Care Quality Commission

Firwood Dental Practice Limited

Firwood Dental Practice

Inspection Report

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Chadderton
Oldham
Greater Manchester
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Tel: 0161 6244297
Website: none

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Overall summary

We carried out this announced inspection on 8 August 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

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 form the framework for the areas we look at during the inspection.

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 not 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 not providing well-led care in accordance with the relevant regulations.

Background

Firwood Dental Practice is in Chadderton and provides private dental treatment to adults and NHS treatment to children.

There is level access for people who use wheelchairs and those with pushchairs. The practice has two parking spaces, with additional on street parking available nearby.

The dental team includes one dentist, one dental nurse, and a receptionist. A dental implantologist attends as necessary, approximately three times a year. The practice has one treatment room.

Summary of findings

The practice is owned by a company and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers 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 registered manager at Firwood Dental Practice was the dentist.

On the day of inspection, we received feedback from 55 people about the services provided. The feedback provided was positive.

During the inspection we spoke with the dentist, the dental nurse and the receptionist. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday, Tuesday and Thursday 9:30am to 1pm and 2pm to 6pm

Wednesday 9:30am to 1pm and 2pm to 7pm

Friday 9:30am to 2pm

Our key findings were:

- The practice appeared clean and well maintained.
- The practice staff had infection control procedures which broadly reflected published guidance.
- Staff knew how to deal with emergencies. Improvements were needed to the life-saving equipment available.
- The practice had systems to help them manage risk.
- The practice staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice had thorough staff recruitment procedures.
- Care and treatment provided was not always consistent with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The practice was providing preventive care and supporting patients to ensure better oral health. The processes for the assessment and monitoring of oral health required improvement.
- The appointment system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice had systems to deal with complaints positively and efficiently.
- The practice staff had suitable information governance arrangements.

We identified regulations the provider was not meeting. They must:

- Ensure the care and treatment of patients is appropriate, meets their needs and ensures their preferences are recorded.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Full details of the regulations the provider is not meeting are at the end of this report.

There were areas where the provider could make improvements. They should:

- Review the practice's infection control procedures and protocols taking into account the guidelines issued by the Department of Health in the Health Technical Memorandum 01-05: Decontamination in primary care dental practices, and having regard to The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance' (In particular the examination of instruments before sterilisation and testing the efficacy of ultrasonic cleaning).
- Review staff training to ensure that all staff have received training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review the practice's waste handling protocols to ensure gypsum waste is segregated and disposed of in compliance with the relevant regulations, and taking into account the guidance issued in the Health Technical Memorandum 07-01.
- Review the fire safety risk assessment and ensure that ongoing fire safety management is effective.
- Review the practice's sharps procedures to ensure the practice is in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services safe?

No action

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

The practice had systems and processes to provide safe care and treatment. They had systems for staff to report and discuss incidents to help them improve.

Staff received training in safeguarding. It was not clear what level the training was. They demonstrated they knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles and the practice completed essential recruitment checks.

Premises and equipment were clean and properly maintained. The practice broadly followed national guidance for cleaning, sterilising and storing dental instruments. Minor improvements could be made to the processes.

The practice had arrangements for dealing with medical and other emergencies. Immediate action was taken to make improvements to the equipment available and the process for checking these.

The practice had systems to identify and manage risks. Improvements could be made to the processes to assess the risks relating to fire safety, sharps and the disposal of gypsum waste.

Are services effective?

Enforcement action

We found that this practice was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement Actions section at the end of this report).

The dentist did not assess patients' needs in line with recognised guidance for periodontal and radiographic assessments. We were unable to confirm the assessment of suitability for dental implants.

The dentist told us they discussed treatment options with patients so they could give informed consent and recorded this in their records. There was no evidence that the risks and benefits of treatment options were discussed with patients.

We saw clear evidence the practice was providing preventive care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit. Patients confirmed that the dentist spent time explaining ways to improve their oral health.

Patients commented that staff were caring and calming during treatment, and helped to put them at ease.

Summary of findings

The practice had arrangements when patients needed to be referred to other dental or health care professionals. The process for referring patients for dental implants required improvement.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

Are services caring?

