

Acacia Dental Practice Limited

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 October 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

Acacia Dental Practice is situated in the town of Bromyard in Herefordshire. It provides private and NHS dental treatment for all age groups. It has been operated by Acacia Dental Practice Limited, a limited company, since 2013. In 2014 the practice moved from first floor premises with no parking on site to a converted bungalow to provide more accessible ground floor premises with on-site parking.

The company secretary is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. The practice has three dentists (one of whom is the registered manager), a dental hygienist, a dental therapist (who was also a dental hygienist), two dental nurses and a trainee dental nurse. The registered manager and clinical team are supported by a receptionist/administrator.

The practice has two dental treatment rooms and a separate decontamination room for the cleaning,

Summary of findings

sterilising and packing of dental instruments. The waiting room is separate from the reception area which helps provide privacy when staff are dealing with patients at the reception desk or on the telephone.

The practice is open from 9am to 5pm Monday to Friday and closes for lunch from 1pm to 2pm.

Before the inspection we sent Care Quality Commission comment cards to the practice so patients could give us their views about Acacia Dental Practice. We collected 14 completed cards and spoke with two patients at the practice. Patients said they were pleased with the service they received and that the practice team were professional, friendly and respectful. Some patients mentioned that their dentist listened to them, explained everything clearly for them and that they felt safe. Those that commented on cleanliness confirmed that the practice was clean and tidy. We reviewed the results of the practice's NHS Friends and Family Test for the nine months from January 2016. These were positive and showed that 100% of the patients who took part were extremely likely or likely to recommend the practice.

Our key findings were:

- The practice was visibly clean and feedback from patients confirmed this was their experience. National guidance for cleaning, sterilising and storing dental instruments was followed.
 - The practice had suitable safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
 - The practice had processes for dealing with medical emergencies.
 - Dental care records provided clear information about patients' care and treatment and patients received written treatment plans.
 - Staff received training appropriate to their roles and were supported to meet the General Dental Council's continuous professional development requirements.
 - Patients were able to make routine and emergency appointments when needed and were gave us positive feedback about the service they received.
 - The practice used the NHS Friends and Family Test, to enable patients to give their views about the practice.
- Results during 2016 showed that patients would recommend the practice. Staff had opportunities to contribute their views through daily discussions, staff meetings and annual appraisals.
- The practice had policies and procedures to help them manage the service but these needed to be reviewed and consolidated. Recruitment arrangements did not ensure that all the required information was always obtained for staff employed.
 - The practice used audit as a means to monitor quality in a range of areas but did not routinely carry out repeat audits to ensure improvements had taken place.
- There were areas where the provider could make improvements and should:
- Review the storage of dental care products and medicines requiring refrigeration including recording the refrigerator temperature.
 - Review the use of rectangular collimators when taking X-rays.
 - Review the practice's recruitment arrangements so an effective process which fully reflects relevant legislation and guidance is in place and the required information in respect of persons employed by the practice is held.
 - Review the availability of a hearing loop to assist those who use hearing aids and information about translation services for patients who do not speak English as their first language or who use British Sign Language.
 - Review the recording arrangements for some aspects of practice management including incoming safety alert information, fire safety arrangements and mandatory training.
 - Review the practice's audit arrangements particularly for radiography, infection prevention and control and dental care records to help improve the quality of service. The practice should check all audits have documented learning points, that improvements can be demonstrated and that repeat audits are used to confirm this.

Summary of findings

- Review the practice's policies and procedures to make information easier to access, to avoid duplication and the possibility that staff may refer to incorrect or out of date information.

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 to assist in the safe management of the service including the care and treatment provided to patients. This included processes to discuss and make improvements when things went wrong although some aspects of this such as systems for audits needed to be strengthened.

There were policies and risk assessments for important aspects of health and safety. These included infection prevention and control, clinical waste management, dealing with medical emergencies, dental radiography (X-rays) and fire safety. Two versions of these were available and needed to be reviewed and consolidated to avoid the potential for confusion. Maintenance records also needed to be better organised. The staff recruitment policy needed to be reviewed to provide robust guidance and procedures regarding the information needed for new staff. Some aspects of maintenance and record keeping in respect of fire safety needed to be reviewed.

Staff were aware of their responsibilities for safeguarding adults and children. The practice had safeguarding policies and procedures and contact information for local safeguarding professionals was readily available for staff to refer to if needed.

