Care Quality Commission

Southcroft Dental Practice Ltd

Southcroft Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 03 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Southcroft Dental Practice is located in the London Borough of Wandsworth. The premises are situated on the ground floor of a converted residential building. There is one treatment room, a dedicated decontamination room, a waiting room with reception area, and a patient toilet.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers and crowns and bridges.

The staff structure of the practice consists of a principal dentist (who is also the owner) and two trainee dental nurses, who also act as receptionists.

The practice opening hours are on Monday, Tuesday, Wednesday, and Friday from 8.30am until 7.00pm. The practice is also on open on Thursday from 8.30am until 2.00pm, and is occasionally open on Saturday from 8.30am until 2.00pm.

The principal dentist was in the process of applying to become a registered manager at the time of the inspection. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

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

Two people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Staff recorded accidents, but there was no system for reporting or recording incidents or significant events.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had undertaken some relevant checks for the clinical staff at the time of employing them, but there was no formal recruitment policy, and not all relevant background checks had been carried out prior to employment.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review the practice's staff recruitment procedures to check the arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; the practice should ensure necessary employment checks are in place for all staff and the required specified information in respect of persons employed by the practice is held.
- Review the practice's system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Undertake a Disability Discrimination Act audit to ensure the provider is undertaking its responsibilities to respond to the needs of disabled people and the requirements of the Equality Act 2010.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control and medical emergencies. We found the equipment used in the practice was well maintained and checked for effectiveness.

However, we noted two areas where safety could be improved. These included having systems in place for identifying, investigating and learning from incidents relating to the safety of patients and ensuring all of the relevant pre-employment checks for staff members had been carried out.

We discussed these issues with the principal dentist on the day of the inspection; they assured us they would take action to resolve these issues in response to our feedback.

Are services effective?

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the GDC. Staff had recently been engaged in an appraisal process to discuss their role and identify additional training needs.

Are services caring?

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

We received positive feedback from the patients we spoke with on the day of the inspection, and from reviewing the results of the NHS Friends and Family Test, which had been carried out since May 2015. Patients felt that the staff were kind and caring. We observed that staff treated patients with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. Patients were invited to provide feedback via the NHS 'Friends and Family Test' survey. The dentists described effective strategies for supporting patients with some hearing or visual impairments. However, the needs of people with disabilities needed to be fully considered through a formal Disability Discrimination Act audit.

Summary of findings

There was a complaints policy in place and we saw that complaints received in the past year had been acted on in line with this policy. Relevant investigations had been carried out and the outcomes of these were recorded. The practice disseminated the outcomes of these investigations by auditing the complaints, setting out action plans, and discussing the issues raised at quarterly staff meetings.

Are services well-led?

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

The practice had clinical governance and risk management structures in place. These were well maintained and disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance.

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

Southcroft Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 03 December 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

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

Two people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We discussed with the principal dentist the systems in place for reporting and learning from incidents. They described what might constitute a significant event, but told us that no such incidents had occurred at the practice in the past year. We noted that no formal policy or other system was in place for reporting and learning from incidents. The principal dentist responded to our feedback on this topic and showed us evidence via email on the day after the inspection that they had formalised their system for recording and responding to incidents through the introduction of a written policy and protocol.

There was an accidents reporting book, but we were told that no accidents had occurred that required to be recorded in the past year. Staff were aware of the process for accident reporting, and had heard of, but did not fully understand, the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The principal dentist and trainee dental nurses told us that they were committed to operating in an open and transparent manner; they told us they would always inform patients if anything had gone wrong and offer an apology in relation to this. However, the staff were not aware of the Duty of Candour [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity]. The principal dentist sent us evidence via email, after the inspection, of a staff meeting which had been held where the Duty of Candour was fully discussed.

Reliable safety systems and processes (including safeguarding)

We spoke with the principal dentist about the management of safer sharps and noted that the treatment of sharps and sharps waste was in accordance with the EU Directive on safer sharps (2013). This ensured that staff were protected against blood borne viruses. The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A single-use system was used to deliver local anaesthetics to patients. It was also practice policy that discarding the used needle was the dentist's responsibility. The practice had a safer sharps risk assessment in place and a practice protocol that could be followed should a needle stick injury occur.

We asked how the principal dentist managed the use of instruments used during root canal treatment. They explained that these instruments were used with one patient only. We saw a robust written protocol for the decontamination of used root canal instruments between appointments and a system for identifying which patient they could be used with. This system prevented errors in patient identification and was in accordance with the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. We also discussed the potential increased risk of instrument fracture when they were re-used in this way. The principal dentist noted that the guidance allowed for re-use of instruments, but considered the possibility of including visual inspections of instruments prior to use to check for signs of weakness.