No action

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

We received feedback about the practice from 55 people, and saw consistently positive feedback to the practice. Patients were positive about all aspects of the service the practice provided. They told us staff were friendly and helpful and very attentive.

The practice provided folders with honest patient testimonials for patients who were considering dental treatment to review and help them to make decisions.

Patients said that they were given helpful, honest explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Are services responsive to people's needs?

No action

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain. The practice was open until 7pm on Wednesdays and several patients commented they appreciated being able to access appointments after work.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. They were aware of interpreter services and arrangements to help patients with sight or hearing loss. Staff showed us how they reviewed the patients who were due to attend each day to identify if any additional assistance was required during their visit.

The practice did not have an electronic appointment system. They recognised that many patients preferred to receive text message reminders for forthcoming appointments. Staff were provided with a mobile phone to manually input and send these.

The practice took patients views seriously. They valued compliments from patients and had processes to respond to concerns and complaints quickly and constructively.

Summary of findings

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

During the inspection, the principal dentist showed a commitment to learning and improvement, staff were open to discussion and feedback. We identified a lack of awareness of nationally agreed evidence based standards and guidance in primary dental care. We identified local sources of professional and peer support for the team to enable them to review their processes and deliver high-quality, sustainable care.

The team had the experience, capacity and skills to deliver the service and address risks identified by their own assessment processes, and during the inspection.

The practice had arrangements to ensure the smooth running of the service. These included systems for the practice team to discuss the safety of the care and treatment provided. There was a clearly defined management structure and staff felt supported and appreciated.

The practice did not consistently act on appropriate and accurate information. For example, the processes for recording assessments and radiographic findings in clinical records. The handwriting on patient clinical records was difficult to read.

The practice did not have effective quality assurance processes to encourage learning and continuous improvement. There was no system to audit or evaluate the quality of dental care records or radiographs.

The practice had systems to obtain and listen to the views of patients and staff.

Requirements notice 

Are services safe?

Our findings

Safety systems and processes, including staff recruitment, equipment & premises and Radiography (X-rays)

The practice had some systems to keep patients safe.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had up to date safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had attended safeguarding training updates but it was not clear to what level. The dentist completed level two training immediately after the inspection and sent us evidence of this. Staff demonstrated they knew about the signs and symptoms of abuse and neglect and how to report concerns, including notifications to the CQC.

There was a system to highlight vulnerable patients on records e.g. children with child protection plans, adults where there were safeguarding concerns, people with a learning disability or a mental health condition, or who require other support such as with mobility or communication.

The practice had a whistleblowing policy, we noted that staff had difficulty locating this on the day. Staff told us they felt confident they could raise concerns without fear of recrimination, but were not aware that they could contact local organisations and sources of support if necessary.

The dentist used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment. In instances where the rubber dam was not used, such as for example refusal by the patient, and where other methods were used to protect the airway, this was suitably documented in the dental care record and a risk assessment completed.

The practice had a business continuity plan describing how the practice would deal with events that could disrupt the normal running of the practice.

The practice had a staff recruitment policy and procedure to help them employ suitable staff. These reflected the relevant legislation. We looked at staff recruitment records. These showed the practice followed their recruitment procedure, including Disclosure and Barring Service (DBS) checks to prevent unsuitable people from working with vulnerable groups, including children. The practice provided a staff handbook which included up to date policies, procedures and health and safety information.

We noted that clinical staff, including the visiting implantologist, were qualified and registered with the General Dental Council (GDC) and had appropriate professional indemnity cover in place.

The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances.

The processes to review fire safety could be improved. Staff carried out a six-monthly fire risk self-assessment. One smoke detector had been installed in the kitchen which was identified as the highest risk area. Two small fire extinguishers, were available and regularly serviced. We discussed how the practice could improve fire safety. For example, by seeking advice from a competent person in relation to the number of smoke detectors and number and type of fire extinguishers that are appropriate for the practice. Staff were aware of actions to be taken in the event of a fire and evacuation procedures.

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file. They had registered their use of dental X-ray equipment with the Health and Safety Executive in line with the Ionising Radiation Regulations 2017 (IRR17).

The X-ray equipment included an OPG (Orthopantomogram) which is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth and gives a 2-dimensional representation of these.

