Mr. Kevin Joseph Brophy

Dr K Brophy Dental Surgery

Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 05 January 2016 as we had received concerning information with regard to infection control and the condition of some of the equipment. We asked 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

Dr K Brophy Dental Surgery provides predominately NHS dental services with private treatment options available for patients. The practice has three consulting and treatment rooms, three dentists who are supported by four dental nurses and a student nurse. The practice also has two dental hygienists, who provided preventative advice and treatments on prescription from the dentists. The practice also provides sedation for its patient population and on referral from other practices in the area. This service is facilitated by a visiting anaesthetist. The practice is managed by the principal dentist who is the owner and supports the whole team.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

We were unable to review Care Quality Commission (CQC) comment cards completed by patients as this was an unannounced inspection. We did review feedback from patients who had completed the 'Friends and Family Test' comment cards and found that the feedback was positive.

Our key findings were:

- Staff reported incidents and kept records of these which the practice used for shared learning.

Summary of findings

- The practice was generally clean but there were areas that needed improvement.
- Staff routinely followed protocols with regard to decontamination of instruments.
- Areas of the practice and some of the equipment had not been maintained to a sufficient standard. However this was rectified following our visit.
- Staff had received some mandatory training.
- Radiography was carried out in line with current regulations.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- The practice had effective safeguarding processes and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- The practice took into account any comments, concerns or complaints.
- Patients were pleased with the care and treatment they received and complimentary about the dentists and all other members of the practice team.

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

- Arrange and carry out regular staff meetings

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 policies and protocols related to the safe running of the service. Staff were aware of these. Processes to reduce and minimise the risk of infection needed improvement. We received evidence this had been addressed following our inspection. The practice had medicines and some equipment for the management of medical emergencies, as determined by current guidance. However, staff had not received training in medical emergencies for some time. This training was carried out post inspection and we received certification to confirm this. We found that the practice had maintained the equipment used to provide services. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and adults.

Are services effective?

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

The practice monitored patients' oral health and gave appropriate health promotion advice. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers. Arrangements for providing sedation for patients who chose this did not meet recognised guidelines from the Society for the Advancement of Anaesthesia in Dentistry (SAAD). Staff had engaged continuous professional development (CPD) but were not meeting all of the other training requirements of the General Dental Council (GDC) with regard to sedation. We were informed following our inspection that the practice no longer provided sedation services to patients.

Are services caring?

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

We spoke with six patients and discussed their experiences. All of the information we received from patients provided a positive view of the service the practice provided. Patients told us that the care and treatment they received was kind and caring. We found that dental care records were stored securely and that confidentiality was maintained at all times.

Are services responsive to people's needs?

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

The practice provided clear information to patients about the costs of their treatment. Patients could access treatment and urgent care when required. The practice had one ground floor surgery and level access into the building for patients with mobility difficulties and families with prams and pushchairs. The team had access to telephone translation services if they needed.

Are services well-led?

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

The principal dentist was responsible for the day to day running of the practice.

Staff described a family type culture where they were comfortable raising and discussing concerns with each other. The practice had some clinical governance and risk management structures in place. However, a system of audits was not being used to monitor and improve performance. For example, there had not been an audit of the quality of x-rays

Summary of findings

taken to identify areas for improvement. A clear schedule to follow for the maintenance of equipment was lacking and some staff did not understand the requirements of some maintenance programs. The practice provided audit results, training documents and remedial equipment maintenance evidence following our inspection to assure us that all areas had been addressed

There was a system for receiving alerts from external agencies such as Medicines and Healthcare products Regulatory Agency (MHRA).

There was a system for carrying out formal appraisals with staff to discuss their role and identify additional training needs.

Dr K Brophy Dental Surgery

Detailed findings

Background to this inspection

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

The inspection took place on 05 January and was conducted by a CQC inspector and two dental specialist advisors.

We informed NHS England area team and Healthwatch that we were inspecting the practice on 29 October 2015; we did receive some information of concern from them with regard to poor infection control and maintenance of the premises and equipment.

