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A1 Teeth

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 7 March 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?
We found that this practice was providing safe care in accordance with the relevant regulations

Are services effective?
We found that this practice was providing effective care in accordance with the relevant regulations

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

Are services responsive?
We found that this practice was providing responsive care in accordance with the relevant regulations

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

Background
A1 Teeth is a dental practice providing mostly NHS dental treatment, with private treatment options for patients. The practice is located in premises in Canterbury Kent.

The practice has three treatment rooms, all of which are on the ground floor.

The practice provides dental services to both adults and children. The practice provides mostly NHS treatment (around 90%). Services provided include general dentistry, dental hygiene, crowns and bridges and root canal treatment. Patients also have the option of private treatment options such as implants and cosmetic dentistry.

The practice's opening hours are – Monday to Friday 8.30am to 5.30pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the 111 NHS service.

The principal dentist/owner 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.

Summary of findings

The practice has three dentists; two hygienists, four qualified and registered dental nurses who share reception duties.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to tell us about their experience of the practice. We collected 48 completed cards and looked at the recent NHS Friends and Family forms which were available at the practice. We collected the views of a further 3 patients after the day of our inspection.

Our key findings were:

• The practice was visibly clean and tidy but some clinical areas needed attention.

• Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.

• Patients at the practice gave positive feedback about their experiences at the practice.

• Dentists identified the different treatment options, and discussed these with patients.

• Patients' confidentiality was maintained.

• The practice was not following the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.

• The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

The practice was tidy; however, we noted that some procedures and areas of the environment did not adhere to the Department of Health guidance HTM 01-05. The practice addressed these shortfalls and sent us evidence following our inspection.

X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

No action

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

All patients were clinically assessed by a dentist before any treatment began.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, wisdom tooth removal and the non-prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

The practice made referrals to other dental professionals when it was appropriate to do so. There were clear procedures for making referrals in a timely manner.

Are services caring?

No action

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

We observed staff being welcoming and friendly when patients came in to book an appointment. We received feedback from 48 patients. Patients praised all staff and gave a positive view of the service; three patients who confirmed that they were happy with the service also said that occasionally there was an extended wait to see the dentist.

Patients commented that treatment was explained clearly and staff said that dentists always took their time

to explain treatment to patients. Patient records were stored securely and patient confidentiality was well maintained.

Summary of findings

Patients said they were able to express their views and opinions.

Are services responsive to people's needs?

No action

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

Patients said they could get an appointment although there was sometimes a wait for routine appointments. Practice staff and patients told us that, patients who were in pain or in need of urgent treatment would be seen the same day.

The practice had access for patients with restricted mobility via level access into the practice. All patient areas were located on the ground floor. The practice had completed a disabled access audit to consider the needs of patients with restricted mobility.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the practice.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

No action

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

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

Staff said the practice was a friendly place to work, and they could speak with the dentists if they had any concerns.

A1 Teeth

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 7 March 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

We also reviewed the information we held about the practice and asked the practice to send us their statement of purpose, a list of staff and any complaints which they had received in the last 12 months.

We reviewed policies, procedures and other documents, made observations, interviewed staff and toured the building. We received feedback from 48 patients about the dental 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 recorded and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred within the last 12 months this being a minor injury to a member of staff. The records showed the staff had taken appropriate action to reduce the risk of this accident happening again. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although the practice was aware of how to make these on-line.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. These were received electronically by the principal dentist who shared them with staff when appropriate.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. The policies had been reviewed in July 2016. In addition there was a copy of Child protection and the dental team, and a link stored on the desktop of the practice computers which contained details of all of the local area teams and their contact information. The policies directed staff in how to respond to and escalate any safeguarding concerns. We spoke with staff who were aware of the safeguarding policies, they knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The relevant contact telephone numbers were available at reception and in each of the treatment rooms.

One of the dentists was the identified lead for safeguarding in the practice. They had received training to level two in child protection to support them in fulfilling that role. We saw evidence that all staff had attended a three yearly training course. In addition all staff had completed on-line refresher training in safeguarding during June 2016.

