Implantium UK Ltd

Dentale Bristol

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 June 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 regulation.

Background

Dentale Bristol is an implant training clinic based in Portishead. Patients who use the service are sometimes referred by their own dentist, and others self-refer. Given the nature of the treatments offered, nobody under the age of 18 is treated at the clinic**.**

The practice has four dental treatment rooms based on the ground floor and a separate decontamination room used for cleaning, sterilising and packing dental instruments. The ground floor is accessible to wheelchair users and patients with limited mobility.

The practice employs seven dentists, four of whom act as tutors to the training delegates, hygienist, three dental nurses, and a practice manager. However there was no registered manager at the practice. 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 to Friday, 09:00am – 1.00pm and 2.00pm -5.00pm. It is closed at weekends. There are

Summary of findings

arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is through an out-of-hours on call service provided by the practice.

We spoke with four patients during the inspection and asked about their experience of the services provided. Feedback from patients was positive about the care they received from the practice. They commented staff put them at ease, listened to their concerns and they had confidence in the dental services provided.

The inspection was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- We found the practice ethos was to provide high quality patient centred implant treatment in a relaxed and friendly environment.
- Staff we spoke with were committed to providing a quality service to their patients. Dentists provided dental care in accordance with current professional guidelines.
- Patients could access treatment and urgent and emergency care when required.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice appeared clean and well maintained. Infection control procedures were robust and the practice followed published guidance.
- The practice had a processes in place for safeguarding adults living in vulnerable circumstances.
- There was a policy and procedure in place for recording adverse incidents and accidents and complaints. The practice reviewed and dealt with complaints according to their policy.
- Staff had received training appropriate to their roles and were supported in their continuing professional development by the provider.
- Patients and relatives we spoke with gave a positive picture of a caring, professional and high quality service.

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

- Review their system of the secondary dispensing of medicines so that the system reflects current legislation for the dispensing of medicines.
- Review their system of staff recruitment to ensure training delegates providing direct patient care at the clinic supply the provider with all necessary documentation under Regulation 19, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 prior to the commencement of their training.

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

The practice had robust arrangements for essential areas such as infection control, clinical waste control, management of medical emergencies at the practice and dental radiography (X-rays). We found all the equipment used in the dental practice was well maintained. The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying, investigating and learning from patient safety incidents. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding vulnerable adults.

No action

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including from the National Institute for Health and Care Excellence (NICE) to guide their practice. We saw examples of positive teamwork within the practice and evidence of good communication with other dental professionals. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

No action

Are services caring?

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

We obtained the views of four patients and relatives on the day of our visit. These provided a positive view of the service the practice provided. All of the patients commented that the quality of care was very good. Patients commented on friendliness and helpfulness of the staff and told us the dentists were good at explaining the treatment proposed.

No action

Are services responsive to people's needs?

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

The service was aware of the needs of patients who were referred to them and took those these into account in how the practice was run. Patients could access treatment and urgent and emergency care when required.

No action

Are services well-led?

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

No action

Summary of findings

Effective clinical leadership was provided by the provider. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. The practice had clinical governance and risk management structures in place. Staff told us they felt well supported and could raise any concerns with the provider. All the staff we met told us they were happy and the practice was a good place to work.

Dentale Bristol

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 10 June 2016. The inspection was carried out by a CQC inspector and a dental specialist adviser.

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

We also toured the premises and spoke with practice staff including, the dentists, dental nurses and receptionists. We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records. We obtained the view of patients on the day of our inspection. Patients gave positive feedback about their experience at the practice.

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

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.

No action

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 and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice reported there were no incidents during 2015-2016 which required investigation. Clear procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The practice maintained a significant event log and all events once recorded were sent to the provider's head office for monitoring. We were told of a recent sharps injury and saw the accident form had been appropriately completed. We saw evidence the incident had been managed in accordance with the company policy and infection control guidelines for the safety and protection of patients and staff.

The dentists 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 reoccurrence. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The provider 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 up to date child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to a flow chart of how to raise concerns and contact details for both child protection and adult safeguarding teams in the local area.

The practice manager was the safeguarding lead professional in the practice and all staff had undertaken safeguarding training in the last 12 months. Staff we spoke with told us they were confident about raising any concerns. The practice reported there had been no safeguarding incidents in the last 12 months.