The dentist did not record the justification for, grade the diagnostic quality of, or report on the findings of the radiographs they took.

Clinical staff completed continuing professional development (CPD) in respect of dental radiography.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

Are services safe?

The practice's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to help manage potential risk. The practice had current employer's liability insurance.

We looked at the practice's arrangements for safe dental care and treatment. The staff followed relevant safety regulation when using needles and other sharp dental items. A sharps risk assessment had been undertaken, mainly in relation to matrix bands. Staff confirmed that only the dentist assembled, re-sheathed and disposed of needles where necessary to minimise the risk of inoculation injuries to staff. Protocols were in place to ensure staff accessed appropriate care and advice in the event of a sharps injury; staff were aware of the importance of reporting inoculation injuries. We discussed how the risk assessment could be improved by including other sharp items and to review the process for single patient use of endodontic instruments.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was checked. The results showing the efficacy of these vaccinations were not available for one member of staff. We saw evidence they had taken action to enquire whether follow up or boosters were required.

Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. Evidence of up to date training was not available for the visiting implantologist.

Emergency equipment and medicines were broadly available as described in recognised guidance. The process to check these to make sure these were available, within their expiry date, and in working order did not include all of the items recommended by the Resuscitation Council UK. Some were missing including three sizes of oropharyngeal airways, a child sized self-inflating bag and masks, and masks for the adult-sized self-inflating bag. Glucagon, which is required in the event of severe hypoglycaemia, was not kept refrigerated and the expiry date had not been adjusted in line with the manufacturer's instructions. The practice took immediate action to address these areas and sent evidence of this.

A dental nurse worked with the dentist when they treated patients in line with GDC Standards for the Dental Team.

The provider had suitable risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The practice had an infection prevention and control policy and procedures. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health and Social Care. Staff completed infection prevention and control training and received updates as required.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment used by staff for cleaning and sterilising instruments were validated, maintained and used in line with the manufacturers' guidance. We noted that instruments were examined using an illuminated magnifying device after sterilisation, rather than before as described in HTM01-05. Staff did foil tests to check the activity of the ultrasonic cleaning device but did not carry out weekly protein residue tests to ensure the effectiveness of the ultrasonic cleaner. These areas were discussed with the dental nurse to review and implement.

The practice had in place systems and protocols to ensure that any dental laboratory work was disinfected prior to being sent to a laboratory and before the work was fitted in a patient's mouth.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. All recommendations had been actioned and records of water testing and dental unit water line management and water quality testing were in place.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed that this was usual.

The practice had policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance. We identified small quantities of gypsum waste were not being disposed of in line with current waste management regulations. Staff confirmed that an appropriate disposal process would be put in place.

Are services safe?

The practice carried out infection prevention and control audits twice a year. The latest audit showed that staff had analysed and commented on the results, and the practice was meeting the required standards. We saw a documented practice improvement plan, which included the replacement of flooring, cabinetry and the dental chair in the treatment room.

Information to deliver safe care and treatment

We discussed with the dentist how information to deliver safe care and treatment was handled and recorded. We looked at a sample of dental care records and noted that individual records were handled and kept securely in line with General Data Protection Regulation (GDPR) protection requirements.

Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with practice protocols and current guidance.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site. This ensured that medicines did not pass their expiry date and enough medicines were available if required.

The practice stored and kept records of NHS prescriptions as described in current guidance. Private prescriptions were provided as necessary.

The dentist was aware of current guidance with regards to prescribing medicines.

Track record on safety

The practice had a good safety record.

There were comprehensive risk assessments in relation to safety issues. The practice had a system to monitor and review any incidents that occurred. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Staff confirmed that in the last few years there had been no safety incidents.

Lessons learned and improvements

The practice had procedures to learn and make improvements when things went wrong.

The staff were aware of the process to record, respond to and discuss incidents to reduce risk and support future learning in line with the framework.

There were adequate systems for reviewing and investigating when things went wrong.

There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The dentist could not demonstrate that the care provided was in-line with current evidence-based practice. For example, they did not document that appropriate assessment, diagnosis and monitoring of periodontal conditions were carried out. They told us they rarely performed a Basic Periodontal Examination (BPE). The BPE is a screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need. The dentist told us they never carry out a detailed periodontal charting (commonly referred to as six-point pocket charting); and was unclear on where the need to carry out a detailed periodontal charting was indicated.