No action



Are services effective?

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

The practice assessed patients' and care and treatment in a personalised way taking into account current legislation, standards and evidence based guidance. They provided patients with written treatment plans and patient feedback confirmed that their care was discussed with them clearly and thoroughly. Referrals to other dental or NHS services were made in line with relevant guidance when this was necessary and the practice worked in partnership with other health professionals.

Clinical staff were registered with the General Dental Council and completed continuous professional development to meet the requirements of their professional registration

Staff understood the importance of obtaining informed consent. The practice team were aware of the importance of taking the Mental Capacity Act 2005 into account when considering whether patients were able to make their own decisions but some of their written information regarding this was incorrect.

No action



Are services caring?

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

The patient feedback we reviewed was positive and showed that patients were happy with the care and treatment they received. Patients told us that the practice team were professional and

No action



Summary of findings

respectful and dealt with them and other members of their family in a caring and supportive way. This view was supported by the practice's NHS Friends and Family Test monthly results for 2016 showing that 100% of patients who completed a form were extremely likely or likely to recommend the practice.

The practice was aware of the importance of confidentiality and this was covered in practice policies and staff training. During the inspection we saw that staff were helpful to patients and greeted them in a welcoming and polite way. Patient feedback confirmed that the dentist explained their treatment clearly and involved them in decisions about their dental care.

Are services responsive to people's needs?

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

The patient feedback we reviewed confirmed that patients received a personalised service that met their needs. The practice was aware of the varied needs of its practice population and took this into account when planning and prioritising the service they provided.

The practice moved to its current premises in 2014 in recognition that its previous first floor premises were unsuitable for patients unable to climb stairs and families with babies and young children. The move to new premises which were all on the ground floor with level access from the car park into the building had addressed this. The car park had designated spaces for patients with disabilities. There was sufficient space within the building for patients who used wheelchairs including the patient toilet.

The practice had out of hours arrangements so patients could obtain urgent as well as routine treatment when they needed.

The practice had a complaints procedure and responded to complaints promptly and constructively. Information about this was available in the practice information leaflet and on their website.

No action



Are services well-led?

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

The practice had policies, procedures and risk assessments to support the management of the service but some elements of these needed to be reviewed and consolidated. Similarly, the practice's arrangements for managing and monitoring the quality of the service including audits of clinical and non-clinical aspects of the service needed to be more robust.

Dental nurses and reception staff received annual appraisal and had personal development plans to identify and plan their learning needs. Staff told us they were well supported by the registered manager. The practice team worked together well.

The practice used the NHS Friends and Family Test to monitor patient satisfaction and obtain their views about the service. The practice used a mixture of informal communication and structured staff meetings to discuss the management of the practice and the care and treatment provided.

No action



Acacia Dental Practice Limited

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.

The inspection was carried out on 5 October 2016 by a CQC inspector and a dental specialist adviser. We reviewed information we held about the provider and information that we asked them to send us in advance of the inspection.

During the inspection we spoke with the dentist/registered manager/dental nurses/receptionist. We looked around the

premises including the treatment rooms. We viewed a range of policies and procedures and other documents and read the comments made by 14 patients in comment cards provided by CQC before the inspection. We spoke with two patients while we were at the practice and reviewed the practice's 2016 NHS Friends and Family Test results.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a brief significant event policy and recording forms for staff to use. Staff we discussed significant events with were aware of the process to follow if they were aware of an event which needed to be reported. We reviewed the three significant event forms completed since 2014. These related to one clinical and two non-clinical events. We saw that the practice had acted on these and made changes where necessary. The registered manager explained that they made sure any significant event was raised with staff immediately as well as at staff meetings at a later date. The topic was a standing item on staff meeting agendas.

The practice was aware of the requirement under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and had guidance for staff to refer to. Suitable accident record forms were used. The practice had recorded two unrelated accidents in the last two years. These had not been recorded as significant events to help ensure a full overview of all incidents where learning could take place.

The registered manager explained that received national alerts of safety issues relating to medicines, equipment and medical devices from local commissioners. They confirmed they checked which were relevant to them and took action when needed. We saw evidence that following a recent medicines recall staff had checked and recorded that they did not have the relevant batch numbers at the practice. The practice did not have a structured system to record that they monitored, checked and acted on alerts. The registered manager said they would do this for future alerts. The practice signed up to receive direct safety alerts from the government website on the day of the inspection to supplement their existing process.