During the inspection we spoke with two dentists, three dental nurses and the practice compliance manager. We spoke with six patients who were all complimentary about the services they had received.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had a system to manage significant and adverse events**,** safety concerns and complaints. There had been one reported significant event within the last year. This event had happened shortly before our inspection, we saw that the incident had been recorded and staff told us that the next step would be to analyse it and discuss measures for reducing the risks of it happening again. We were sent a completed record of the incident following our inspection. This confirmed that the practice had followed their system and had arranged staff training as a result.

There was also an accident reporting book which we checked. The practice compliance manager showed us that they filed completed accident forms separately to protect the privacy of people involved. They had a system for cross referencing these so they could easily identify and locate them if needed. None of the accidents recorded were serious enough to have been reportable to either RIDDOR or CQC.

The practice had a system to share information and alerts received from other authorities such as the Medicines and Healthcare products Regulatory Agency (MHRA). These were shared with staff so that any relating to dentistry could be actioned.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures for safeguarding children and vulnerable adults, which had been updated annually. The policies were localised and contained the direct contact details of the local authority safeguarding team and what to do out of hours. This information was displayed prominently and all staff were aware of the procedure to follow.

The principal dentist was the safeguarding lead. All staff had completed safeguarding training to the appropriate level. Staff we spoke with were confident when describing potential abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the procedure for whistleblowing if they had concerns about another member of staff's performance. Staff told us they would be confident about raising such issues with either the group manager, or principal dentist.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. 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. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment.

Medical emergencies

The practice had some arrangements to deal with medical emergencies. There was an automated external defibrillator (AED - a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Staff had not received annual training in how to use this. The practice had the emergency medicines set out as advised in the British National Formulary guidance. Oxygen and some other related items such as airways were available. However, the practice did not have a self-inflating bag or any face masks in line with the Resuscitation Council UK guidelines. We received confirmation following our inspection that pocket masks and the self-inflating bag had been purchased and were available. Also staff had taken time to familiarise themselves with the new equipment so that they were confident to use them should they need to.

The emergency medicines were all in date and stored securely with emergency oxygen in a central location known to all staff. The practice monitored the expiry dates of medicines and equipment so they could replace out of date items promptly.

Training for medical emergencies had lapsed for some staff; therefore we could not be assured that should a medical emergency occur at the practice, staff would be able to respond appropriately. Following our inspection we received confirmation that medical emergency training had been booked for all staff on 3 February 2016. We received certification to prove that this training had taken place. As the practice provided sedation, staff are required to achieve

advanced medical emergency training to adhere to guidelines from the Society for the Advancement of Anaesthesia in Dentistry (SAAD). This had not been achieved by any staff involved with sedation. Following our inspection we received information from the provider that they had decided not to continue providing sedation services and were in talks with the local commissioning authority to remove this service from their contract.

Staff recruitment

The practice showed us evidence that they had obtained the required information for members of the team before they had contact with patients.

The practice's written procedures contained clear information about the required checks for new staff. This included protocol to follow for prospective employees explaining to them what documents they would be expected to provide and what checks the practice would carry out. These included educational certificates, a valid UK Passport or National Identity Card, General Dental Council (GDC) and professional indemnity certificates (if applicable) and Hepatitis B vaccination evidence if available.

The Disclosure and Barring Service carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had obtained DBS checks for all staff employed there.

The recruitment protocol informed applicants that the practice would carry out a DBS check and informed them what documentation they would need to provide for this. The information informed applicants that they would be asked to provide a written explanation of any gaps in employment. The protocol also explained that as well as requesting references from applicants' most recent employers the practice would also contact previous employers where the work included contact with children or vulnerable adults.

Monitoring health & safety and responding to risks

The practice created a business continuity plan which described situations which might interfere with the day to day running of the practice and treatment of patients, or extreme situations such as loss of the premises due to fire, flood or utilities. Essential information such as contact details for utility companies and practice staff were available should they need them.

The practice had a practice wide risk assessment which addressed specific risks associated with dentistry as well as general day to day health and safety topics. This was reviewed annually to ensure that it reflected current guidance.

We saw that there was a fire risk assessment carried out in July 2015. The fire safety records showed that the practice had carried out fire checks and tests regularly and that they tested the fire alarm every week. We saw evidence of regular fire drills every two months and staff could demonstrate a good understanding of what to do if a fire was suspected.

