

The practice was also able to refer patients to a range of other specialists in primary and secondary care if the treatment required was not provided by the practice. For example, there was a system in place for referring patients to hospital consultants using a fast track process for patients with a suspected case of cancer.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. A copy of the referral letter was available to patients. 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.

The reception staff kept a log book of referrals and noted each stage in the process when it was complete to ensure that patients had been seen in a timely manner. They also audited the referral process periodically to check that the systems in place had been effective.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to principal dentist 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. Some patients, who were undergoing complex treatment, were also asked to sign formal, written consent forms and copies of these were held with the patient's dental care record.

All of the staff members were aware of the Mental Capacity Act 2005. (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves). The principal dentist was able to 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 feedback we received from patients was all positive and referred to 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.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area. We noted that the doors of the treatment rooms were sometimes left open, but staff noted that the corridor outside the rooms was infrequently used, and that doors were closed when patients requested this and when sensitive discussions around treatment plans were being held. We found that staff were aware of, and had considered strategies for, protecting patients' dignity.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in both paper and electronic formats. Records stored on the computer were password protected and regularly backed up. Paper records were stored in locked filing cabinets and were not left unattended in the reception area.

Involvement in decisions about care and treatment

The practice displayed information in the reception area which gave details of the private dental charges or fees. This information was also provided in written treatment plans which were given to patients to consider prior to agreeing to any treatment.

We spoke with the principal dentist and the periodontist on the day of our inspection. They told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the dental care records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. The patient feedback we received confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment, particularly in relation to more complex treatment plans. 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 any of the dentists or hygienists. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and guides to different types of dental treatments. The reception staff also held a stock of information leaflets about different treatments which were given to patients to take away when they needed them.

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. The practice staff had access to a telephone interpreter service which could be used to support people to access the service.

The premises were wheelchair accessible, with access via a ramp at the entrance and level access to the treatment rooms, all of which were situated on the ground floor. The reception staff also told us that they asked patients to let them know if they needed any support to access the service. A note of these requests was kept with patient's dental care record to prompt staff to offer support when booking appointments or during treatment. For example, the staff kept a note of patients who were hard of hearing and who therefore either needed printed instructions or good visual contact for lip reading.

Access to the service

The practice opening hours are on Monday, Tuesday, Thursday and Friday from 8.00am to 6.00pm, Wednesday from 8.00am to 8.00pm, and Saturday from 8.00am to 2.00pm.

We asked one of the receptionists about access to the service in an emergency or outside of normal opening hours. They told us that there was an answerphone message which directed patients to other local out of hours services or to contact the dentist 'on call' over the weekend. Messages left on the answerphone were directed to one of the dentists so that they could call the patient back and determine their level of need. The dentist then either arranged to see the patient, or referred them to another service, depending on the outcome of their telephone assessment.

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

Concerns & complaints

There was a complaints policy in place. We saw that it described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed at the reception desk. Two complaints had been recorded in the past year. We saw that these had been investigated and responded to in line with the practice policy.

Patients were also invited to give feedback through a patient satisfaction survey and a suggestions box situated in the reception area. The information received demonstrated that patients were satisfied with their care.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. Staff were aware of these and acted in line with them.

However, we noted some examples where improvements were required to ensure the systems in place were used effectively. For example, the outcome of the Legionella risk assessment and the policy for the recording and investigation of incidents had not been fully implemented. The practice manager and principal dentist were responsive to our feedback in these areas. They sent us evidence after the inspection confirming that appropriate steps had been taken to improve in this area.

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

There were regular staff meetings to discuss key governance issues. We reviewed minutes from meetings held in the past year and noted that topics such as medical emergencies, infection control, and patient referrals were discussed.

Leadership, openness and transparency

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

We found staff to be hard working, caring towards the patients and committed to the work they did. Staff told us they enjoyed their work. We noted that staff had received regular one to one supervision sessions. Formal appraisals had also been planned for staff in June 2016. These would provide staff with an opportunity to review their own performance and elicit their goals for the future.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control, clinical record keeping, and X-ray quality. One of the dental nurses demonstrated how the outcome of these audits had been used to improve the quality of the service. For example, the outcome of a recent infection control audit had led to the purchase of a new ultrasonic cleaner.

All staff 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). Dental nursing staff had been encouraged to complete additional training. For example, some of the dental nurses had completed training which allowed them to take X-rays.

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

The practice gathered feedback from patients through the use of a feedback form with a suggestions box in the waiting area. The majority of feedback had been positive. The practice had responded to feedback, for example, by reviewing the type of seating available in the waiting area and considering the opening hours available.

The staff we spoke with told us the principal dentist and practice manager were open to feedback regarding the quality of the care. The supervision system and staff meetings also provided appropriate forums for staff to give their feedback.