We spoke with the lead 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, namely the European Union Directive; Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. These guidelines help protect staff from blood borne diseases. The systems and processes we observed were in line with the current EU Directive regarding the use of safer sharps.

The practice used a single use local anaesthetic delivery system. Dentists were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. However we saw the policy relating to the management of sharps (instruments and needles) was due for review in June 2014 and had not yet been reviewed.

Staff were aware of the company and practice policy in relation to raising concerns about another member of staff's performance (a process sometimes referred to as 'whistleblowing'). Staff also knew they could contact the Care Quality Commission (CQC) if any concerns remained unaddressed.

We asked to see the practice risk assessments. We were shown the Fire risk assessments that had been completed by the provider's designated person in December 2015 with four medium risks identified and one high risk. The manager told us they were not aware of any action taken or plans to address these safety risks.

The manager showed us a practice risk assessment which had been completed in February 2016 along with the servicing of all firefighting equipment. We saw a number of policy documents which reflected current activity in the practice and the most recent guidance from the provider.

Staff recruitment 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 such as face visors, gloves and aprons to ensure the safety of patients and staff.

No action

Are services safe?

Although the practice mainly provided dental implants; dentists may be required to carry out root canal treatment on certain occasions. We asked the lead dental nurse how they treated the use of instruments used during root canal treatment. They explained these instruments were single patient use only. We were shown a comprehensive kit of rubber dam instruments. Patients can be assured the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had 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. Staff had received training in how to use this equipment. 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 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 and stored in a central location known to all staff.

Records seen showed weekly checks were carried out to ensure emergency medicines were within their expiry date. Staff had attended their annual training in emergency resuscitation and basic life support as a team within the last 12 months and told us they felt confident they could use the equipment effectively.

One member of staff was trained in first aid and a first aid box was available in the practice.

Staff recruitment

There were clear recruitment and selection procedures in place that described the process for employing new staff. They included seeking references, proof of identity, immunisation status and checking qualifications and professional registration. The practice policy was 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. We looked at the recruitment files for some of the most recently employed members of staff and found that these were all complete and recruitment was robust.

We saw the practice had a recruitment policy which detailed the checks required to be undertaken before a person started work. However we noted it did not contain all the requirements laid out in the relevant regulation: Regulation 19, Schedule 3 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 prior to the commencement of work at the practice. We also noted that recruitment records were not available in the dental practice, or easily accessible from head office, should the need to check or clarify information for the safety of patients.

We also saw that not all the required information for trainee staff undertaking one of the courses provided at the practice had been obtained. For example there was no reference to a DBS being obtained or ensuring appropriate references had been received. We discussed this with the practice manager and she told us they would review the policy in the light of the information supplied to ensure they fully met the relevant regulations regarding the safe recruitment of staff.

We saw all relevant staff had personal indemnity insurance (this is an insurance professionals are required to have in place to cover their working practice) In addition there was employer's liability insurance which covered all employees working in the practice and was valid. The staff professional registration with the General Dental Council (GDC) was checked annually. 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.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. There were records to demonstrate fire detection and firefighting equipment such as fire alarms and emergency lighting were regularly tested.

The provider had a risk management process for the practice manager to implement, including a detailed log of all risks identified, to ensure the safety of patients and staff

members. For example, we saw risk assessments which included radiation, Legionella (legionella is a term for particular bacteria which can contaminate water systems in buildings), fire safety, general health and safety. Any identified hazards in these assessments and the controls or actions needed to mitigate the risks had been completed.

The practice manager told us the risk assessments would be reviewed annually. The practice had a file relating to the Control of Substances Hazardous to Health 2002 (COSHH) regulations which was comprehensive and provided details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

The practice had a 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 within the practice. The practice had in place an infection control policy that was regularly reviewed. Through direct observation of the cleaning process and a review of practice protocols we observed that HTM 01 05 (national guidance for infection prevention control in dental practices') Essential Quality Requirements for infection control were being met. We also saw that audit of infection control processes had been carried out in March and June 2016 which confirmed compliance with HTM 01 05 guidelines.

We observed the four dental treatment rooms; waiting area, reception and toilet were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available 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.

The lead dental nurse 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 they described the method they used which was in line with current HTM 01 05 guidelines. We were shown a Legionella risk assessment had been carried out at the practice by a competent person in November 2014 which was to be reviewed again in 2016. The assessment by the competent person designated the building as low risk because the building was relatively new. 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 practice had a separate decontamination room for instrument processing. The lead 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 which met the essential requirements of HTM 01-05.