The principal dentist explained that root canal treatment and other treatment, where appropriate, was carried out where practically possible using a rubber dam in line with the guidance produced by the British Endodontic Society. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). We were shown the practice rubber dam kit.

The principal dentist acted as the practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child would display that would alert them to possible signs of abuse or neglect. They also had an awareness of the issues around vulnerable elderly patients who presented with dementia. We saw that the practice had a policy in place in relation to child and adult safeguarding and evidence that staff had completed recent training in safeguarding. We also saw a protocol which contained the telephone numbers for contacts outside the practice if there was a need, such as for the local authority responsible for safeguarding investigations.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an

Are services safe?

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 emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Oxygen and other related items, such as manual breathing aids and portable suction, were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff.

The expiry dates of medicines, oxygen and equipment were monitored using a monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. Although there was a history of staff attending update training in dealing with emergencies in dental practice, none had been carried out since 2013. However, the principal dentist told us they had already identified this issue. We were informed that the three members of staff were booked to attend a relevant training session on 12 December 2015.

Staff recruitment

The staff structure of the practice consists of a principal dentist and two trainee dental nurses, who also act as receptionists.

We reviewed the staff recruitment records and noted that the last member of staff who had joined the practice was one of the trainee dental nurses, who had been recruited in 2014. There was no formal recruitment policy for the practice to follow during any recruitment process. However, the majority of the relevant checks to ensure that the person being recruited was suitable and competent for the role had been carried out. This included a check of identity, the use of an application form and formal interview, a copy of each person's employment history in the form of a Curriculum Vitae (CV), copies of relevant qualifications and professional registration with the General Dental Council (GDC), where necessary. A relevant check of medical history, in the form of an immunisation record, had also been obtained.

Other checks and relevant documents had not been carried out or recorded. For example, the practice had not obtained written or verbal references for the two trainee dental nurses. We also found that one of the trainee dental nurses had not had a Disclosure and Barring Service (DBS) check prior to employment. The other nurse had been asked to present a copy of her most recent DBS check, but a new check had not been carried out by the principal dentist. We discussed these issues with the principal dentist on the day of the inspection; they assured us they would take action to resolve these issues in response to our feedback. The principal dentist had had a DBS check carried out in 2014.

Monitoring health & safety and responding to risks

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that new fire extinguishers had been installed in June 2015.

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

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the principal dentist via email. These were disseminated to staff, where appropriate.

There were informal arrangements to refer patients to other practices when the practice was closed during holiday periods, or should the premises become unfit for use. There was also some written guidance for staff on what to do should the premises become affected by, for example, a power failure or flood. However, not all emergency arrangements had been considered. For example, the practice relied on a paper appointments book with no other back up. There was also no list of key contacts, for example, for the servicing of electrics or plumbing, which could be referred to in the event of service failures.

Infection control

Are services safe?

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice utilised a separate decontamination room for the processing of used dental instruments and equipment. We reviewed practice policy and protocols in relation to infection control and found that HTM 01-05 requirements were being met. The protocols were reviewed on a regular basis to take into account changes in national guidelines. It was observed that a current audit (November 2015) of infection control processes confirmed compliance with HTM 01-05 guidelines. The principal dentist maintained overall responsibility for infection control and ensured that the nurses followed the current national guidelines.

A trainee dental nurse described the end-to-end process of infection control procedures. They explained the decontamination of the treatment room environment. We were shown how the working surfaces, dental unit and dental chair were cleaned. 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 bacterium found in the environment which can contaminate water systems in buildings). The nurse described the method used to flush the water lines, which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor in 2013. The report contained recommendations which the practice had followed up. For example, the practice carried out and recorded quarterly water quality checks.

It was noted that the dental treatment room, waiting area, reception and toilet were visibly clean and tidy. Hand-washing facilities were available including wall-mounted liquid soap, rubs and paper towels in the treatment room and toilet. Hand-washing protocols were also on display.

The drawers and cupboards of the treatment room and decontamination room were inspected. These were well stocked, clean and free from clutter. Instruments were either pouched or stored appropriately for use during each clinical session. Those not used during the day's session were reprocessed in accordance with current guidelines. It was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate routine personal protective equipment, such as gloves and aprons, available for staff and patient use.

The dental nurse demonstrated to us the decontamination process from taking the dirty instruments through to clean and ready for use again. The process followed a well-defined system of zoning from dirty through to clean. The practice used a system of manual scrubbing as part of the initial cleaning process. Following inspection with an illuminated magnifier, instruments were placed in an autoclave (steriliser). Instruments were then pouched, or stored appropriately, until required. All pouches were dated with an expiry date.