The practice had a policy regarding the legal requirement, the Duty of Candour and guidance about this from the General Dental Council (GDC) was available for staff to refer to. The legislation requires health and care professionals to tell patients the truth when an adverse incident directly affects them.

Reliable safety systems and processes (including safeguarding)

The practice was aware that there were areas of social and economic deprivation in Bromyard and the surrounding areas and that as a result they would have patients whose circumstances might make them vulnerable. The staff were aware of their responsibilities regarding potential concerns about the safety and well-being of children, young people and adults living in challenging circumstances. The practice had child and adult safeguarding policies and procedures based on local and national safeguarding guidelines. The registered manager was the practice's lead for safeguarding. Up to date contact details for the relevant safeguarding professionals in Herefordshire were readily available for staff to refer to. The practice's information leaflet included a note to patients that they could speak to staff there if they had any safeguarding concerns.

Staff had completed safeguarding training at a level suitable for their roles. This was provided as face to face training at the practice by a national dental organisation. Staff described examples where the practice had identified a concern regarding a patient's wellbeing and liaised with health and safeguarding professionals to ensure they were safe.

We saw evidence to confirm that the dentists used a rubber dam during root canal treatment in accordance with guidelines issued by the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment.

The practice was working in accordance with the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the EU Directive on the safer use of sharps which came into force in 2013. We confirmed that the practice used single use 'safer sharps' syringes to minimise the risk of injury to dentists and dental nurses.

Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. There was an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. We saw evidence that staff had recently completed training relevant to their role including management of medical emergencies, basic life support training and training in how to use the defibrillator.

Are services safe?

The practice had the emergency medicines as set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. One medicine was not available in the relevant child size dose. The practice ordered this and confirmed that it was due to be delivered to them on 13 October 2016. Staff carried out checks of the emergency medicines and equipment to monitor that they were available, in date, and in working order. Responsibility for this was delegated to a member of staff. They checked the oxygen and AED daily and the medicines monthly. We saw the records they kept to confirm they had done these checks. These included the batch numbers of each item of medicine and their expiry dates. One item was near to its expiry date. The practice informed us they had ordered a replacement which the pharmacy had confirmed would be delivered on 13 October 2016.

Staff recruitment

There was a recruitment policy but this was not sufficiently detailed to ensure the practice obtained all of the information required. The registered manager confirmed that they would review this policy with reference to relevant legislation and guidance.

We looked at the recruitment records for the two staff appointed in the last year. These showed that the practice had obtained some but not all of the required information. There was no information to show they had obtained satisfactory evidence of employment in a healthcare related setting where this was relevant. The registered manager recalled that they had obtained a verbal reference for one of these staff but had not made a written record of this. They also explained that they had known the person for five years and so were aware of their conduct in their previous working role. Photographic evidence of identity was not available although other proof of identity including General Dental Council registration certificates was.

The practice had accepted Disclosure and Barring Service (DBS) checks obtained by previous employers for these staff. Their recruitment policy did not describe the circumstance in which they would accept a previous DBS certificate rather than requesting a new one or include a risk assessment regarding this. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had evidence that the clinical staff were registered with the General Dental Council (GDC) and that their professional indemnity cover was up to date. The registered manager checked this as part of staff appraisals each year.

Monitoring health & safety and responding to risks

The practice had a variety of health and safety related policies and risk assessments. These covered both general workplace and specific dentistry related topics and were contained in the two folders referred to above. There were two sets of risk assessments for some topics but with different review dates which could lead to confusion.

The practice had information about the control of substances hazardous to health (COSHH). This included risk assessments for relevant dental products and materials. There was also a box file containing product manufacturers' COSHH data sheets. These were loose in the box which could make it difficult to find a specific one if staff needed the instructions urgently.

The practice had latex free disposable gloves available to remove the risk to patients or staff who may be allergic to latex.

The practice had a fire risk assessment completed by the registered manager in September 2015 and emergency lighting, smoke detectors and emergency exit signs were fitted. We saw certification to show that internal doors had been treated to increase their fire resistant properties.

We saw stickers on the fire extinguishers showing that they had been checked by a specialist contractor in 2015 and were due to be checked again during October 2016. The practice did not have a fire log to record routine daily, weekly and monthly checks in respect of fire safety precautions at the practice. There was no maintenance arrangement with a specialist company to complete checks of the smoke detectors and emergency lighting. On 12 October 2016 the registered manager confirmed that they had tested the emergency lighting, smoke detectors and fire alarm and had added these to a list of monthly tasks to complete.