The practice used a system of manual scrubbing and ultrasonic cleaning baths 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 ultrasonic baths and autoclaves used in the decontamination process were working effectively. We were shown the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always completed and up to date. We also noted weekly protein tests were carried out.

The lead dental nurse explained the systems in place to ensure safe infection control practices for implant procedures. The dental nurse told us the single use items that formed part of the dental implant system were for single patient use only. They also explained that during the placement of implants the dentists used a single use surgical drape pack system for the treatment room. These surgical drapes were used to cover all non- essential areas

of the treatment room and the patient. Included in the pack were surgeon and nurse gowns, head covers for both staff and patients to prevent the spread of infection during the procedure.

The dentists also used sterile single use bags of irrigant which is used as a coolant for the dental drills during the procedure. On the day of our inspection an implant procedure took place and we saw the infection control processes for implant procedures were being followed.

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 was in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. Clinical waste was stored in special clinical waste bins adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients could be assured they were protected from the risk of infection from contaminated dental waste.

We observed 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.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the practice autoclaves had been serviced and calibrated in August 2015 and were due to be serviced again in August 2016. The practice X-ray machines had been serviced and calibrated as specified under current national regulations in February 2016. Portable appliance testing (PAT) had been carried out in April 2015 and were to be tested again in April 2017. We also noted that fire alarms, emergency lighting and extinguishers were maintained regularly during 2015 and 2016.

We observed the practice had equipment to deal with minor first aid problems such as minor eye problems. The batch numbers and expiry dates for local anaesthetics, prescribed medicines such as antibiotics and dental implants were recorded in patient dental care records. These medicines were stored securely for the protection of patients. We found that although there were systems in place for secondary dispensing which reflected the practices policy, these processes were not wholly in accordance with current legislation. We informed the provider of the areas which need to be addressed and they said they would ensure that systems would be put into place to reflect current legislation.

Radiography (X-rays)

We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This documentation consisted of the names of the Radiation Protection Advisor and the Radiation Protection Supervisor, local rules and the necessary documentation pertaining to the maintenance of the X-ray equipment.

We were shown a radiological audit had been carried out in January 2016 and the results of the audit confirmed that 96% of the X-rays taken in the sample were of Grade 1 quality. Dental care records seen where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. These findings showed X-rays were taken in accordance with the Faculty of General Dental Practice (FGDP) good practice guidelines and the practice was acting in accordance with national radiological guidelines thus protecting patients and staff from unnecessary exposure to radiation.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with one of the dentists who provided specialised dental implant treatment. They explained they carried out consultations, assessments and treatment in line with recognised general professional guidelines with respect to implant treatment.

The dentist described to us how they carried out their assessment of patients for a course of implant treatment. 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 patient's medical history was updated at subsequent visits. This was followed for example by an examination of the patients jaw and tooth relationships and assessment of bone and gum health to ascertain if implant treatment was appropriate. Following the clinical assessment, the diagnosis was then discussed with the patient and treatment options explained in detail. All of the dental care records we saw were detailed, accurate and fit for purpose.

Where relevant, preventative dental information was given in order to improve the outcome of implant treatment 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 during the course of the treatment which could last many months.

Health promotion & prevention

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

The dentist we spoke with explained that preventative advice 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 for prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated the dentists 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.

Staffing

The practice employs 10 dentists, four of whom act as tutors to the training delegates. They also employ an hygienist, three dental nurses, and a practice manager.

All the dentists told us they received appropriate professional development and training. We checked their training records and saw they had engaged in continuing professional development (CPD) with a view to meeting the requirements of the General Dental Council. This included responding to emergencies, infection control, safeguarding training and radiography and radiation protection training. Staff had access to policies which contained information that further supported them in the workplace. Records showed professional registration was up to date for all staff.

There was an induction programme for new staff to follow to ensure they understood the protocols and systems in place at the practice. The member of staff who had carried out the induction had dated the document when completed but had not signed for accountability purposes.it was therefore not possible to evidence whose induction had taken place.

There was an appraisal system in place to identify training and development needs. We saw these appraisals had led to the production of personal development plans for members of staff. Staff we spoke with told they were supported to achieve these goals and the plans were monitored.