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. Staff were aware of the COSHH file and of the strategies to minimise the risks associated with these products.

The dental care record system included alerts about information that the team needed to be aware of such as whether patients had allergies or were taking medicines used to thin the blood.

Infection control

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. However there were some areas where the practice was not meeting the HTM01- 05 essential requirements for decontamination in dental practices. One of the dental nurses held lead responsibility for infection prevention and control (IPC).

We saw that dental treatment rooms, decontamination room and the general environment were generally clean. However, Surgery three was visibly dirty and not in use on

Are services safe?

the day of our inspection. The dental chair in surgery three was visibly dirty had significant rips and tears in the chair covering and the right arm of the chair was broken. Tubing for the suction apparatus had been repaired with porous tape and inside of the suction unit components had been clamped with forceps and the filter had been wedged with a torn piece of cardboard to block a gap. With these defects it would be impossible to maintain an appropriate level of cleanliness. We received confirmation that all of the issues in surgery three had been addressed. We received photographs of the repaired suction internally and externally and of the chair repairs. Photographs received also confirmed a good standard of cleanliness in surgery three.

The practice employed a cleaner for general cleaning at the practice and we saw that cleaning equipment was not safely stored in line with guidance about colour coding equipment for use in different areas of the building. We saw there was only one mop and bucket for cleaning the floors of the surgeries, staff areas and toilets. This poses a risk of the spread of infection. There was a poster with the colour coding required to separate different areas for appropriate and effective cleaning but not the corresponding coloured mops, buckets and cloths.

During the inspection we observed that the dental nurses cleaned the surfaces, dental chair and equipment in treatment rooms between each patient. We saw that the practice had a supply of personal protective equipment (PPE) for staff and patients including face and eye protection, gloves and aprons. There was also a good supply of wipes, liquid soap, paper towels and hand gel available. The decontamination room and treatment rooms had designated hand wash basins separate from those used for cleaning and rinsing instruments.

A dental nurse showed us how the practice cleaned and sterilised dental instruments between each use. The practice had a defined system which separated dirty instruments from clean ones in the decontamination room, in the treatment rooms and while being transported around the practice. The practice had a separate decontamination room where the dental nurses cleaned and sterilised instruments. The training that staff had received; with regard to infection control was basic and poor. We were sent confirmation following our inspection that all staff had been booked to attend appropriate infection control training on 2 March 2016 and certification to confirm that this training had been completed by staff.

The dental nurse showed us the process of decontamination including how staff scrubbed and rinsed the instruments. However we saw that following scrubbing they did not rinse or check them for debris with a magnified lamp before using the autoclave (equipment used to sterilise dental instruments). Following a cycle in the autoclave instruments were packaged and date stamped according to current HTM01-05 guidelines. However we found a number of instruments that had visible debris on them. These instruments were bagged, dated and intended for re-use on patients. We brought this to the attention of the practice owner who removed the instruments from use for re-processing. Staff confirmed that the nurses in each treatment room checked to make sure that they did not use packs which had gone past the date stamped on them. Any packs not used by the date shown were processed through the decontamination cycle again.

The dental nurse showed us how the practice checked that the decontamination system was working effectively. However, not all of the maintenance checks were carried out, such as protein residue checks for the washer disinfector. The provider explained that the washer disinfector was not currently in use and that they had not had the equipment checked by an engineer but were in the process of arranging this. They showed us how the autoclave use was recorded and monitored electronically on a data card. However, the checks required to ensure that all of the decontamination equipment was working effectively had not been carried out, such as helix testing of the autoclaves. Records were not fully completed and or up to date. Following our inspection we received confirmation that log books had been purchased to record all of the necessary checks for the equipment used and that the washer disinfector had been de-commissioned.

The practice used single use dental instruments whenever possible. However we found evidence that these were being re-used such as, matrix bands, disposable suction tips and rose head burs. The manufacturer's instructions state that these are for single use only.

A specialist contractor had carried out a legionella risk assessment for the practice and we saw documentary evidence of this. Legionella is a bacterium which can

contaminate water systems in buildings. We saw that staff carried out regular checks of water temperatures in the building as a precaution against the development of Legionella. The practice used a continuous dosing method to prevent a build-up of legionella biofilm in the dental waterlines. Regular flushing of the water lines was carried out in accordance with the manufacturer's instructions and current guidelines.

