

Oxford Dentist Limited

Newbury Smile Studio

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 February 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Newbury Smile Studio is a small dental practice offering private dental treatment to adults and children. Newbury is a market town in Berkshire. There are two dental surgeries, one is situated on the ground floor the other surgery is located on the first floor. There is level access from the street. Approximately 500 patients are registered at the practice. The majority of patients are adults.

The staff structure of the practice consisted of two dentists, two visiting specialist dentists, one dental hygienist, two dental nurses/receptionists and one dental nurse/practice manager/receptionist. The practice facilities include two treatment rooms, one consultation/recovery room, one reception and waiting area, and a decontamination room.

The practice is open Monday to Friday from 9am to 5pm. The practice will open outside of these hours by arrangement with individual patients. There was an answer phone message directing patients to emergency contact numbers when the practice is closed.

The practice principal/provider is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

Summary of findings

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

We obtained the feedback of three adult patients and four children on the day of our inspection and Seventeen patients who had completed comment cards. Two patients contacted CQC directly to leave feedback about the practice. We also read patient testimonials on the practice website. All patients comment cards, feedback and testimonials were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff and the dental treatment they had received.

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.
- There was a lead staff member for safeguarding patients. All staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- 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 they felt they were listened to and that they received good care from the practice team.
- The practice had implemented procedures for managing comments, concerns or complaints.
- Patients could access treatment and urgent and emergency care when required.
- Patients could book appointments up to 12 months in advance.
- The provider had a clear vision for the practice and staff told us they were supported by the practice principal.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available in accordance with current guidelines.

- The practice appeared clean and well maintained.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Staff received training appropriate to their roles and were supported in their continuing professional development by the practice principal.
- Staff we spoke with felt supported by the practice principal and were committed to providing a quality service to their patients.
- The practice offered an Implant treatment service to patients. Following referral the service was carried by a specialist dentist, who attended the practice to carry out the implant treatment.
- Conscious sedation was carried out in accordance with current guidelines from the Society of the Advancement of Anaesthesiology in Dentistry (SAAD).

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

- Review the practice recruitment policy and procedures relating to Disclosure and Barring Service (DBS) checks for staff.
- Review the practice fire risk assessment and consider patients who are undergoing conscious sedation in the practice.
- Review the practice arrangements relating to the provision of a hearing loop for those hard of hearing, signage to indicate the emergency alarm cord in the accessible toilet in case of an emergency and access to translation services for those for whom English is not a first language.
- Review the system of capturing patient feedback and consider how to inform patients of changes made as a result of surveys and feedback.
- Review the location of the equipment and medicines held for medical emergencies.

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 followed, for the management of medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

The practice used an external contractor to assist the practice with compliance with the legal obligations for radiation (X rays).

Staff told us that they knew the location of equipment held for medical emergencies however it was stored in an area that may be difficult to access in a timely manner in the event an incident.

Staff had an awareness of safeguarding issues, which were informed and supported by practice policies. The policies contained local authority safeguarding contact information. Staff were able to illustrate scenarios of when they might identify concerns and knew how to contact the relevant authorities. We spoke with five members of staff and they confirmed they had received training in safeguarding adults and children.

Infection control processes for the decontamination and sterilising of dental equipment were safely managed.

Procedures for recruiting new staff were followed consistently. All of the appropriate checks including employment references and proof of identification were carried out when new staff were employed with the exception of Disclosure and Barring Service (DBS) checks. The staff were suitably trained and skilled to meet patient's needs and there were sufficient numbers of staff available at all times.

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). Consultations were carried out in line with current guidelines such as those from the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their dental needs including a review of their medical history. Dental care records were detailed and included details of risks of conditions such as oral cancer and advice about alcohol and tobacco consumption.

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.

No action



Summary of findings

Staff engaged in continuing professional development (CPD) and met the training requirements of the General Dental Council (GDC). Although there had not been any recruitment of staff for a number of years we saw evidence new staff could expect to receive induction training and would be engaged in a probationary process to review their performance and understand their training needs.

Are services caring?

