Portman Healthcare Limited

College Street Dental Practice

Inspection Report

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Date of inspection visit: 11 November 2016
Date of publication: 25/01/2017

Overall summary

We carried out an announced comprehensive inspection on 11 November 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 this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

College Street Dental Practice is a converted domestic premises situated near the centre of the town with easy access to bus routes. It has four dentists; a visiting implantoligist and a part time hygienist service. There are four dental consulting rooms, an office, reception area and two waiting rooms. The premises had disabled access via the use of a ramp into the practice and facilites were accessible on the ground floor level. There was nearby on street parking and public car park.

The practice provides both private and NHS general dental services to children and adults and also provides an in house dental implant service from thevisiting implantoligist once a month; for those patients who require such treatment. The dental hygienist service is available on two days of the week.

Fees are displayed in information leaflets available in the practice for patients and on the website. The practice has a team of four dentists and a visiting dental implantologist, four dental nurses and two trainee dental nurses, a practice manager and three receptionists.

The practice manager 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 is open Monday 08.30am -7.00pm – Tuesday - Friday 08.30am – 5.00pm, Saturday 08.30am – 1.00pm. It

Summary of findings

is closed Sundays. The practice is closed alternate Saturdays and every Sunday but the out of hour's emergency arrangements were displayed in the practice and were available via the practice telephone answering service.

The information was not available on the practice website but in discussion with the registered manager and provider we were told they would rectify this as soon as possible.

We reviewed 58 CQC comment cards that had been left for patients to complete prior to our visit. In addition we spoke with three patients on the day of our inspection. Feedback from patients was positive about the care they received from the practice.

They commented that staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided. Patients we spoke with and the comment cards reviewed told us staff were kind, caring, competent and put patients at their ease.

Our key findings were:

- The practice demonstrated they sought to provide patient centred dental care in a relaxed and friendly environment.
- There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse and maintaining the required standards of infection prevention and control.
- Infection control procedures were robust and the practice followed published guidance.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The dental practice had effective clinical governance and risk management processes in place; including health and safety and the management of medical emergencies.
- Dentists provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The service was aware of the needs of the local population and took these into account in how the practice was run.
- Patients could access urgent treatment and emergency care when required.
- The practice had a comprehensive system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits
- The use of digital radiographs to help explain necessary treatment to patients while in the chair.
- Premises appeared well maintained and visibly clean. Good cleaning and infection control systems were in place. The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the air compressor, autoclave, fire extinguishers, oxygen cylinder and the X-ray equipment.
- There were sufficient numbers of suitably qualified staff who maintained the necessary skills and competence to support the needs of patients.
- Staff were up to date with current guidelines, supported in their professional development and the practice was led by a proactive registered manager.
- There was a process in place for reporting untoward incidents and disseminating shared learning when these occurred in the practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

There were systems in place to help ensure the safety of staff and patients. These included safeguarding children and adults from abuse, maintaining the required standards of infection prevention and control, responding to medical emergencies and dental radiography (X-rays). The practice carried out and reviewed risk assessments to identify and manage risks.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency. In the event of an incident or accident occurring the practice documented, investigated and learnt from it.

Are services effective?

No action

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

The practice kept detailed electronic records of the care given to patients including comprehensive information about patients' oral health assessments, treatment and advice given. The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

We saw examples of teamwork within the practice and evidenced good communication with other dental professionals to provide specialist services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering better Oral Health 3rd edition.(DBOH) Comments received via the CQC comment cards reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes they experienced. In the waiting room we saw evidence of health promotion information.

Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan and in line with the General Dental Council requirements for registrants.

Are services caring?

No action

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

We reviewed 58 completed CQC comments and received feedback on the day of the inspection from three patients about the care and treatment they received at the practice. The feedback was positive with patients commenting on the excellent service they received, professionalism and caring nature of the staff and ease of accessibility in an emergency. Patients commented they felt involved in their treatment and that it was fully explained to them.

Summary of findings

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

Are services responsive to people's needs?

No action

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

The practice offered routine and emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

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

The service was aware of the needs of the local population and took those these into account in how the practice was run. We observed the reception desk was compliant with the Equality Act 2010 and had a hearing loop available. The practice provided patients access to telephone interpreter services when required.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

No action

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

The practice assessed risks to patients and staff and carried out a programme of audits as part of a system of continuous improvement and learning. There were clearly defined leadership roles within the practice and staff told us they felt well supported.

The practice had accessible and visible leadership with structured arrangements for sharing information across the team, including holding regular meetings which were documented for those staff unable to attend. Staff told us they felt well supported and could raise any concerns with the practice owner and practice manager.

The practice had systems in place to seek and act upon feedback from patients using the service.