The practice had a business continuity plan describing how the practice would deal with a wide range of events which could disrupt the normal running of the practice. This included details of relevant contacts and a communication flowchart to help staff co-ordinate information if they

Are services safe?

needed to deal with a significant disruption to the service. We noted that some contact information was out of date, for example the local Clinical Commissioning Group is no longer at the address listed.

Infection control

The practice was visibly clean and tidy and this was confirmed by information from patients. Cleaning equipment was available and stored appropriately. The practice used a cleaning agency to carry out general cleaning of non-clinical areas at the practice and used cleaning schedules to monitor that the various cleaning tasks were completed. We saw that the practice had audited completion of these for a four month period up to January 2016. This audit found that staff had only completed these records for five out of 16 weeks but these had not been re-audited to make sure this had improved. The registered manager informed us that they had addressed this with the cleaning agency and were satisfied that the cleaners were completing the records.

The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections.

The practice had an infection prevention and control (IPC) policy and one of the dental nurses was the IPC lead for the practice.

We saw full IPC audits using a recognised format from the Infection Prevention Society (IPS) which were completed in July 2015 and July 2016. In the first of these the practice had achieved a score of 96% and in the second a score of 98% showing that improvements had been made. We asked why the audits had not been carried out twice a year as set out in HTM01-05. The practice explained and provided evidence that they had attempted to do an audit in April 2016 but had been unable to access the IPS website to facilitate this. However, the audit could have been completed as a paper exercise without access to the IPS site.

In addition to the IPS audit we saw five instrument cleanliness audits. Two of these audits were not dated and the others were dated July 2015 and January 2016. Each audit identified that some instruments were not sufficiently clean following the cleaning and sterilisation process. The instruments concerned were dental mirrors and an

instrument used to pack and smooth dental fillings. The audits showed this was discussed with staff to reinforce the importance of robust cleaning. New mirror heads were purchased to replace scratched ones which had become difficult to clean. The practice had not carried out a re-audit since January 2016 to check that this issue had been resolved.

We reviewed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We found that they met the HTM01-05 essential requirements for decontamination in dental practices.

Decontamination of dental instruments was carried out in the separate decontamination room by the dental nurses who worked together throughout the day to process instruments. The separation of clean and dirty areas in the decontamination rooms and treatment rooms was clear. The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments.

The practice kept records of the expected decontamination processes and checks. These included those which confirmed that equipment was working correctly. We saw that instruments were packaged, dated and stored appropriately. The practice confirmed that they used single use instruments whenever possible in line with HTM01-05 guidance and did not re-use items designated as single use only. The practice had two autoclaves - equipment used to sterilise instruments. One of these was new but the other was old and had paint missing from the top outside surface and the seal on the water tank inlet was coming away. However, both had been examined and revalidated during 2016 to confirm that they worked effectively. The registered manager told us they would ask the company to confirm that the machine remained suitable for use.

The practice had personal protective equipment (PPE) such as heavy duty and disposable gloves, aprons and eye protection available for staff and patient use. We saw that staff working in the decontamination room used eye protection to protect them from splashes. One treatment room and the decontamination room had designated hand wash basins for hand hygiene and liquid soap and paper towels. The second treatment room did not have a separate hand wash basin. Staff had completed infection control and handwashing training to maintain their awareness.

Are services safe?

Suitable spillage kits were available to enable staff to deal with mercury spillage and with any loss of bodily fluids safely.

The practice had an up to date Legionella risk assessment carried out by a specialist company every two years. Legionella is a bacterium which can contaminate water systems in buildings. The most recent assessment was completed in November 2014 and contained ten recommendations. The registered manager confirmed that all but one of these had been actioned. The company were due to return to the practice to review the risk assessment in October 2016. We saw that staff carried out routine water temperature checks and kept records of these. The practice used an appropriate chemical to prevent a build-up of potentially harmful biofilm, such as Legionella, in the dental waterlines. Staff confirmed they carried out regular flushing of the water lines in accordance with current guidelines and the chemical manufacturer's instructions. They used a testing regime certified by the manufacturer of the chemical used.