There were guidelines to assist staff in the use and handling of chemicals in the practice. The policy identified the risks associated with the Control Of Substances Hazardous to Health (COSHH). There were risk assessments which identified the steps to take to reduce the risks which included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. The manufacturers' product data sheets were available for staff to refer to in the event of an occurrence involving chemicals in the COSHH file. We saw the COSHH file had been reviewed on an annual basis to ensure that all materials and cleaning products had been included.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in March 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. The principal dentist said that only dentists handled sharp instruments such as needles. However, we observed nurses removing needles and handling sharps during our inspection. We brought this to the attention of the principal dentist who spoke with staff immediately.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were located in accordance with the guidance which states sharps bins should not be located on the floor, and should be out of reach of small children.

Discussions with dentists and a check of patients' dental care records identified that dentists were using rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society recommend that dentists should be using rubber dams. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the

rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

Medical emergencies

The dental practice was equipped to deal with any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the emergency medicines and found they were all in date and stored appropriately. We saw the practice had a designated member of staff who was responsible for checking and recording expiry dates of medicines, and replacing when necessary and the records showed that these checks had been carried out regularly.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. There was an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed the AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training. Additional emergency equipment available at the practice included: airways to support breathing, manual resuscitation equipment (a bag valve mask) and portable suction.

Staff recruitment

There was a recruitment policy at the practice. We looked at the recruitment files for all staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We found that all members of staff had received a DBS check. We found that all of the documents required were available.

Monitoring health & safety and responding to risks

The practice had a health and safety policy. In addition the practice had completed environmental risk assessments. For example there were risk assessments conducted for: the autoclave, electrical safety, bodily fluids, blood borne infections and radiation (X-rays).

A fire risk assessment had been carried out in February 2017 by an external company. The risk assessment had identified that fire warden training was required and the principal dentist assured us they would complete this training in the near future.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy for staff to refer to that detailed the local practices to govern effective infection control. We saw that dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures and there were records and documentation to demonstrate this.

The practice had a clinical waste contract with a recognised company. We saw that clinical waste was collected regularly. The waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam and teeth that had been removed. Amalgam is a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury. There were also spillage kits for bodily fluids which were in date.

The practice used the temporal separation method for the cleaning and sterilisation of dental instruments. Although, decontamination processes were only conducted in

treatment room 1 (used by the hygienist). We noted that there was not a clear flow from dirty to clean areas to reduce the risk of cross contamination and infection in one of the treatment rooms. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We saw how instruments were being cleaned and sterilised at the practice, with a dental nurse demonstrating the decontamination process. We saw the procedures were not as outlined in the published guidance (HTM 01-05). We witnessed an unmeasured dose of enzymatic detergent being dispensed into a sink, with no plug and with the tap running to facilitate initial scrubbing of contaminated instruments. We discussed this with the staff concerned and the principal dentist. This process was addressed immediately by facilitating a correct dilution of enzymatic detergent in a separate bowl within the sink, to allow a full contact time with the contaminated instruments and to allow scrubbing techniques that did not produce an aerosol.

After cleaning the dental instruments were rinsed, we noted that the instruments were not routinely examined using an illuminated magnifying glass, which was available. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments). The practice had three autoclaves. At the completion of the sterilising process, all instruments were dried, and stored in draws in the treatment rooms. We saw instruments being used during the day and that at intervals would be exposed to the 1.5 metre aerosol around the dental chair. Staff told us that at the end of the day these instruments were pouched and date stamped with a yearlong expiry date. We explained that these instruments were not sterile at the point of pouching and dating. We discussed this with the staff concerned and the principal dentist. Staff removed all of the potentially contaminated instruments and re-processed them. The instruments were then pouched and the pouches were date stamped to show when they would expire before being stored ready for re-use. We were informed following our inspection that further training had been conducted with regard to HTM 01-05 for al staff and that the practice processes had been changed as a result to reflect the current guidance.