College Street Dental Practice

Detailed findings

Background to this inspection

This inspection took place on 11 November 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector, a second inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

We informed the NHS England area team we were inspecting the practice; however we did not receive any information of concern from them.

During the inspection we toured the premises and looked at the storage arrangements for emergency medicines and equipment and the arrangements for providing conscious sedation. We were shown the decontamination procedures for dental instruments and the systems that supported the patient dental care records. We spoke with nine members of staff including, dentists the practice manager, receptionists, qualified and trainee dental nurses and three patients.

To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

Patients gave positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place to learn from and make improvements following any accidents or incidents. The practice had accident and significant event reporting policies which included information and guidance about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The practice maintained a significant event folder for recording when something went wrong; this system also included the reporting of minor injuries to patients and staff. Records seen showed that incidents were managed in accordance with the practices accident reporting policy.

There had been two accidents/incidents in the last 12 months both relating to sharps injuries to staff. The incident report forms had been completed in full and there was evidence shared learning followed the incidents. This was recorded in practice meeting minutes.

We discussed with three dentists how they would manage a significant incident such as wrong tooth extraction; they detailed a process that involved a discussion and feedback with any patient that might be involved. This indicated an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The practice manager told us if there was an incident or accident that affected a patient; they would give an apology and inform them of any actions taken to prevent a recurrence. The practice manager knew when and how to notify CQC of incidents which cause harm. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) as well as from other relevant bodies such as, Public Health England.

The practice manager told us they reviewed all alerts and spoke with staff to ensure they were acted upon. A record of the alerts was maintained and accessible to staff.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. These included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission. The practice had a safeguarding lead professional who was the point of referral should members of staff encounter a child or adult safeguarding issue.

Staff had completed safeguarding training and demonstrated to us, when asked, their knowledge of how to recognise the signs and symptoms of abuse and neglect. There was a documented reporting process available for staff to use if anyone made a disclosure to them. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities.

Staff demonstrated knowledge of the whistleblowing policy and were confident they would raise a concern about another staff member's performance if it was necessary.

We spoke with a dental nurse about the prevention of needle stick injuries. They explained the treatment of sharps and sharps waste was in accordance with the current EU directive with regard to the safe sharp regulations 2013 thus helping to protect staff from blood borne diseases.

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments). The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The practice used a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. Dentists were also responsible for the disposal of used sharps and needles.

However we saw documentary evidence there had been two recent sharps injuries to staff in the decontamination room. We saw the correct protocol had been followed after the incident to ensure their health and well-being and the protection of patients.

Are services safe?

We asked the lead dental nurse, how the practice treated the use of instruments used during root canal treatment. They explained these instruments were single patient use only. The practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam. They explained root canal treatment was carried out where practically possible using a rubber dam. (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). Instances where this was not possible dentists used a variety of other methods to prevent inhalation or swallowing root canal instruments.

Staff files contained evidence of immunisation against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva) and there were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

Medical emergencies

The practice had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automated external defibrillator (AED). (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 had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date, clearly labelled and stored in a central location known to all staff.

Staff spoken with showed us documentary evidence which demonstrated regular checks were done to ensure the equipment and emergency medicines were in date and safe to use. Records showed all staff had completed on site training in emergency resuscitation and basic life support. Staff spoken with demonstrated they knew how to respond in the event of a medical emergency.

Staff recruitment

The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. It was the practice policy to carry out Disclosure and Barring service (DBS) checks for all newly appointed staff. These 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. Records confirmed these checks were in place. We looked at the recruitment files for three members of staff and found they contained appropriate recruitment documentation.

The practice manager told us newly employed and agency staff had been taken through an induction process to ensure they were familiarised with the way the practice operated. This was corroborated with documentary evidence which had been signed to demonstrate completion of the process. We were told all newly employed staff met with the practice manager to ensure they felt supported to carry out their role.

The practice had a system in place for monitoring staff had up to date medical indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and ongoing.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. Records showed that fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly tested.

The practice had a comprehensive risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, we saw a fire risk assessment and a practice risk assessment had been completed within the last 12 months. The practice had a comprehensive file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations, including substances such as disinfectants, blood and saliva.

Are services safe?

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service. The plan included staffing, electronic systems and environmental events.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a written infection control policy which included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

The practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum 01-05 decontamination in primary care dental practices (HTM01-05)' and complied with the requirements of the DOH publication 'Code of Practice' July 2015. These documents and the practice policy and procedures for infection prevention and control were accessible to staff.

There was a dedicated decontamination room in the practice which was used for cleaning, sterilising and packing instruments. There was clear separation of clean and dirty areas in the treatment rooms and the decontamination room with signage to reinforce this. These arrangements met the HTM01- 05 essential requirements for decontamination in dental practices.