The practice's arrangements for segregating and storing dental waste reflected current guidelines from the Department of Health. The practice used an appropriate contractor to remove dental waste from the practice. We saw the necessary waste consignment and duty of care documents and that the practice stored waste securely before it was collected. The clinical waste bag in the decontamination room was loose on the floor and not held in a bin with a foot operated lid. The practice confirmed on 12 October 2016 that they had ordered a bin immediately and that this was already in place.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. This was available for staff to refer to and they were aware of what to do. The practice had documented information about the immunisation status of each member of staff. Appropriate secure boxes for the disposal of sharp items were used.

Equipment and medicines

We saw the maintenance and revalidation records for the X-ray equipment and the equipment used to sterilise instruments. An engineer was at the practice on the day of the inspections servicing the compressor. We saw that the portable electric appliances had stickers showing they had been tested for safety during the last year as did the fire extinguishers. Staff were not able to locate the formal

records for these during the inspection. The annual fire extinguisher service was due in October and on 12 October 2016 the registered manager informed us that the engineer had been to do this the day after the inspection.

The registered manager confirmed that the practice's insurance policy included appropriate pressure vessel insurance for the compressor and equipment used to sterilise instruments. The practice had the required certification for the fixed electrical installation within the building when it was converted from a domestic bungalow in 2014. No gas safety certificate was available on the day of the inspection. On 12 October 2016 the registered manager informed us that a gas engineer was booked to do this on 14 October 2016.

The practice kept a small supply of antibiotics. This was stored securely. The dentists kept a record of antibiotics prescribed and provided for specific patients from this stock. A member of staff who had previously trained to work in a GP practice dispensary described their stock control arrangements for these to us. They kept a record of the quantity, batch numbers and expiry dates of each pack of antibiotics and checked this every two to three months. They monitored national medicines recall alerts and used the record to establish whether they had issued any that the recall applied to. The practice provided patients with copies of the manufacturers' patient information leaflets. NHS prescription pads were stored securely and the practice had clear records of stock held including serial numbers. Individual prescriptions were not endorsed with the practice stamp until a dentist had filled them in and signed them.

The practice stored temperature sensitive medicines and dental materials in a suitable refrigerator. Staff told us that they monitored the refrigerator temperature but they did not keep records of this for monitoring purposes.

Radiography (X-rays)

We looked at records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). We established that the required information was available including the local rules, the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the notification to the Health and Safety Executive that radiography equipment was used at the premises. The records showed that the practice had arrangements for maintaining the

Are services safe?

X-ray equipment and that relevant annual checks were up to date. We could not find an inventory of equipment used to take X-rays but the registered manager told us this information was available in each treatment room. The radiography records were stored in a file with other practice information and this made them more difficult to refer to. The registered manager told us they agreed that a separate radiography file would make it easier to find information when needed. Following the inspection they confirmed this had been done and that an inventory of the equipment was included in this.

We confirmed that the dentists' IRMER training for their continuous professional development (CPD) was up to date.

The practice used beam aiding devices to help maximise the accuracy of images. They did not use rectangular collimators a particular type of equipment attached to

X-ray machines to reduce the dose of X-rays patients received. The registered manager told us these devices did not fit the practice's X-ray machines. Rectangular collimators are however normally designed with universal fittings. The X-ray equipment was digital which eliminated the need for staff to handle chemicals used to develop traditional X-rays.

We saw evidence that the practice justified, graded and reported on the X-rays they took. We saw an audit of X-ray quality dated July 2015. This audit looked at the quality of 50 X-rays taken during 2013 and 2014 and established that 98% of the images obtained were satisfactory. This meant that X-rays taken during 2013 and 2014 were not audited for up to two years after they were taken, no audit had been carried out within the last year and X-rays taken during 2015 had not been audited.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists were aware of and took into account published guidelines such as those from National Institute for Health and Care Excellence (NICE), the Faculty of General Dental Practice (FGDP) and other professional and academic bodies. This included NICE guidance regarding antibiotic prescribing, wisdom tooth removal and dental recall intervals. The registered manager explained that in some cases exact recall intervals needed to be flexible, for example to accommodate families who wanted to have appointments together.

The practice kept detailed records about patients' dental care and treatment and assessed each patient's risk of tooth decay and gum disease. Dental records included the condition of the patient's gums using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed in relation to a patient's gums. The dentists referred patients who needed ongoing advice, support and treatment in relation to their gum health to the practice's dental hygienist and/or dental therapist.