The practice carried out audits of infection control every six months using the format provided by the Infection Prevention Society. The practice also completed an annual IPC report in line with guidance from the Department of Health code of practice for infection prevention and control. However, some of the entries were not a true reflection of infection control at the practice and as a result the value of the audits was compromised. It was noted that the person responsible for the completed audits was not clinically trained and did not have sufficient understanding to carry out an infection prevention audit effectively.

The practice had a record of staff immunisation status in respect of Hepatitis B a serious illness that is transmitted by bodily fluids including blood. There were instructions for staff about what they should do if they injured themselves with a needle or other sharp dental instrument including the contact details for the local occupational health department.

The practice stored their clinical and dental waste in line with current guidelines from the Department of Health. Their management of sharps waste was in accordance with the EU Directive on the use of safer sharps and we saw that sharps containers were well maintained and correctly labelled. The practice had an appropriate policy and used a safe system for handling syringes and needles to reduce the risk of sharps injuries.

The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary required waste consignment notices.

Equipment and medicines

We looked at the practice's maintenance information. On the day of our inspection there was little documentation to ensure that each item of equipment was maintained in accordance with the manufacturer's instructions. This included the equipment used to sterilise instruments, X-ray equipment and the dental chairs and suction. The practice had carried out PAT testing of the electrical equipment used in the practice to ensure it is safe to use in February 2016. PAT is the abbreviation for 'portable appliance testing'. The dental chair in surgery three had rips and tears in the covering and one of the arm rests was split with the foam interior exposed. Tubing that was attached to the suction had been repaired with porous tape which cannot be cleaned effectively. We received photographic evidence and invoices to show that the dental chair and suction unit had been repaired. The automatic X-ray developer had been poorly maintained. The log book where chemical changes and efficacy checks for the automated developer were recorded showed that the last chemical change was August 2015. Staff told us that the chemicals and water had been replenished more frequently but the changes had not been recorded. We received confirmation that the practice had implemented a chemical change and cleaning procedure to be carried out every two weeks and an efficacy check to be carried out weekly. This would ensure that radiographs developed would be of a suitable quality consistently and reduce the need for re-takes due to processing errors.

Prescription pads held by the practice were securely stored. We saw that the practice had written records of prescription pads to ensure that the use of these was monitored and controlled.

The batch numbers and expiry dates for local anaesthetics were always recorded in the dental care records. However, we found that local anaesthetic cartridges had been removed from their blister packs and stored loose in drawers which were dusty and visibly dirty.

Radiography (X-rays)

The practice had not been working in accordance with the Ionising Radiation Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). They did not have named Radiation Protection Adviser, although the provider was the Supervisor. The practice had not maintained a usable radiation protection file and lacked key documentation. Such as, inventory of equipment, critical examination packs for each X-ray machine, the expected engineer maintenance logs and notification to the Health and Safety Executive (HSE). Following our inspection we were sent all of these documents and assurance that radiography was now being carried out in line with current legislation.

Are services safe?

We saw evidence of the recorded reasons why each image (X-ray) and X-rays were checked to ensure their quality and accuracy. The dentists had graded each image taken to quality assure this process. We saw clinical audits for the quality of the X-rays conducted; to assist them to monitor their own performance in this aspect of dentistry.

The dentists involved in taking X-rays had completed the required training.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We found that the practice planned and delivered patients' treatment with attention to their individual dental needs and views about the outcomes they wanted to achieve. The dental care records we saw were clear and contained detailed information about patients' dental treatment.

The dentists were using a structured oral health assessment screening tool. This was to help them monitor patients' oral health and communicate areas of concern to patients in a more effective way. The tool used a traffic light style red, amber, green system which the dentists said they and their patients found helpful in understanding their risks of developing dental problems.

The records contained details of the condition of the gums using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed and offer tailored advice to help patients improve their dental health). We saw that the dentists also checked and recorded the soft tissue lining the mouth and external checks of patients face and necks which can help to detect early signs of cancer.