The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of manual scrubbing and an automated washer disinfector for the initial cleaning process, following inspection with an illuminated magnifier; the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.

We were shown the systems in place to ensure the autoclaves used in the decontamination process were working effectively. It was observed the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always completed and up to date. All recommended tests utilised as part of the validation of the washer disinfector were carried out in accordance with current guidelines, the results of which were recorded in an appropriate log file.

Staff confirmed to us their knowledge and understanding of single use items and how they should be used and disposed of according to the guidance.

The lead dental nurse for decontamination we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out at the practice by a competent person in 2014. The recommended procedures contained in the report were carried out and logged appropriately. These measures ensured patients and staff were protected from the risk of infection due to Legionella.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. This was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection.

We saw the general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

We saw the four dental treatment rooms, waiting areas, reception and toilets were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was

Are services safe?

apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

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

There was a good supply of cleaning equipment which was colour coded and stored appropriately. It followed published National Patient Safety Association (NPSA) guidance on the cleaning of dental primary care premises. The practice had a cleaning schedule in place that covered all areas of the premises and detailed what and where equipment should be used.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. The practice manager had a system for monitoring the immunisation status of each member of staff for the safety and protection of patients and staff.

Equipment and medicines

There were systems in place to check all equipment had been serviced regularly, including the compressor, autoclaves, X-ray equipment and fire extinguishers. Records showed contracts were in place to ensure annual servicing and routine maintenance work occurred in a timely manner. A portable appliance test (PAT – this shows electrical appliances are routinely checked for safety) had been carried out annually by an appropriately qualified person to ensure the equipment was safe to use.

The practice had policies and procedures regarding the prescribing, recording, use and stock control of the medicines used in clinical practice. The practice had in place a prescription logging system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. Prescriptions pads were stored securely and details were recorded in patients' dental care records of all prescriptions issued.

The practice also dispensed their own medicines as part of a patients' dental treatment for certain oral surgery procedures. These medicines were a range of antibiotics. The dispensing procedures were in accordance with current guidelines and medicines were stored according to manufacturer's instructions. The local anaesthetic cartridges were stored safely and staff kept a detailed record of stock in each treatment room.

We observed the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

Radiography (X-rays)

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the three yearly maintenance logs and a copy of the local rules.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept detailed electronic records of the care given to patients. We reviewed the information recorded in patient dental care records to corroborate information received from the dentists. The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. Two dentists we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, diagnosis was then discussed with the patient along with various treatment options.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved.

Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements. Comments received via CQC comment cards reflected patients were very satisfied with the assessments, explanations, the quality of the dentistry and outcomes.

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

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health toolkit' (Delivering better oral health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England).

The practice was focused on the prevention of dental disease and the maintenance of good oral health. To facilitate this aim the practice had appointed a dental hygienist to work alongside the dentists in delivering preventative dental care.

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

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

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

The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

Patients reported they felt well informed about every aspect of dental care and treatment pertaining to the health of their teeth and dental needs.

Staffing

Are services effective?

(for example, treatment is effective)

The practice manager planned ahead to ensure there were sufficient staff to run the service safely and meet patient needs.

The practice manager kept a record of all training completed by staff to ensure they had the right skills to carry out their work. Mandatory training included basic life support and infection prevention and control. New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Dental nurses received day to day supervision from the dentists and support from the practice manager.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was an effective appraisal system in place which was used to identify training and development needs. Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs.

Working with other services

The practice manager explained how the dentists worked with other services. Dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice or other practices within the group. The practice used referral criteria and referral forms developed by other primary and secondary care providers such as special care dentistry and oral surgery. We saw several examples of referrals made by the dentists.

The referral forms seen had been appropriate and contained comprehensive information. We observed the practice used a referral tracking system to monitor referrals from the practice. This ensured patients were seen by the right person at the right time.

Consent to care and treatment

Staff explained to us how valid consent was obtained for all care and treatment. The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

Both dentists we spoke with explained how they implemented the principles of informed consent; they had a very clear understanding of consent issues. The dentists explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they understood their treatment options.

The dental hygienist we spoke with also had a good understanding of the principles of informed consent. They also reaffirmed consent to treatment from the patient before undertaking their clinical interventions.

The dentists further explained how they would obtain consent from a patient who suffered with any mental impairment which meant they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed.

The dentists went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. We saw and were told by staff they had undertaken specific MCA training. In discussion with all staff they demonstrated a good working knowledge of its application in practice. All staff understood consent could be withdrawn by a patient at any time.

The staff we spoke with were also aware of and understood the use of the Gillick competency test in relation to young persons (under the age of 16 years). The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We reviewed dental care records to corroborate our information. Treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. Consent to treatment was recorded. Feedback in CQC comment cards confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed 58 completed CQC comments cards. Comments from patients were consistently positive about how they were treated by staff at the practice. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

The practice manager told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

Treatment rooms were situated away from the main waiting areas and we saw doors remained closed during consultations. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy.