We checked the records to demonstrate that equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. The records demonstrated the equipment was in good working order and being effectively maintained. We saw that the autoclaves and the compressor had recently been serviced in March 2017.

We used an illuminated magnifying glass to check a random sample of dental instruments that had been cleaned and sterilised. We found the instruments to be clean and undamaged. However whilst observing the decontamination process we noted that staff did not routinely inspect instruments using the illuminated magnifying glass to ensure that they were clean and undamaged.

The practice had access to occupational health facilities through the local hospital. We saw records which demonstrated staff had received inoculations against Hepatitis B. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections such as Hepatitis B.

The practice had a risk assessment for dealing with the risks posed by Legionella carried out by an external contractor in February 2017. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. All actions resulting from the risk assessment had been addressed such as water temperature testing was being carried out and recorded.

Equipment and medicines

The practice kept records to demonstrate that equipment had been maintained and serviced in line with the manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in February 2017.

We saw that in all of the treatment rooms, the work surfaces and cabinetry were damaged to a standard that posed an infection control risk as they could not be cleaned effectively. We discussed this with the principal dentist. We were shown the plans and dates for a new decontamination room to be installed. However this would not address the damaged treatment room work tops and cabinets. Following our inspection we received evidence that the worktops and cabinets had all been replaced.

In one of the treatment rooms we noted that the dental chair did not have a cover on the back of the backrest. Also

Are services safe?

one of the upholstery was ripped with the internal padding exposed. This posed a risk of infection as it could not be cleaned effectively, but also a risk of injury with the internal mechanisms of the chair exposed at the back. Following our inspection we received photographic evidence that the chair had been repaired and no longer posed any risks.

The practice had all of the medicines needed for an emergency situation, as recommended by the British National Formulary (BNF). Medicines were stored securely and appropriately and there were sufficient stocks available for use.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

The pressure vessel checks on the compressor which produced the compressed air for the dental drills and hand pieces had been completed in March 2017.

Radiography (X-rays)

The practice had a Radiation Protection file which contained all of the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had three intraoral X-ray machines (intraoral X-rays are small images taken inside the mouth).

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being the principal dentist. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for expert advice regarding the machinery and radiation safety. The Ionising Radiation Regulations 1999 (IRR 99) requires that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) to be appointed and identified in the local rules. The local rules are bespoke operating procedures for the area where X-rays are taken and the amount of radiation required to achieve a good image. Each practice must compile their own local rules for each X-ray set on the premises. The local rules set out the dimensions of the controlled area. This is a set parameter around the dental chair/patient and the lowest dose possible. Applying the local rules to each X-ray taken means that X-rays are carried out safely with doses of radiation kept as low as reasonably practicable. The role of the RPA and the RPS is to ensure the equipment is operated safely and only by qualified staff. The RPS must be somebody who has a radiography qualification and is on the premises whilst X-rays are being conducted. The RPS has oversight of radiation safety in the practice.

Records showed the X-ray equipment had last been inspected in May 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years to ensure it is safe and working correctly. Documents in the practice showed the Health and Safety Executive (HSE) had been informed that radiographs were being taken on the premises. This was a requirement of the Ionising Radiation (Medical Exposure) Regulations 2000.

All patients were required to complete a medical history form and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic and paper dental care records for each patient. They contained information about the patients' assessments, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental professionals. The dental care records showed a thorough examination had been completed, and identified risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form at each visit. Following the patient's first visit the information was transferred into the electronic records and updated at each following visit. This allowed dentists to check the patient's medical history before treatment began. The patients' medical histories included any health conditions, medicines being taken and whether the patient might be pregnant or had any allergies.

The dental care records we checked showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of the timescales for recalling patients; prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart); and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had a variety of information for patients in the waiting room. There were leaflets in reception and posters about treatments and health education information for patients.

Discussions with dentists identified that patients were assessed on an individual basis to check their risk of dental decay. This, when required resulted in patients being offered fluoride application varnish and/or a higher concentration fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This had been produced to support dental teams in improving patients' oral and general health.