The dentists we spoke with were aware of various best practice guidelines including National Institute for Health and Care Excellence (NICE) guidelines and the Faculty of General Dental Practice Guidelines.

Health promotion & prevention

The practice was aware of the Public Health England 'Delivering Better Oral Health' guidelines and were proactive in providing preventative dental care as well as carrying out restorative treatments. Staff told us that they discussed oral health with their patients. For example, effective tooth brushing, oral hygiene, prevention of gum disease, and dietary / lifestyle advice. We looked at dental care records for five patients and saw that oral health advice given was routinely recorded. Patients we spoke with said that they had all been given oral health advice.

We observed that the practice provided targeted health promotion materials, by issuing and discussing advice sheets and leaflets to patients during consultations.

The water supply in Kent does not contain fluoride and the practice offered fluoride varnish applications as a preventive measure for adults and for children.

Staffing

We checked that all staff were registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration as a dental professional and its activity contributes to their professional development. The staff training files we looked at showed details of the number of hours training they had undertaken and training certificates received. However there were no formal procedures in place for the provider to review and monitor training. The practice provided a training matrix following the inspection to show that they were aware of when all training was completed and dates when training needed to be refreshed. Staff we spoke with told us that they were supported in their learning and development and to maintain their professional registration.

The practice had recently implemented formal procedures for appraising staff performance. Staff spoken with said they felt supported and involved in discussions about their personal development on an informal basis but were in the process of attending meetings to discuss their performance and progression. They told us that the dentists were supportive and always available for advice and guidance.

Working with other services

We saw evidence that the practice liaised with other dental professionals and made appropriate referrals to other services when this was needed. For example, they referred children who needed orthodontic treatment to specialists in this aspect of dentistry. The practice had arrangements with the local out of hours dental provision for emergency treatment when the practice was closed and details on how to access this service was displayed inside and outside the practice, on the practice website and in the patient information leaflet.

Consent to care and treatment

The practice had a consent policy which was up to date and based on guidance from the General Dental Council (GDC). The dentists described the methods they used to

Are services effective?

(for example, treatment is effective)

make sure patients had the information they needed to be able to make an informed decision about treatment. They told us that they often used diagrams and models as well as X-rays to illustrate information for patients.

The Mental Capacity Act 2005 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. Staff at the practice had completed specific training about the MCA and consent. Members of the team told us that at present they had few patients where they would need to consider the MCA when providing treatment but were aware of the relevance of the legislation in dentistry.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The patients we spoke with were complimentary about the care and treatment they received at the practice. Some highlighted that they had been patients for many years. Patients commented on the kindness of their dentist as well as the positive attitudes approach of the whole team. All the staff we met spoke about patients in a respectful and caring way and were aware of the importance of protecting patients' privacy and dignity. This view was reflected in information patients had written in compliments made directly to the service.

We observed that the staff provided a personable service as they knew their patients well. They were welcoming and helpful when patients arrived for their appointments and when speaking with patients on the telephone.

Patients indicated that they were treated with dignity and respect at all times. Doors were always closed when patients were in the treatment rooms. Patients we spoke with told us that they had no concerns with regard to confidentiality; we noted that there had been no complaints or incidents related to confidentiality and that dental care records were stored securely.

Involvement in decisions about care and treatment

We looked at dental care records and saw that the dentists recorded information about the explanations they had provided to patients about the care and treatment they needed. This included details of alternative options which had been described. One dentist explained and showed us how they described a complicated extraction to patients using leaflets about the subject and diagrams of teeth. We saw another example where a patient had been to the practice for an emergency appointment. The dental care records showed that the dentist gave them information about the risks and benefits of the possible treatment options. They provided temporary treatment so that a full treatment plan could be discussed in a longer appointment and the patient had time to come to a decision.

Patients told us that they felt involved in their care and had been given adequate information about their treatment, options and fees. Staff told us and we saw they took time to explain the treatment options available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS dental treatment and private dental treatment. The practice statement of purpose and patient leaflet provided information about the types of treatments that the practice offered.

The practice had a system to schedule enough time to assess and meet patient's needs. Each dentist had their own time frames for different treatment types and procedures. Staff told us that although they were busy they had enough time to carry out treatments without rushing and patients confirmed they had not felt rushed. The practice were able to book longer appointments for those who requested or needed them, such as those with a learning disability.