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

We received positive feedback from seventeen patients. The practice also received patient feedback through patient surveys, testimonials and social media. Feedback was consistently positive. Patient survey results were complimentary about the practice staff and treatment received. Patient survey results told us the staff were kind and caring and that they were treated with dignity and respect at all times. The most recent patient survey had mentioned additional opening hours would be helpful and the practice was currently considering the matter. The practice was not feeding back to patients the results of surveys and should consider methods for informing patients.

We found that electronic 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 had good access to appointments, including emergency appointments, which were available on the same day. They would see any patient in dental pain, extending their working day if necessary.

There was a complaints policy in place. Complaints were addressed in a timely way to the satisfaction of the complainant. Systems were in place for receiving more general feedback from patients with a view to improving the quality of the service. The practice obtained patient feedback through surveys and testimonials. The culture of the practice promoted equality of access for all. The practice staff had specific knowledge of individual patient needs. This was evident in the support offered to patients to assist with a visual or hearing impairment or mobility needs. The facilities for people with limited mobility had been considered when the building was designed and provided accessible toilet facilities and ground floor access. The practice did not have access to a hearing loop for patients who were hard of hearing. The practice did not have a sign to identify the emergency alarm cord in the adapted toilet in the event of an emergency. The practice did not have access to translation services for those hard of hearing should the need arise.

No action



Are services well-led?

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

No action



Summary of findings

Leadership at the practice was provided by the principal dentist. The governance arrangements such as policies and procedures for the practice were well organised and effective. All staff had a good understanding of these. The culture of the practice encouraged openness and the team worked closely to support each other. Staff commented they felt listened to and that their learning needs were supported.

Whilst the practice had a fire risk assessment by a competent person it did not cater for patients who may be undergoing conscious sedation. The provider should consider the issues of conscious sedation in relation to patient fire safety and evacuation techniques in an emergency.

The practice shared learning through formal team meetings.

The practice ethos focussed on providing patient centred care and patient feedback was sought verbally; and through surveys and testimonials.

Newbury Smile Studio

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 16 February 2017. The inspection was led by a CQC inspector and a specialist advisor. Prior to the inspection we reviewed information submitted by the provider.

During our inspection we reviewed policy documents and spoke with five members of staff (practice principal /dentist, one dental hygienist, one dental nurse, one dental nurse/ receptionist/practice manager and one dental nurse/receptionist). We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. A dental nurse demonstrated how they carried out decontamination procedures of dental instruments.

Seventeen patients provided feedback about the service. We also spoke with three adult patients and four children. We looked at written comments about the practice on the practice website, comments left about patient experiences. Two patients also contact CQC direct to leave feedback. Patients were positive about the care they received from the practice. They were complimentary about the friendly, professional and caring attitude of the dental staff. Patients commented that they were likely to recommend 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

There was a system in place for reporting and learning from incidents. There had been no significant events related to patients or staff in the past year.

We discussed the investigation of incidents with the practice principal who confirmed if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result. Practice staff were aware of their responsibilities under the Duty of Candour.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any such incidents in the past 12 months.

The practice had systems to receive safety alerts, such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) by email which were shared with staff working in the practice. This included printing them and leaving them in a central location for all staff to refer to or discussing them in meetings.

Whole staff team meetings were held at least monthly and there were regular team briefs. Team meetings were recorded and we looked at a sample of team meeting minutes. We saw records of when actions resulting from team meetings were addressed and signed off as closed.

Reliable safety systems and processes (including safeguarding)

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

The practice had a safeguarding policy reviewed in the last 12 months. The policy referred to national guidance. The guidance included information about local authority contacts for safeguarding concerns. We were shown staff training records and could see that staff had received appropriate training in the last twelve months.

The practice had carried out a range of risk assessments and implemented policies and protocols to mitigate risks

and keep patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice had a current policy about the re-sheathing of needles, giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff were aware of the contents of this policy. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to handling sharps and needle stick injuries and prevent injuries.

The dental hygienist told us they always worked with nursing support as required by national guidance. Dental nurses spoken with corroborated this and rotas were seen to confirm this.