The dentists also checked patients' general oral health including monitoring for possible signs of oral cancer.

The practice asked all patients to fill in a medical history form and checked and updated this information at each check-up appointment.

Health promotion & prevention

The practice was in an area which did not have fluoridated water. The practice had fluoride toothpaste available and prescribed this if a patient's risk of tooth decay indicated this would be beneficial. Similarly, they used fluoride varnish for children in accordance with guidance in the Delivering Better Oral Health Tool-kit from the Department of Health.

The practice's medical history forms included questions about smoking and alcohol consumption both of which have an impact on oral health. We found that one of the dentists did not always record patients' alcohol consumption in their notes. We made the registered manager aware of this.

The practice was aware of the specific dental needs of the population. They told us that there were high levels of social and economic deprivation and a high incidence of children under three with decayed, missing or filled teeth. They therefore prioritised NHS dental treatment allocation for children and patients who were exempt from NHS charges. The practice used the dental therapist to increase their capacity to provide NHS dental treatment for children. Dental hygienist services were available to NHS patients based on assessed need using the same criteria as private patients.

A range of dental care products were available for patients to buy.

Staffing

We confirmed that clinical staff undertook the required for their registration with the General Dental Council (GDC). The practice had evidence that clinical staff held current GDC registration. The practice held copies of staff training certificates and we saw evidence that staff kept records of their individual CPD.

The practice completed annual appraisals for staff which included identifying personal development plans (PDPs). For example, a dental nurse's PDP showed they had expressed an interest in completing additional decontamination training and a complaints management course.

The appraisal process was structured and included a self-assessment questionnaire to help staff prepare for their appraisal. The appraisal documentation specifically reminded staff of the General Dental Council Standards for the Dental Team. It also included a section to confirm staff had met their continuous professional development (CPD) declaration requirements. We noted that one dental nurse's appraisal included a subsequent written acknowledgement from the registered manager. This was a positive overview of the staff member's progress, a reminder to research suitable courses and that they could be released from work to attend training days.

In addition to training in clinical topics staff also completed training in other essential areas. These included safeguarding, health and safety, management of medical emergencies, basic life support and defibrillator training,

Are services effective?

(for example, treatment is effective)

hand washing and infection control, consent and information governance. The registered manager did not have a structured process to help them maintain an overview of training completed by the staff team.

The practice had a structured induction checklist for new staff. These showed the dates each topic was covered with the member of staff.

Working with other services

The practice had a referral policy based on guidance from the GDC, NICE and other relevant dental organisations. They referred patients, including children, to NHS dental hospitals and access clinics or to private dental practices when needed. This was usually because a patient needed specific specialist treatment that Acacia Dental Care did not provide. The dentists also referred patients to the dental hygienist and dental therapist working at the practice.

The practice referred patients for investigations in respect of suspected oral cancer in line with NHS guidelines. This included making referrals under the national two week wait arrangements and we saw an example of a recent appropriate referral.

The dentists told us they gave patients a copy of their referral letters. Reception staff described their referral tracking arrangements. These included telephoning the service a patient was being referred to enquire what the usual waiting time for an appointment would be. They asked patients to inform them if they did not receive an appointment by the end of this period. They used the search facility on the practice computer system to monitor referrals and recorded the outcome of each referral before this was recorded as completed on their system.

Consent to care and treatment

Members of the team we discussed this with understood the importance of obtaining and recording patients' consent to treatment. Written consent was obtained for private and NHS treatment provided at the practice. Consent for NHS treatment was recorded using the appropriate NHS forms. Information we reviewed from patients confirmed that they received clear information to assist them to make informed decisions about their treatment.

The practice had a written consent policy which referred to the Mental Health Act 2007. The policy did not refer to the Mental Capacity Act (MCA) 2005 although the registered manager and members of the team completed MCA training. Staff were aware of and could explain the relevance of this legislation to the dental team. The 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 practice website contained incorrect information regarding obtaining written consent on behalf of adults who may not be able to consent to treatment on their own behalf. The registered manager said they would amend this.

The practice consent policy referred to decision making where young people under the age of 16 may be able to make their own decisions about care and treatment. The registered manager gave us an example of a situation where the practice had needed to consider this when planning and arranging treatment for a young person.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We gathered patients' views from 14 completed cards and spoke with two patients. Patients told us that the practice team were professional and respectful and dealt with them and other members of their family in a caring and supportive way. This view was supported by the practice's NHS Friends and Family Test monthly results for 2016 showing that 100% of patients who completed a form were extremely likely or likely to recommend the practice.