The nurse also demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the automatic control test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained in accordance with current guidelines. For example, sharps bins were clearly labelled, wall mounted and not overfilled. The practice used an appropriate contractor to remove dental waste from the practice. Waste 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. Patients' could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, we saw records showing that the autoclaves had been maintained to the standards set out in the Pressure Systems Safety Regulations 2000 with the most recent service having been carried out in August 2015. We also observed that a portable appliance test (PAT) had been carried out June 2015.

We saw that medicines, such as local anaesthetics, were stored safely and NHS prescription pads were securely stored to prevent loss of prescriptions due to theft. The practice had a dedicated refrigerator for the storage of dental materials. The refrigerator was checked regularly to ensure that the temperature remained within the recommended range.

Are services safe?

Radiography (X-rays)

There was 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. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules.

The maintenance log was within the current recommended interval of three years. The next service was due in 2016. We also saw evidence that staff had completed radiation training.

A copy of the most recent radiological audit was available for inspection. We also checked the dental care records to confirm the findings. The audits and records showed that dental X-rays were justified, reported on and quality assured every time. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The principal dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. They described how they carried out patient assessments using a typical patient journey scenario. The assessment began with a medical history questionnaire where the patient was asked to disclose any health conditions, medicines being taken and allergies. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis and treatment options were discussed with the patient.

The patient dental care record was updated with the proposed treatment. A written 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.

We checked a sample of dental care records These showed that the findings of the assessment and details of the treatment were recorded appropriately. The records were structured and contained sufficient detail about each patient's dental treatment. Details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth were recorded. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need).

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentist was aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, alcohol use and dietary advice. The dentist was aware of, and was following, the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. The dentist also carried out examinations to check for the early signs of oral cancer.

The waiting room and reception area at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The practice had a range of oral hygiene products that patients could purchase that were suitable for both adults and children.

Staffing

Staff told us they received appropriate professional development and training. We checked three staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and X-ray training. We noted that the principal dentist needed to renew their training in responding to emergencies. They showed us that they were booked on to an appropriate course in December 2015.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice. This made use of a staff handbook containing relevant protocols.

Staff told us they had recently been engaged in an appraisal process which reviewed their performance and identified their training and development needs.

Working with other services

The practice had a system in place showing how they worked with other services. The dentist was able to refer patients to a range of specialists in secondary and tertiary care services if the treatment required was not provided by the practice. The practice had a file containing a list of the secondary and tertiary care providers that a dentist could refer patients to, where appropriate. This file contained the details of the referral criteria for each provider and included services such as orthodontics, oral and maxilla facial surgery and special care dentistry.

A referral letter was prepared and sent to the provider with full details of the dentist's findings and a copy was stored on the practice's records system. When the patient had

Are services effective?

(for example, treatment is effective)

received their treatment they were discharged back to the practice. Their treatment was monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. The dentist had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients. The dentist felt that patients should be given time to think about the treatment options presented to them. This made it clear that a patient could withdraw consent at any time and that they had received a detailed explanation of the type of treatment required, including the risks, benefits and options. Costs were made clear in the treatment plan. The dental care records we saw confirmed this approach had been followed and recorded. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments.

The dentist gave us a specific example of how they had taken a patient's mental capacity issues into account when providing them dental treatment. They were aware of the Mental Capacity Act 2005 (MCA). and explained how they would manage a patient who lacked the capacity to consent to dental treatment. (MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves).They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

There were two patients with booked appointments on the day of our inspection. We spoke with both of these patients. They described a positive view of the service. The practice had also collected feedback through the 'NHS Friends and Family' test since May 2015. The results of the survey indicated a high level of satisfaction with care. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. The principal dentist was committed to continuously developing their communication skills. They had noted some negative feedback via the NHS choices website and taken action to address the concerns raised. They told us they had recently sought additional advice about working with young children and booked themselves to attend a communication-skills training course.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment room was situated away from the main waiting area and we saw that the doors were closed at all times when patients were having treatment. Conversations between patients and dentists could not be heard from outside the rooms, which protected patients' privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in a paper format in locked filing cabinets. Computers were password protected and regularly backed up to secure storage; screens at reception were not overlooked which ensured patients' confidential information could not be viewed.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and in a practice information leaflet which gave details of the private and NHS dental charges or fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The principal dentist decided on the length of time needed for their patients' consultation and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours, emergency 'out of hours' contact details and practice policy documents. This information was also explained in the patient information leaflet which was given to new patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. We noted that it was part of the staff induction to discuss issues around equality and diversity with reference to the practice's policy on this topic.

One of the dental nurses told us the service was situated in a diverse area with a range of languages spoken. They told us that they were able to speak different languages, which supported some patients when they were accessing the service. For example, they were able to speak Polish. They also showed us that they had access to a telephone translation service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired.