We discussed how the dentist used radiographs as part of the assessment process. They did not document a justification for taking radiographs; including where OPGs had been taken in preference to intra-oral radiographs. The clinical records showed that the dentist did not grade the diagnostic quality of, or report on the findings of the radiographs they took. For example, we looked at radiographs where levels of bone loss as a result of periodontal disease was visible on radiographs. Another radiograph showed evidence of possible infection. These had not been documented in the patients' clinical notes. There was no documentation to show whether the patients had been informed of the findings, or whether their condition was stable. We highlighted the availability of evidence-based guidance from the Faculty of General Dental Practice (UK).

The practice occasionally offered dental implants. These were placed by a visiting specialist who had undergone appropriate post-graduate training in this speciality. The implants were restored by the dentist at the practice following successful healing. We reviewed the process for the provision of dental implants. Patients were verbally referred to the visiting specialist. The provider told us that the dentist and specialist performed a joint consultation together with each patient. We saw examples of information provided to each patient which included the options discussed during the consultation, encouraged them to take time to make their decision, and stressed the importance of good oral hygiene. The practice could not demonstrate that a full and appropriate assessment of patients' suitability for dental implants was carried out. For example, where patients had periodontal disease or the patient was a smoker. The dentist told us that patients were informed of risks and benefits but this was not documented.

The practice encouraged patients to provide feedback after having dental implants. Patients reported they were happy with the results of their treatment, several commented the treatment had enabled them to eat and speak properly again. The practice made this information, including honest feedback where patients had experienced more discomfort than expected or where implants had taken longer than anticipated to heal, readily available to other patients who were considering implant therapy to help them make decisions about their care.

Helping patients to live healthier lives

We saw clear evidence the practice was providing preventive advice to support patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentist told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay. We saw the practice was recently congratulated by NHS England for fluoride varnish on 70% of children compared with the locality rate of 63%.

The dentist told us that where applicable they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

The practice was aware of national oral health campaigns in supporting patients to live healthier lives. For example, local stop smoking services. They directed patients to these schemes when necessary.

The dentist described to us the procedures they used to improve the outcome of periodontal treatment. This involved bespoke and detailed preventative advice, we saw well-documented evidence of these discussions and demonstrations of how to use interdental cleaning brushes in patients' clinical records. Patient comments confirmed

Are services effective?

(for example, treatment is effective)

that the dentist spent time explaining ways to improve their oral health. Several patients commented that the dentist always provided good advice on looking after teeth to them, and their children at every visit.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentist told us they gave patients information about treatment options so they could make informed decisions. There was some evidence that options were explained and discussed. We could not see documented evidence that the dentist explained and discussed the risks and benefits of these; or whether patients had been informed of the findings on radiographs which may influence their decisions. Patients confirmed the dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005 and capacity assessment templates. The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. We noted some confusion around the process to gain consent in certain circumstances. For example, from carers and family members. The policy also referred to Gillick competence, by which a child under the age of 16 years of age can consent for themselves. The staff were aware of the need to consider this when treating young people under 16 years of age.

Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

The practice kept dental care records containing information about the patients' current dental needs, past treatment and medical histories. The dentist did not consistently document assessments of patients' treatment needs in line with recognised guidance. Clinical records were hand written and we noted that the dentist's handwriting was difficult to read.

Patients' dental care records were not audited to check that the dentist recorded the necessary information. We discussed how the practice could use audits to review their current procedures and demonstrate improvements.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. for example, the implant dentist had undergone additional training and was included on the General Dental Council specialist register for oral surgery.

Staff new to the practice had a period of induction based on a structured induction programme. We confirmed clinical staff completed the continuing professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at annual appraisals, informal discussions and staff meetings. We saw evidence of completed appraisals and how the practice addressed the training requirements of staff.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The dentist confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. Patients who required three or more dental implants were referred for treatment by the implantologist in a hospital. We saw positive feedback from patients who had been referred for this treatment.

The practice had systems and processes to identify, manage, follow up and where required refer patients for specialist care when presenting with bacterial infections.

The practice also had systems and processes for referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist.