The waiting room and reception area were separate which helped provide privacy when reception staff were dealing with patients. Staff told us that if a patient needed or wanted more privacy to discuss something they would take them into another room. The position of the receptionist's computer screen meant that it could not be seen by patients at the desk. No personal information was left where another patient might see it and the receptionist described their 'clear desk' approach to ensure no personal information was visible.

The practice had a confidentiality and information governance policies and these were included in staff induction and ongoing training. Reception staff understood their responsibility to take care when dealing with patients' information in person or over the telephone.

Reception staff described sensitive and discreet ways in which they assisted patients who might have difficulty understanding written information about their care, treatment and payment options.

Involvement in decisions about care and treatment

We saw evidence that the practice recorded information about patient's treatment options, and that they discussed the risks and benefits of these with them. Patients needing treatment were given a written treatment plan. In the case of NHS patients they used the appropriate NHS form for this.

Several patients who completed CQC comment cards commented the practice communicated well. They said their dentist gave them clear information about their treatment at each appointment and that they felt valued and listened to.

The practice used aids such as dental models and photographs to help them explain treatment needs to their patients, including children.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was aware of the make-up of its practice population and alert to their differing needs. They recognised that the area had an ageing population and pockets of social and economic deprivation. They explained that they targeted their NHS provision as far as possible at exempt patients and tried to ensure treatment was available to people whose circumstances might make them vulnerable. For example, they told us that within Herefordshire a fifth of children under three had at least one decayed, filled or missing tooth. They used the practice's dental therapist to increase the volume of appointments available for children.

We gathered patients' views from 14 completed CQC comment cards and spoke with two patients during the inspection. All the information we reviewed provided a positive picture of a service which worked to meet patients' needs. Some patients mentioned significant improvements in their dental health which they attributed to the practice's attention to their care and treatment.

We discussed the appointment booking system with reception staff. They explained that check-up appointments were booked for 10 minutes and appointments for fillings were between 20 and 30 minutes. They told us that appointments for other treatments were booked according to the treatment needed; the dentists used the instant messaging on the computer system to let them know how much time they should book.

The practice had a patient information leaflet and additional information was available in the waiting room and on the practice website. Patients were provided with written information about the fees for private and NHS treatment and the details of a national dental payment plan used by the practice.

Tackling inequity and promoting equality

The practice moved to its current premises in 2014 in recognition that its previous first floor premises were unsuitable for patients unable to climb stairs and families with babies and young children. The registered manager had completed an assessment of the new premises in relation to access to the building for patients with disabilities. The new premises were all on the ground floor

with level access from the car park into the building. The car park had designated spaces for patients with disabilities. There was sufficient space within the building for patients who used wheelchairs including the patient toilet. The patient toilet had grab rails but did not have a call bell.

Staff told us that they did not have any patients who were unable to manage a conversation in English. They did not have current details for translation services, including British Sign Language, should they need this. Although they did not believe they had any patients who needed these at present the registered manager agreed to source the necessary information. They also explained that one member of staff spoke Polish and that as there was a Polish community in Herefordshire they could call on them if needed. The practice did not have an induction hearing loop to assist patients who used hearing aids.

The practice had an equality and diversity policy. Staff gave us an example of the help and support they provided to make it easier for certain patients to come for their appointments.

Access to the service

The practice was open from 9am to 5pm Monday to Friday and was closed for lunch between 1 and 2pm. Information from patients confirmed they were able to make appointments easily, including at short notice. Several members of staff told us that each dentist had an hour kept free each day to see patients with pain or other dental emergencies. The receptionist confirmed that even if the emergency spaces were filled the practice saw patients with pain on the day.

The registered manager provided out of hours on-call cover for the practice's private patients during the evenings from Monday to Thursday and took part in an on-call rota with other local private dental practices on Friday evenings and at weekends. Relevant telephone numbers were provided in the practice's answerphone message. The message advised NHS patients to use the NHS 111 telephone number if they needed urgent treatment when the practice was closed.

Staff told us the dentist made follow up telephone calls to patients following more complex dental procedures to make sure they were alright.