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, dentists had particularly highlighted the risk of dental disease and oral cancer.

Information on display in the reception area gave patients information and advice on stopping smoking. This included contact details for other agencies who could be of assistance.

Staffing

The practice had three dentists; two hygienists and four qualified dental nurses. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We looked at staff training records held in staff files and these identified that clinical staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training certificates showed how many hours training staff had undertaken together with which training courses were attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. The practice manager kept records to monitor the number of hours each dental professional had completed each year. Examples of training completed included: radiography (X-rays), infection control, and medical emergencies.

Records at the practice showed that appraisals had been completed for staff and they had implemented personal development plans for staff. The appraisals were very detailed, identified training needs and supported development of staff.

Working with other services

The practice made referrals to other dental professionals based on risks or if a patient required treatment that was not offered at the practice. Staff demonstrated a good knowledge of when and how to make referrals and on making urgent referrals for patients who had suspected oral cancer. This was to the maxillofacial department at the

Are services effective?

(for example, treatment is effective)

local hospital Staff demonstrated these were faxed through immediately to the hospital where the referral had been made. These referrals were tracked through a log at reception, and we saw evidence that referrals had been made promptly. Patients were offered the details of any referral made on their behalf.

Consent to care and treatment

The practice had a consent policy. The policy made reference to the different aspects of consent. The practice also had a policy regarding adults who lacked capacity and this made reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. None of the staff at the practice had completed training in the MCA. However, staff could, when questioned describe how the MCA would affect their work and patients and how they would implement it. We received copies of certificates to show that all staff had conducted MCA training following our inspection.

Consent was recorded in the practice using the standard NHS FP17 form. This form recorded both consent and provided a treatment plan. The dentists discussed the treatment plan with the patients and explained the treatment process. This allowed the patient to give their informed consent. A hard copy of the consent form was retained by both the practice and the patient. We also saw examples of detailed consent forms for more complex treatment options such as implants and other private treatments, which were bespoke to the patient's needs.

Discussions with dentists identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. However, staff said it was unusual for children to come to the practice unaccompanied by either a parent or guardian

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The reception desk was located away from the waiting room. Staff said they were aware of the need for confidentiality and if it were necessary there were areas of the practice where this could happen, such as the reception office or an unused treatment room. Staff said that patients' individual treatment was discussed in the treatment room not at reception.

We gathered patients' views from 48 completed Care Quality Commission comment cards and 16 NHS Friends and Family forms which were available at the practice. We also obtained the views of a further two patients following the day of our inspection.

Patients were positive about the practice and their experience of being a patient there. People said they could not fault the service they received and thought that the practice was excellent. People described finding the practice premises pleasant and the staff as helpful, unhurried and the dentists as gentle. All 16 patients who filled in a Friends and Family form had selected the option confirming that they were 'extremely likely' to recommend the practice.

During the inspection the interactions we saw between practice staff and patients were polite, and helpful. It was evident that the team knew their patients well.

The practice had an up to date confidentiality policy. The reception desk located away from the waiting room. Staff confirmed that if more than one patient was in the waiting room and one wished to speak privately they would use the back room for this.

Involvement in decisions about care and treatment

We spoke with two patients following our inspection. Feedback from patients was positive with patients saying they were happy with the dental service they received. Patients spoke positively about the staff and said the facilities were clean and comfortable. Patients said they felt involved in their treatment. Patients said they were encouraged to ask questions and talk with staff about their treatment.

The practice offered both NHS and private treatments and the costs were clearly displayed in leaflets and posters in the practice. This information was also provided in individual treatment plans following consultations.

We spoke with two dentists about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence in the patient care records of how the treatment options and costs were explained and recorded before treatment started. All patients were given a written copy of the treatment plan which included the costs.