Working with other services

The practice was a referral practice and was relatively self-contained but dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice.

Consent to care and treatment

The dentist we spoke with explained how they implemented the principles of informed consent and had a clear understanding of consent issues. They explained how

No action

Are services effective?

(for example, treatment is effective)

individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options.

They told us patients should be given time to think about the treatment options presented to them, patients would be brought back to the practice to discuss complex treatment options where necessary. This process made it clear that a patient could withdraw consent at any time.

The dentist went further explained how they would obtain consent from a patient who suffered with any mental impairment which may mean 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. They told us they would involve relatives and carers if appropriate to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. All other staff spoken with demonstrated informed understanding of the Act.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Treatment rooms were situated away from the main waiting areas and we saw doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patient's privacy. Patient's clinical records were stored electronically and in paper form.

Computers were password protected and regularly backed up to secure storage with paper records stored in lockable records storage cabinets in a secure room. Practice computer screens were not overlooked which ensured patients confidential information could not be viewed at reception. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

Before the inspection, we sent Care Quality Commission (CQC) comment cards so patients could tell us about their experience of the practice. Unfortunately, no patients had completed CQC patient comment cards so we obtained the views of four patients and/or relatives accompanying the patient on the day of our visit. These provided a positive view of the service the practice provided.

All of the patients commented the quality of care was very good. Patients told us treatment was explained clearly and the staff were caring and put them at ease. They also said the reception staff were always helpful and efficient. During the inspection, we observed staff in the reception area. We observed they were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans.

We saw evidence in the patient records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

No action

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 via the website. Patients we spoke with told us they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival who kept patients informed if there were any delays to appointment times.

During the inspection we looked at examples of information available to patients. We saw the practice waiting area displayed a wide variety of information including leaflets about the services the practice offered. The practice website also contained useful information to patients such as different types of treatments which patients could download and how to provide feedback about the services provided.

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 took into account any special circumstances such as whether a patient was very nervous, had a disability and the level of complexity of treatment.

Tackling inequity and promoting equality

The practice had an equality and diversity policy in place and provided training to support staff in understanding and meeting the needs of patients.

The practice had disability access into the building and all treatment rooms and facilities were on the ground floor thus making them accessible for patients with reduced mobility. Parking was available outside the practice.

Staff had access to translation services via an online or telephone translation service. Dental care records included alerts about the type of assistance patients required.

Access to the service

The practice displayed its opening hours on the door to the practice, in the premises and in the practice information leaflet. Opening hours were Monday to Friday 9:00am – 1.00pm and 2.00pm - 5.00pm. It is closed at weekends.

Staff told us patients were seen as soon as possible for urgent care during practice opening hours and this was normally within 24 hours. Appointments were available each day to accommodate this. Patients spoken with felt they had good access to routine and urgent appointments.

There were arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours on call service provided by the practice.

Concerns & complaints

The practice had a complaint policy and a procedure that set out how complaints would be addressed, who by, and the time frames for responding. Information for patients about how to make a complaint was seen in the waiting area and patient website.

The practice had one written complaint during 2016. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients and found there was an effective system in place which ensured a timely response.

No action

Are services well-led?

Our findings

Governance arrangements

The practice had a practice manager however there was no Registered Manager as required by the regulations.

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 regular 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

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 provider 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 provider and worked as a team toward the common goal of delivering high quality care and treatment.

Effective clinical leadership was provided by the provider. The practice ethos focussed on providing high quality patient centred care in a relaxed and friendly environment. The patients we spoke with reflected this approach.

The provider was aware of and complied with the requirements of the Duty of Candour. The provider 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

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 evidence of systems to identify staff learning needs which were underpinned by an appraisal system and a programme of clinical audit. For example we were shown the dental nurses received an annual appraisal.

We found there was a programme of clinical audits taking place at the practice. These included infection control, clinical record keeping, X-ray quality and antibiotic stewardship. Where areas for improvement had been identified in the audits, action had been taken. There was evidence that repeat audits had been completed to monitor improvements had been maintained.

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 had a compliments book in the waiting area which had a

No action

Are services well-led?

number of very positive comments recorded. These included the following words and phrases: excellent care and treatment. Professional and courteous. Results of treatment couldn't be more satisfactory.

The practice regularly asked patients for feedback at the end of treatment and the results seen corroborated the comments received from patients and relatives during the inspection.