Concerns & complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a complaints policy and procedure based on national guidance from the General Dental Council (GDC), British Dental Association (BDA) and other dental organisations. Reception staff showed us that they had information sheets for patients about how to make a complaint at reception if a patient asked for one. The procedure explained who patients should contact about concerns and how the practice would deal with their complaint. It contained contact details for the General Dental Council, the Dental Complaints Service, the national dental scheme the practice belonged to and local commissioners.

We looked at the records of three complaints the practice had received about the service they provided in the previous two years. These showed they had responded promptly and constructively to the concerns raised. A fourth complaint shown to us by the registered manager did not relate to the regulated activities provided by the practice. We noted that complaints were discussed at staff meetings to involve staff in learning from these. The practice kept the complaints records fastened in a notebook. This could pose a problem if a patient wished to view records relating to them. The registered manager informed us on 12 October 2016 that they had already set up a new system to store any complaints individually.

Are services well-led?

Our findings

Governance arrangements

The registered manager was responsible for the day to day management of the service and for clinical leadership at the practice. The practice was a member of a national dental organisation which provided payment plans and quality assurance for dental practices but did not subscribe to the quality assurance scheme.

The practice had policies, procedures and risk assessments to support the management of the service. These were based on national guidance from organisations such as the General Dental Council (GDC) and the British Dental Association (BDA).

The practice had two separate folders for policies and procedures as well as storing them on the practice computer system. The information in one folder originally related to the previous practice premises and the address had been amended when the practice moved to the new building. These documents had been reviewed by the registered manager in September 2015. The other folder contained policies and procedures which the registered manager had developed in February 2016 and so were more recent. We did not fully compare the contents of the two files but noted some differences in content. We highlighted to the registered manager that having different sets of documents with different review dates could cause confusion for staff. The registered manager informed us on 12 October 2016 that they had set aside the period 24 – 29 October to review and consolidate the practice documentation to resolve this.

As a relatively small team the practice staff were able to take part in informal discussions during the working day. The practice also held structured meetings which we were told were held three to four times a year. Notes of the meetings were made for future reference so staff who were not present could keep up to date. We looked at the minutes for the last three meetings. These followed a set agenda which included audits, complains, CPD, health and safety, infection control, information governance and significant events. They also had a section for other matters such as staffing and social events for the team.

Leadership, openness and transparency

During the inspection we observed that the practice team worked well together and were friendly and cheerful. Staff we asked told us the registered manager was supportive and approachable.

The practice had policies regarding harassment and the Duty of Candour and these were available for staff to refer to. There was a whistleblowing procedure for staff to follow if they identified concerns at the practice. This included information about external contacts if they felt unable to report their concerns to the registered manager.

Management lead through learning and improvement

Dentists, other members of the clinical team and reception staff had personal development plans identifying learning needs. The dental nurses and receptionist had annual appraisals. We saw evidence that the clinical staff maintained their continuous professional development (CPD) by doing a mixture of on-line and face to face training. The registered manager's CPD folder showed that they had completed a wide range of training during 2016.

We saw that practice carried out a variety of audits. Audits are intended to help dental practices monitor the quality of treatment and the overall service provided. The audits we saw included grading of X-rays, infection prevention and control, clinical record keeping, and tooth survival rates following root canal treatment.

There was insufficient information recorded about the actions needed when audits identified areas for improvement. Repeat audits had not always been carried out to confirm that improvements had been achieved. The results of clinical records audits in 2014 had not been analysed and no clinical record audits were available for 2015 or 2016. The most recent audit relating to the quality of X-rays was completed in July 2015 but related to X-rays taken during 2013 and 2014. Instrument cleanliness audits in 2015 and January 2016 all showed a proportion of instruments checked were not sufficiently clean. The practice had taken action regarding this but had not carried out another audit to ensure improvements had been maintained.

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

The practice used the NHS Friends and Family Test to obtain patients views about the practice. We saw the practice's results for the nine months from January 2016.

Are services well-led?

These showed that 100% of the patients who filled in a form said that they were either extremely likely or likely to recommend the practice. The registered manager told us that the move to new premises and been prompted partly due to feedback from patients about the problems with access at the previous first floor premises.

Because the team was relatively small they said they were able to deal with things as and when they arose. They described the practice as being a friendly and supportive place to work and said they felt listened to by the registered manager. The practice also used annual appraisals and staff meetings to provide staff with opportunities to contribute.