We found that the practice was flexible and able to adapt to the needs of the patients, and to accommodate emergency appointments. Patients we spoke with confirmed this and told us that they could usually get an appointment when they needed one and that they had been able to access emergency appointments on the same day.

Tackling inequity and promoting equality

The practice had recognised the needs of its patient population. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

The practice was accessible to wheelchairs and patients with pushchairs by a level entrance and a ground floor treatment rooms. The waiting area could accommodate a wheel chair or pushchair even though the area was small.

Access to the service

Appointment times and availability met the needs of the patients. The practice surgery hours were Monday, Wednesday, Thursday and Friday 8.45am to 5:30pm and 8.45am – 7.30pm on Tuesdays. Information about opening times was displayed at the entrance to the practice in the waiting room, and patient information leaflet.

Patients needing an appointment could book by phone or in person Patients with emergencies were usually seen on the same day even if there were no appointments available, staff would work later to accommodate them.

If patients required emergency treatment when the practice was closed, the answer phone message would direct them to the local NHS dental out of hours service. This was also displayed in the waiting room, on the entrance door and patient information leaflet.

Concerns & complaints

The practice had a complaints process which was available in print at the practice. We looked at information available about comments, compliments and complaints for the last year. The practice had only received one complaint in the last year and we saw it had been handled in accordance with the practice complaints policy and resolved to the patient's satisfaction.

We also looked at the practices summary of more formal complaints. These showed that the practice had listened to patients views and concerns, investigated and offered explanations and where necessary an apology. The complaint summary identified the learning for the practice such as improving communication with patients.

Are services well-led?

Our findings

Governance arrangements

There was a range of operational policies, procedures and protocols to govern activity. All of these policies, procedures and protocols were subject to annual review and staff had signed to indicate that they had read and understood each document. Staff we spoke with were aware of the policies, procedures and protocols, their content and how to access them when required.

The practice undertook a series of practice wide audits to monitor and assess the quality of the services they provided. Some audits had not been of value as they had been completed by staff who did not have full understanding of the requirements the audit was measuring. The practice addressed this shortfall and conducted another audit for infection control which was a more accurate reflection of the infection control processes at the practice. Other audit records we looked at related to audits for medicines, legionella checks and record keeping. There was evidence that these were taking place regularly. The findings of the audits documented an analysis of results, areas identified for improvement, and actions taken.

Leadership, openness and transparency

The practice was run by the principal dentist who is also the owner. The practice manager had left the a few months earlier and it had proved difficult to recruit a suitable replacement. The compliance manager had taken on some of the practice manager duties and was responsible for the oversight of all matters relating to governance. Staff did not have a full understanding of the requirements of the regulations under the Health and Social Care Act 2008 and how these applied to dental practices. However, we received many documents and training records to show that the provider had addressed this and was still working towards a better understanding.

We saw that relationships between members of the practice team were professional, respectful and supportive. Staff in all roles described the practice as a good place to work where they were supported by the partners and other team members.

Learning and improvement

Staff engaged in some continuing professional development (CPD), in line with standards set by the General Dental Council (GDC). We saw that the practice had implemented a system for ensuring that staff were up to date with their CPD and that the gaps we identified with regard to medical emergencies and infection control had been addressed. We also found that there was a system in place for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE).

There was a system for reporting and recording significant events or incidents with a view to sharing learning and preventing further occurrences. We were informed of a significant event that had occurred recently. Following our inspection, staff had used this as a learning tool, using their significant event reporting process to look at what happened in more detail. Staff had experienced an event with an aggressive patient. As a result of the analysis of the event, conflict resolution training had been booked for staff to help them deal with difficult encounters more effectively.

The practice had not had any team meetings since October 2014 which had previously been used to share information. Staff told us that they did convene daily on an informal basis to discuss practice issues but these were not documented.

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

The provider explained the practice had a good longstanding relationship with its patients. The practice was participating in the continuous NHS Friends and Family Test (FFT). The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The latest results showed that patients were extremely likely to recommend the practice to family and friends.

Staff told us that the dentists were approachable and that they could discuss anything they needed to whenever they needed to.