The practice monitored all referrals to make sure they were dealt with promptly.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were friendly and helpful and very attentive. We saw that staff treated patients respectfully, appropriately and kindly and were friendly towards patients over the telephone.

Patients said staff were compassionate, understanding and kind and helpful when they were in pain, distress or discomfort.

Information folders, patient testimonials and thank you cards were available for patients to read. The dentist actively reviewed all patient feedback and responded personally, where appropriate.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting area did not provide privacy when reception staff were dealing with patients. Staff told us that if a patient required or asked for more privacy they would take them into another room. They showed how they used the diary to schedule gaps between appointments for allow for additional private discussions to be held in the treatment room with the dentist, without inconveniencing other patients. The appointment book was not visible to patients and staff did not leave patients' personal information where other patients might see it.

Involving people in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the

Accessible Information Standards and the requirements under the Equality Act. The Accessible Information Standard is a requirement to make sure that patients and their carers can access and understand the information they are given:

- Staff were aware of the availability of interpreter services available for patients who did not have English as a first language. They told us they did not have the need for these.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community services. They helped them ask questions about their care and treatment.

Staff told us they gave patients clear information to help them make informed choices. Many patients' comments confirmed that staff listened to them, did not rush them and discussed options for treatment with them. Treatment consent forms encouraged patients to take time to make decisions about their care. The dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

The practice's website and information leaflet provided patients with information about the range of treatments available at the practice.

The dentist described to us the methods they used to help patients understand treatment options discussed. These included for example, models, diagrams, written treatment options, honest patient feedback and information leaflets to help them better understand the diagnosis and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

Staff were clear on the importance of emotional support needed by patients when delivering care.

Patients described high levels of satisfaction with the responsive service provided by the practice. The staff had been employed by the practice for many years. Many patients commented on the friendly and personal service provided by the team. Many had, or would recommend the practice to others.

The practice had made reasonable adjustments for patients with disabilities, in line with a disability access audit. These included step-free access. Staff had identified a small lip on the doorframe at the practice entrance and provided a small, custom made ramp to facilitate seamless entry. They installed a hand rail in the narrow toilet and included information about access in the patient information leaflet. The sofas in the waiting room were low; staff made higher chairs available from the staff room, in cases where patients would struggle to use the low sofas comfortably. The receptionist and dental nurse showed us how they reviewed the patients who were due to attend each day to identify if any patient needed the ramp, a higher chair or any additional assistance during their visit.

The practice did not have an electronic appointment system. They recognised that many patients preferred to receive text message reminders for forthcoming appointments. The practice provided a mobile phone for staff to manually input and send these. Patients commented on their appreciation of this service. Staff told us that they provided appointment cards and telephoned some patients before their appointment to make sure they could get to the practice, in accordance with their preferences.

Timely access to services

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

The practice displayed its opening hours in the premises, and included it in their practice information leaflet and on their website. They were open until 7pm on Wednesdays and several patients commented they appreciated being able to access appointments after work.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested urgent advice or care were offered an appointment the same day. Patients commented that staff accommodated requests for same day appointments, had enough time during their appointment and did not feel rushed.

The practice website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint.

The dentist was responsible for dealing with these. Staff told us they would tell them about any formal or informal comments or concerns straight away so patients received a quick response.

They told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

The practice had not received any complaints in the last 12 months. We saw how complaints received prior to this were logged and documented appropriately. One patient commented that on one occasion they had cause to disagree with the staff, and that during this they had been treated with respect.

Are services well-led?

Our findings

Leadership capacity and capability

The team had the experience, capacity and skills to deliver the service and address risks identified by their own assessment processes, and during the inspection.

We identified local sources of professional and peer support for the team to enable them to review their processes and deliver high-quality, sustainable care. We will re-visit the practice in due course to ensure that improvements are made.

The team worked closely together and were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

Vision and strategy

The staff worked to a clear set of values. The practice had realistic plans which included refurbishment of the premises to improve the facilities for patients and staff.

Services were provided in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. Although the processes to assess treatment needs required improvement; we saw good evidence that the dentist encouraged patients to improve their oral health.

Culture

The practice had a culture of sustainable care.

Staff stated they felt respected, supported and valued. They told were proud to work in the practice.