Where it was necessary dentists gave patients information about preventing dental decay and gum disease. We saw examples in patients' dental care records. Dentists had discussed the risks associated with smoking and diet, and this was recorded in patients' dental care records. The practice had a member of staff trained to deliver smoking cessation advice and posters in the waiting room gave additional information.

Patients' follow-up appointments were in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There was parking available directly outside the practice. The practice had three treatment rooms, all of which were on the ground floor.

The practice had separate staff and patient areas, to assist with confidentiality and security. We saw there was a sufficient supply of instruments to meet the needs of the practice.

We spoke with two patients after the inspection. Patients said they had experienced issues with obtaining routine appointments. Patients also said they found reception staff always helpful, friendly and approachable. Staff said that when patients were in pain or where treatment was urgent the practice had made efforts to see the patient the same day. Patient confirmed this.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The practice scheduled emergency slots for patients who were in pain or who required urgent treatment. In addition there was a sit and wait system for patients who were unable to get an emergency appointment but who were in pain or who required emergency treatment. Staff said that generally the practice ran to time, and waiting times were kept to a minimum.

Tackling inequity and promoting equality

The practice was on the ground floor. This included three treatment rooms. The practice had level access into the building which would allow patients using a wheelchair or with restricted mobility to access treatment at the practice.

The practice had a ground floor toilet unfortunately due to the constraints of the building it could not be adapted for the use of patients with mobility problems. However, the practice had made arrangements with the building next door for their patients should they need to use an accessible toilet facility.

The practice did not have a hearing loop installed, but had purchased an electronic ear trumpet for patients who were hard of hearing.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said they had not needed to use interpreters in the past, but could access one if required.

Access to the service

The practice's opening hours were: The practice's opening hours are – Monday to Friday 8.30am to 5.30pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the 111 NHS service.

Concerns & complaints

The practice had a complaints procedure. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction. Information about how to complain was on display in the practice leaflet.

From information received before the inspection we saw that there had been four complaints received in the 12 months prior to our inspection. We saw that the complaints had been analysed and actions had been identified to address these complaints. All had been rectified and staff had received training as a result.

Are services well-led?

Our findings

Governance arrangements

The principal dentist and the compliance manager ensured that all policies were updated on a regular basis. We saw a number of policies and procedures at the practice and saw they had been reviewed and where relevant updated in the year before the inspection visit.

We spoke with staff who said they understood their roles and could speak with any of the dentists if they had any concerns. Staff said they understood the management structure at the practice. We spoke with two members of staff who said the practice was a good place to work and they felt supported as part of the team.

We looked at a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment

Leadership, openness and transparency

Staff told us that the principal dentist or the compliance manager was easy to approach and contact either by telephone or email and always responded promptly when contacted.

The practice had conducted staff meetings and we looked at the meeting minutes for the last year. Topics discussed included, infection control, patient complaints and other procedural issues such as appointments and staffing.

Staff at the practice said there was a close team and they were able to express their views during daily chats. Staff said dentists were approachable and were available to discuss any concerns.

Discussions with different members of staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy and staff could demonstrate what they would do if they felt that they needed to raise any concerns if they had any issues with a colleagues' conduct or clinical practice. They told us how they would do this, if necessary, both internally and with identified external agencies.

Learning and improvement

We saw that the practice was carrying out a schedule of audits throughout the year. Records showed that audits had been completed over several years demonstrating a commitment to improvement. Regular auditing allowed the practice to identify both areas for improvement, and where quality had been achieved. This was particularly in respect of the clinical areas. Examples of completed audits included: a radiography (X-rays) audit conducted in January 2017. For each completed audit there was a summary sheet which identified the strengths and weaknesses. Therefore staff were able to analyse what improvements were required.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period.

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

The practice was open to suggestions from their patients and could demonstrate some improvements that had made as a result. The waiting area had been remodelled after patients had mentioned it was tired and could be more comfortable.

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the reception area. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box being used was specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. Results showed that the majority of patients, around 99% and sometimes 100%, who had completed feedback cards, had said they were likely or extremely likely to recommend the practice to family and friends.