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 sheet of rubber, usually latex that is used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an oxygen cylinder, and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. An automated external defibrillator (AED) was situated in with the emergency equipment in an area accessible only to staff and staff were aware of its location and how to use it. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen. We saw that the emergency equipment was located on the ground in a corner on the first floor. The staff told us that the emergency equipment was not easily accessible in an urgent situation. The practice principal told us he would review the location and of the emergency equipment for ease of access.

Are services safe?

Staff received annual training in using the emergency equipment. This equipment was checked for safe use each day the practice was open and the checks were documented.

Staff recruitment

The staff structure of the practice consisted of two dentists, two visiting specialist dentists, one dental hygienist, two dental nurses/receptionists and one dental nurse/practice manager/receptionist.

Many of the staff had been in post for a number of years. 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. Staff recruitment records showed that this policy had been consistently applied in all cases.

We were shown staff recruitment files which showed that the practice had not completed a Disclosure and Barring Service (DBS) checks for staff and were not aware of the requirement to do this. We saw evidence that one member 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). We discussed this with the practice principal who told us they would review and amend the practice policy so all staff would have a DBS check carried out.

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 considered the risk of fire, had clearly marked exits and an evacuation plan. There were also fire extinguishers situated at suitable points in the premises. The practice carried out fire drills and records showed the last drill was carried out during December 2016. A record of assessment of the effectiveness of the fire drill had been completed and discussed with the whole staff team.

We saw that a practice fire risk assessment had been carried out during May 2016. However the assessment did not consider the issues of patients who maybe undergoing

conscious sedation at the time of an incident. We spoke with the practice principal who told us that he would arrange for a review the fire risk assessment by a competent person to cater for patients undergoing conscious sedation at the time of any unexpected fire incident.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We were shown a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. The COSHH file was regularly reviewed to ensure old product sheets were discarded and new ones made available. COSHH products were securely stored.

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). We saw evidence relevant alerts were discussed during monthly staff meetings which facilitated shared learning.

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 lead infection control nurse carried out audits of infection control processes at the practice using a recognised industry assessment tool.

We observed that the premises appeared clean, tidy and clutter free in patient areas. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment and decontamination rooms.

We asked a dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice 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 we spoke with explained the decontamination of the general treatment room

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environment following the treatment of a patient. They demonstrated how the working surfaces, dental units and dental chairs were decontaminated. This included the treatment of the dental water lines.

Environmental cleaning was carried out in accordance with the national colour coding scheme by the practice staff throughout the building. We were shown a schedule of cleaning which evidenced that cleaning was carried out in a systematic way and checked by staff.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched and dated with an expiry date in accordance with HTM01-05. We saw that each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

Instruments were decontaminated by being scrubbed clean of debris then rinsed and inspected under a light magnification device prior to being placed in an autoclave (steriliser). When instruments had been sterilised, they were pouched and stored appropriately until required. Pouches were dated with a date of sterilisation and an expiry date in accordance with HTM 01-05.

We observed that the practice carried out validation checks of the autoclave to assure that it was working effectively. Twice daily checks included the automatic control test and steam penetration test. Paper records and data loggers were used to record the essential daily validation checks of the sterilisation cycles.

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 stored. 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. We saw waste consignment notices which confirmed practice waste was appropriately managed by the practice.

We were shown staff recruitment files showed that contained evidence that staff regularly attended training courses in infection control. The staff recruitment files contained evidence to show that clinical staff were 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.)

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 principal 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 during 2016. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures at sentinel taps and records seen corroborated this.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents which showed the air compressor, fire equipment and X-ray equipment had all been inspected and serviced within the last 12 months. We saw the Certificates for pressure equipment that had been issued in accordance with the Pressure Systems Safety Regulations 2000.

We observed Portable appliance testing (PAT) had been completed during February 2017 in accordance with current guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

We were shown the expiry dates of medicines, oxygen and equipment were monitored using daily, weekly and monthly check sheets to support staff to replace out-of-date medicines and equipment promptly and ensure it was available and safe to use at all times.

The practice carried out inhalation sedation for patients who were very nervous of dental treatment (Inhalation sedation involves breathing a mixture of nitrous oxide gas in combination with oxygen which can help anxious patients to become more relaxed and co-operative during treatment without experiencing pain). We saw that the practice had appropriate oxygen monitoring equipment and the correct gas scavenging arrangements.