The practice was not fully wheelchair accessible as they were steps from the outside up to the entrance. There was a rail alongside these steps to support people with limited mobility. We asked the principal dentist about wheelchair access. They told us that they directed people to a nearby community clinic if they needed a fully wheelchair accessible service. The practice had not carried out a full Disability Discrimination Act (DDA) audit to identify and consider what reasonable adjustments could be made to the premises to accommodate the needs of disabled patients.

Access to the service

The practice opening hours were on Monday, Tuesday, Wednesday, and Friday from 8.30am until 7.00pm. The practice is also on open on Thursday from 8.30am until 2.00pm, and is occasionally open on Saturday from 8.30am until 2.00pm.

Reception staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could generally get an appointment when they needed one. One of the reception staff told us that the dentist always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case. The appointment schedules showed that patients were given adequate time slots for appointments of varying complexity of treatment.

Concerns & complaints

Information about how to make a complaint was contained in an information leaflet for new patients and there was a display in the waiting area prompting patient to request the complaints policy from reception staff, if they required it. There was a complaints policy which described how the practice handled formal and informal complaints from patients.

There had been two complaints recorded in the past year which had been picked up via the NHS choices website. These complaints had been responded to in line with the practice policy. A record was kept of what had occurred and actions taken at the time to address the problem. As these were anonymous complaints it had not been possible to respond to patients directly.

We also observed a patient attend the practice on the day of the inspection who made a verbal complaint. The principal dentist spent time with the patient to explore the reasons behind the complaint and agreed a new appointment time the following week to further address their concerns. The principal dentist told us this would be recorded as a complaint and dealt with in line with the practice policy.

We asked the principal dentist how staff were informed about the outcomes of complaints with a view to sharing

Are services responsive to people's needs?

(for example, to feedback?)

learning points and preventing a recurrence. They told us the complaints were audited and discussed at a quarterly staff meeting. We reviewed the outcome of the most recent complaints audit which listed actions taken to improve the service, including the booking of additional training for staff, where required. Minutes from the practice meetings were not kept, but we saw that the date the meeting was held, and who attended was recorded. The standing agenda for the quarterly meetings included a review of complaints.

Are services well-led?

Our findings

Governance arrangements

The principal dentist maintained a governance system based on the seven key skills of clinical practice as set out by the Faculty of General Dental Practice of the Royal College of Surgeons. This comprised a file of policies and protocols in relation to subjects such as infection control, medical emergencies, radiography, record keeping and legislation and good practice guidelines. We found that the policies and protocols were personalised to the practice. For example, in the infection control section the principal dentist had incorporated photographs of the actual equipment and processes used in the practice to illustrate various procedures used in infection control. The policies and protocols were all frequently reviewed and updated. Staff were aware of the policies and procedures, and acted in line with them.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. For example, we saw a file which contained a risk-management system for the control of substances hazardous to health (COSHH). However, improvements could be made to ensure all of the potential risks associated with the running of the practice were identified and well managed. These included establishing a system for recording and reviewing incidents, as well as the carrying out of pre-employment checks. We discussed these issues with the principal dentist on the day of the inspection; they assured us they would take action to resolve these issues in response to our feedback.

There were quarterly staff meetings to discuss key governance issues. There was a standing agenda for these meetings and a list of which staff had attended each meeting, although written minutes were not kept. We noted that the standing agenda covered key governance issues including infection control and complaints.

Leadership, openness and transparency

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

We found staff to be hard working, caring towards the patients and committed to the work they did. We found the principal dentist provided effective clinical leadership to the whole dental team.

Staff told us they enjoyed their work and were supported by the principal dentist. They had recently been engaged in an appraisal process which commented on their own performance and elicited their goals for the future.

Learning and improvement

The practice had systems in place to facilitate learning and improvement. For example, the governance file was set out in language and a way that inexperienced and new members of staff could use and refer to during their induction and probationary training period. The principal had also put together a 'patient journey' file which described how members of staff should treat the patient during the whole patient journey from initial contact with the practice by to the end of a course of dental treatment.

The practice also carried out a number of audits covering, for example, infection control and dental radiography to help maintain standards. Although the practice had not undertaken a recent clinical record keeping audit, the principal had introduced a number of structured 'rubber stamp' templates for each dental care record. This ensured that each patient assessment followed a consistent approach and standard with respect to recording important information such as soft tissue examinations, condition of the gums and status of oral hygiene and a risk assessment in relation to dental recall intervals.

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

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

The practice gathered feedback from patients through the 'NHS Friends and Family Test' and by monitoring the NHS choices website. The majority of feedback was positive about the quality of care received. The principal dentist had analysed and responded to negative feedback when it

Are services well-led?

had been received. For example, adverse comments on the NHS choices website had been reviewed, leading to discussions with staff, changes in protocols and the provision of additional training, where necessary.

Staff told us that the principal dentist was open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.