We observed staff in the reception area were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

To maintain confidentiality electronic dental care records were password protected and paper records were securely stored. The design of the reception desk ensured any paperwork and the computer screen could not be viewed by patients booking in for their appointment. Policies and procedures in relation to data protection, security and confidentiality were in place and staff were aware of these.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected. Staff described to us how they involved patient's relatives or carers when required and ensured there was sufficient time to explain fully the treatment options. Dental care records we looked at corroborated and reflected this.

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS fees was displayed in the reception and waiting areas. Information was also available in a practice information folder in the waiting areas and on the practice website which detailed the costs of both NHS and private treatment.

We evidenced in records seen the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment planning forms for dentistry where applicable and estimates and treatment plans for private patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet and on their website. The services provided included prevention advice and treatment alongside the specialist dental care available**.** During our inspection, we looked at examples of information available to patients. We saw the practice waiting areas displayed a variety of information. These included a practice folder that explained opening hours, emergency 'out of hours' contact details and arrangements about how to make a complaint.

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

We observed the appointment diaries were not overbooked and this provided capacity each day for patients with dental pain to be fitted into urgent slots for each dentist. The dentists decided how long a patient's appointment needed to be and considered any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment. Patients we talked with advised us they had been able to obtain emergency treatment when needed and we observed space was left daily in the appointment book of both clinicians so they could provide urgent care when required.

Tackling inequity and promoting equality

The practice had a comprehensive equality, diversity and human rights policy in place and provided training to support staff in understanding and meeting the needs of patients.

They had completed a Disability and Discrimination Act (DDA) assessment and made adjustments, for example to accommodate patients with limited mobility. There was wheelchair access to the ground floor waiting area and to facilities on the ground floor.

Information was in English but translation services could be utilised if necessary via access to a language line.

Access to the service

The practice displayed its opening hours on the website, in the waiting room and in leaflets. It is open Monday 08.30am -7.00pm – Tuesday - Friday 08.30am – 5.00pm, Saturday 08.30am – 1.00pm and closed on Sundays. When the practice is closed the emergency contact numbers are displayed outside the practice and available via the telephone answering service.

The 58 CQC comment cards seen reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the practice manager or principal dentist they ensured these were responded to appropriately and in a timely manner.

The practice had received four written and five verbal complaints in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response and sought to address the concerns promptly and efficiently to effect a satisfactory outcome for the patient. The registered manager told us, and we saw this corroborated in practice meeting minutes, complaints were discussed amongst the team and any learning identified was implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. We saw risk assessments and the control measures in place to manage those risks, for example fire and infection control. Staff we spoke with were aware of their roles and responsibilities within the practice.

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We looked in detail at how the practice identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks for example fire, use of equipment and infection control. Lead roles, for example in infection control and safeguarding supported the practice to identify and manage risks and helped ensure information was shared with all team members.

There were relevant policies and procedures in place to govern activity. There was a full range of policies and procedures in use at the practice and accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, record keeping, inoculation injuries and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. There were monthly practice meetings to discuss practice arrangements and audit results as well as providing time for educational activity. We saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed.

Leadership, openness and transparency

We saw from minutes of staff meetings, they were at regular intervals and staff told us how much they benefited from these meetings. The practice had a statement of purpose that described their vision, values and objectives. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty. Staff felt confident they could raise issues or concerns at any time with the practice manager and / or principal dentist who would listen to them.

We observed and staff told us the practice was a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff felt well supported by the practice manager and worked as a team toward the common goal of delivering high quality care and treatment.

The service was aware of and complied with the requirements of the Duty of Candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The practice manager encouraged a culture of openness and honesty. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

We saw there was a comprehensive system to monitor and continually improve the quality of the service; including through a detailed programme of clinical and non-clinical audits. These included for example, audits of record keeping, radiographs, the cleanliness of the environment, antimicrobial prescribing and consent. Where areas for improvement had been identified in the audits, action had been taken. For example through discussion and training at practice meetings.

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

The practice had systems in place to seek and act upon feedback from patients using the service. The practice gathered feedback from patients through the NHS Friends

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and Family Test (FFT), NHS Choices, compliments and complaints. Results of the most recent Family and Friends Test (FFT) indicated that 100% of patients who completed the survey were happy with the quality of care provided by the practice and patients were either highly likely or likely to recommend the practice to family and friends. The practice had a five star Rating on NHS Choices website with three positive comments posted in the last 12 months.

The practice regularly asked patient feedback at the end of treatment and the results seen corroborated the comments received on the CQC comment cards.