The practice principal, assisted by dental nurses, provided conscious sedation for patients. (These are techniques in which the use of a drug or drugs produces a state of

Are services safe?

depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The practice had protocols for conscious sedation, giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.' Records showed that the practice principal who carried out, and dental nursing staff who assisted in conscious sedation, had the appropriate training and skills to carry out the role.

Radiography (X-rays)

We were shown a radiation protection file which was maintained in line with the Ionising Radiation Regulations

(IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the documentation pertaining to the maintenance of the X-ray equipment. We saw evidence the X-ray equipment had been serviced in January 2016. The practice used an external contractor to assist with X ray compliance and the legal duties.

We saw evidence both dentists had completed radiation training within recommended timescales. X-ray audits were being conducted on an annual basis. We reviewed the records of the last audit conducted in December 2016 demonstrated X-ray quality a date for re audit had been planned for December 2017.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. We spoke with one dentist and asked them to describe how they carried out their assessments. The assessment began with the patient completing a medical history update covering any health conditions, medicines being taken and any allergies suffered. We saw patients being asked to complete a medical history questionnaire when they booked in for their appointment to give to the dentist. 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 told us and records corroborated they 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 them. Treatment plans were available for each patient on request, which included information about the costs involved. Patients were referred to the practice information leaflet for cost information on routine treatments. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of a number dental care records to confirm the findings. These showed that the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums and soft tissues lining the mouth were noted using the basic periodontal examination (BPE) scores. (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 maintained a focus on oral disease prevention and employed a dental hygienist as part of this ethos. The Dentist and Hygienist told us they discussed oral health with their patients, for example, around effective tooth brushing. They were aware of the need to discuss a general preventive agenda with their patients. They told us they

held discussions with their patients, where appropriate, around smoking cessation, sensible alcohol use and diet. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed there were health promotion materials displayed in the reception area. These supported patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition. We discussed oral health education with the practice principal who told us that he was considering adding a display cabinet in the reception area for oral health products and developing oral health promotion within the practice.

Staffing

Staff told us they received appropriate professional development and training. We checked the staff recruitment files and saw that this was the position in most cases. The training covered the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding, infection control and X-ray training. There was a written induction programme for new staff to follow and evidenced in the staff recruitment files that this had been used at the time of their employment.

Many of the staff employed had worked at the practice for a number of years. Staff told us that the practice principal was supportive and invested in staff through regular training opportunities to promote clinical excellence at the practice.

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.

Staff at the practice explained how they worked with other services, when required. The dentists and hygienist were 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 complex orthodontic work.

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 in the practice records system. We looked at examples of referral letters. These were comprehensively completed and referrals took

Are services effective?

(for example, treatment is effective)

place in a timely way to avoid delay to treatment. The electronic records noted the dates when referrals were made, when the appointment had been completed and further actions required for follow up. They contacted other providers to check on the progress of their patients and kept the referring dentist informed about the outcomes.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient. Patients were asked to sign formal written consent forms for specific treatments. We looked at a number of patient dental care records and saw consent to treatment was recorded including specific patient consent for the use of inhalation sedation.

All of the staff 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. Clinical staff had completed on line training in relation to the MCA in 2016. The dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, check for appropriate lasting power of attorney authorisation to act on a person's behalf, along with 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 Seventeen comments cards we received, all made positive remarks about the staff's caring, professional and helpful attitude. Patients indicated 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.

We saw that the practice collected patient testimonials and displayed them on the practice website for the public to view. The testimonials were positive and supportive of the treatment that the practice gave to patients.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and the dentists/hygienist therapist 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 electronically recorded and password protected.

Involvement in decisions about care and treatment

The practice detailed information about services on the practice website. This gave details of the range of services available, dental charges or fees and payment options (such as membership of private dental schemes). A leaflet detailing private treatment costs was displayed in the waiting area.

We spoke with five staff on duty on the day of our inspection. All of these staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records 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 treatment planning forms for dentistry where applicable.