The practice focused on the needs of patients. Staff knew the patients well and they anticipated any assistance that they might require, such as assistance to access the practice, or the provision of a higher chair. They manually sent text messages to inform patients of forthcoming appointments. Patients commented that they appreciated the personal and caring service that staff provided.

There were processes to act on incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Staff told us they could raise concerns, they were encouraged to do so and discuss these together. They had confidence that these would be addressed.

Governance and management

There were clear responsibilities, roles and systems of accountability to support good governance and management.

The dentist had overall responsibility for the management and clinical leadership and day to day running of the practice, with support from staff. Staff knew the management arrangements and their roles and responsibilities.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

There were processes for identifying and managing risks. We discussed how improvements could be made to the processes in relation to fire safety, the disposal of gypsum waste, the availability and checking of emergency equipment and sharps.

Processes were not in place to monitor and improve performance. We identified concerns in the processes to assess treatment need.

Appropriate and accurate information

The practice did not consistently act on appropriate and accurate information. For example, the results of radiographs were not recorded in clinical records and there was no evidence that patients were informed about radiological findings. The handwriting on patient clinical records was difficult to read.

The systems to monitor the quality and improve performance were ineffective. Quality was monitored and measured solely on the feedback and the views of patients.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

Are services well-led?

The practice used patient surveys, online reviews and verbal comments to obtain patients' views about the service. We saw consistently high levels of satisfaction with the service provided.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. The latest results showed 100% of the most recent respondents would recommend the practice. Staff obtained honest treatment-specific patient feedback and testimonials, which were available to patients considering undergoing the same procedures to help them make decisions about their care.

The practice gathered feedback from staff through meetings, and daily informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were some systems and processes for learning, continuous improvement and innovation.

The practice did not have effective quality assurance processes to encourage learning and continuous improvement. There was no system to audit or evaluate the quality of dental care records or radiographs. Opportunities were missed to identify the concerns we found with patient assessments, the use of radiography and record keeping. Staff carried out audits of infection prevention and control. They had clear records of the results of these audits and the resulting action plans and improvements.

During the inspection, the principal dentist showed a commitment to learning and improvement, staff were open to discussion and feedback. We identified a lack of awareness of nationally agreed evidence based standards and guidance in primary dental care. We saw certificates of regular attendance at learning events and seminars but could not see evidence that these were used to review and improve practise. They valued the contributions made to the team by the individual members of staff who had been employed at the practice for many years.

The dental nurse and receptionist had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff told us they completed 'highly recommended' training as per General Dental Council professional standards. This included undertaking medical emergencies and basic life support training annually.

The General Dental Council also requires clinical staff to complete continuing professional development. Staff told us the practice provided support and encouragement for them to do so.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • The provider did not have systems to ensure that care was provided in accordance with current guidelines and research to develop and improve their system of clinical risk management. For example, periodontal assessments and taking radiographs at recommended intervals as part of the assessment. • The practice did not ensure that comprehensive dental care records were maintained. In particular, the legibility of hand written records and ensuring that assessments and explanations of these, and any risks or benefits were documented appropriately. • The provider did not carry out clinical audits. For example, of dental care records or radiographic quality. Opportunities were missed to identify and act on deficiencies in these areas.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **There was insufficient evidence to demonstrate that care and treatment was being designed with a view to achieving service user preferences or ensuring their needs were met. In particular:** • The provider did not ensure that patients' needs were assessed in compliance with current legislation, and took into account relevant nationally recognised evidence-based standards and guidance. For example, periodontal examinations and clinical assessment of the selection criteria and appropriate use of radiographs. • The provider could not demonstrate that a full and appropriate assessment of patients' suitability for dental implants was carried out. For example, where patients had periodontal disease or the patient was a smoker. • The provider did not document a justification for, grade the diagnostic quality of, or report on the findings of the radiographs they took. **Service users were not being enabled or supported to understand their care and treatment choices. In particular:** • The provider could not demonstrate that patients were informed of their condition. For example, the findings of radiographic assessment where bone loss or deterioration of existing restorations were visible on radiographs, or whether their condition was stable. • The provider could not demonstrate that patients were informed of risks and benefits of treatments options proposed. For example, in relation to the provision of dental implants.