The patient feedback we received 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 dentists and hygienist decided on the length of time needed for their patient's consultation and treatment according to patient need. The practice provided its own emergency out of hour's service. Urgent same day appointments were available for both patients that were registered and those that were not registered at the practice. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

We spoke with the principal dentist who provided patients with referrals to specialised dental implant treatment. The implants were carried out at the practice by a specialist dentist brought in specifically to provide implants to patients. The practice principal explained how they carried out consultations, assessments and treatment in line with recognised general professional guidelines from the FGDP with respect to implant treatment.

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 patients. The practice website contained a variety of information, including opening hours and costs. There was also a printed patient information leaflet at the practice.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its service. There was an equality and diversity policy to which staff could refer. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff showed us they provided written information for people who were hard of hearing.

The practice was designed with patient accessibility in mind. Patients who used a wheelchair could access the practice from the ground level and there was a ground floor

treatment room with an accessible ground floor accessible toilet. However we saw that whilst the accessible toilet was fitted with an emergency alarm cord it was unsigned. We discussed this with the practice principal who told us that he would place a sign by the emergency alarm cord to avoid confusion in case of an emergency.

We saw that the practice did not have arrangements in place for those patient's hard of hearing and those patients for whom English was a second language. The practice principal told us they would review the need for a hearing loop, and make arrangements to ensure the availability of a translation service to ensure that those for whom English is a second language could access services more easily.

We observed that the seating in the waiting area was of standard design and the area uncluttered.

Access to the service

The practice was open Monday to Friday from 9am to 5pm. The practice would open at other times by arrangement with individual patients. There was an answer phone message directing patients to emergency contact numbers when the practice was closed.

The receptionist told us 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 of their concerns. The feedback we received via comment cards and testimonials confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had been one complaint recorded during 2016 regarding fees. We looked at the complaint in detail. The practice handled the complaint in a timely way and resolved the complaint to the satisfaction of the patient.

Patients were also invited to give feedback through the practice website, social media and testimonials. The practice used patient surveys, in which patients could remain anonymous. We noted that the practice did not inform patients of changes as a result of their feedback. We

Are services responsive to people's needs?

(for example, to feedback?)

spoke with the practice principal who told us they would review feedback and consider providing patients with information about actions taken as a result of their comments.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. The governance arrangements for this location were overseen by the practice principal and practice manager who was responsible for the day to day running of the practice. There were relevant policies and procedures in place And staff were aware of these and acted in line with them. There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

We saw and were told Regular staff meetings took place at the practice with records maintained of all staff meetings. We saw evidence minutes from staff meetings were circulated. The practice principal told us about the governance structures and protocols at the practice. A systematic process of induction and staff training was in place which ensured staff were aware of, and were following, the governance procedures.

Leadership, openness and transparency

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

We found staff to be dedicated in their roles and caring towards the patients. We found the dentists provided effective clinical leadership to the dental team.

Staff told us they enjoyed their work and were supported by the practice principal. All staff had received a documented appraisal in the last 12 months.

Learning and improvement

We found there were a number of clinical audits taking place at the practice. These included infection control,

clinical record keeping and X-ray quality. There was evidence of repeat audits at appropriate intervals and these demonstrated that standards and improvements were being maintained. For example, radiography, specialist referrals, medical history, infection control and record keeping audits.

Staff were being supported to meet their professional standards and complete continuing professional development (CPD) set by the General Dental Council (GDC). We saw evidence that the clinical staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the GDC. Training was completed through a variety of resources including the attendance at face to face and online courses. Staff were given time to undertake training which would increase their knowledge of their role.

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

The practice gathered feedback from patients through the use of patient surveys and the NHS Friends and Family test. For example, during the July 2016 survey, 50 patients confirmed that there were happy with the service and treatment provided by staff at the practice. The patients did make comments about time keeping, treatment plans and costs. These were fed back through to staff via the staff meetings. Patients indicated they were fully satisfied with the service.

Staff told us that the practice principal was open to feedback regarding the quality of the care. All staff were aware of the practice whistleblowing policy and felt they could raise concerns, which would be acted upon by the practice principal. The practice whistleblowing policy contained information about where staff could obtain assistance outside of the practice management structure. Staff indicated they were fully satisfied with practice principal and the service given to patients.