Mr. Theo Visser

All Smiles Dental Practice - Lincoln

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 21 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found 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

All Smiles Dental Practice is a dental practice providing private dental care for adults with a small NHS contract to provide care for children. Where private treatment is provided some is provided under a fee per item basis and some under a dental insurance plan. The practice is situated in a converted domestic property.

The practice has three dental treatment rooms, one on the ground floor and two on the first floor. There were two separate decontamination rooms, one on the ground floor and one on the first floor, where cleaning, sterilising and packing dental instruments takes place. There is also a reception and a waiting area on both floors as well as other rooms used by the practice for office facilities and storage. The practice is open from 8.45am to 5.30pm Monday to Friday and closes for lunch each day from 1.00pm to 1.45pm.

The practice has two dentists who are able to provide services including the provision of dental implants (a dental implant is a metal post that is placed surgically into the jaw bone to support a tooth and endodontic (root canal) treatment. They are supported by three dental nurses, a trainee dental nurse, a dental hygienist and a practice manager. Other staff included a dedicated receptionist.

Summary of findings

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent CQC comment cards to the practice for patients to complete to tell us about their experience. We also spoke with patients on the day of our inspection. We received feedback from 41 patients. These provided a very positive view of the services the practice provides. Patients commented on the high quality of care, the friendliness and thoughtfulness displayed by staff, the cleanliness of the practice and the professionalism of all staff.

Our key findings were:

- Patients commented that they received excellent care, staff went above and beyond what was expected, were professional at all levels and appointments were easily available and flexible.
- The practice was visibly clean and well maintained.
- The practice had suitable facilities and was well equipped to treat patients and meet their needs, with the exception of the availability of a hearing loop which was purchased following our inspection.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- We found that staff reported incidents and accidents which were investigated and learning implemented to improve safety. There was a log of significant events in place which helped to identify any themes or trends and illustrate what actions had been taken.
- We found that risks were assessed and mitigating actions implemented where appropriate. However the practice did not have a fire risk assessment in place but this was undertaken after our inspection.
- The practice had available medicines and equipment for use in a medical emergency which were in accordance with national guidelines.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Governance arrangements were in place for the smooth running of the service.

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

- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the refrigerator temperature is monitored and recorded.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).

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.

The practice had a system in place to identify, investigate and learn from significant events.

There were sufficient numbers of suitably qualified staff working at the practice.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

Use of X-rays on the premises was in line with the Regulations.

Infection control procedures were in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health, with the exception of the arrangements for hand hygiene in one of the decontamination rooms. However the practice carried out a risk assessment of this and implemented a protocol to mitigate the risks. Infection control procedures were audited to ensure they remained effective.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The clinicians used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

Staff demonstrated a commitment to oral health promotion.

The staff received on-going professional training and development appropriate to their roles and learning needs.

Clinical staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

The practice had a process in place to make referrals to other dental professionals when appropriate to do so.

Are services caring?

No action

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

We received feedback from 41 patients and these provided an extremely positive view of the service the practice provided. Comments reflected that the quality of care was very good.

Patients commented on the considerate, attentive and welcoming nature of the staff.

We saw that treatment options were explained to patients in order for them to make an informed decision.

Summary of findings

We observed that patients were treated with dignity and respect and we were given examples of instances when staff had gone out of their way to help or support patients.

The confidentiality of patients' private information was maintained. Treatment doors were left open during treatment if this was the patient's preference.

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 ground floor treatment room was accessible for patients using wheelchairs, or with prams or pushchairs.

The practice had access to telephone interpreter services should they be required.

Patients said they were easily able to get an appointment and patients who were in pain or in need of urgent treatment were seen on the same day.

There was information available to support patients to raise complaints. There had only been one complaint in the last year and we found this had been responded to in a timely way. When complaints had been made they were responded to appropriately. It had been fully discussed in the practice and lessons had been learnt from the complaint and action taken as a result to improve the service.

Are services well-led?

No action

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

There was strong and effective leadership within the practice provided by the principal dentist and practice manager. Staff were clear about their role and responsibilities. When issues arose they were dealt with promptly.

The practice had policies and protocols in place to assist in the smooth running of the practice.

Clinical audit was used as a tool to highlight areas where improvements could be made.

There was an open culture within the practice and staff were well supported and able to raise any concerns within the practice.

Feedback was obtained from patients in order to monitor satisfaction.

All Smiles Dental Practice - Lincoln

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

We carried out an announced, comprehensive inspection on 21 October 2016. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We reviewed information we held about the practice prior to our inspection.

During the inspection we spoke with the principal dentist and the associate dentist, the practice manager, the lead dental nurse, two dental nurses, the hygienist and the receptionist.

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents
The practice had systems in place to report, investigate and learn from significant events, incidents and accidents. Events were recorded on either an incident or significant event form, which recorded the investigation, discussion and learning from the event. We saw evidence that events were discussed at practice meetings and learning from them implemented. For example following an incident at the reception desk, panic alarms had been introduced to increase security for staff. There had been eleven significant events or incidents recorded in the last 12 months. We discussed with the practice manager the reason for having both an incident and a significant event form in use and they told us that going forward they would use only the significant event form to avoid confusion. There was a log of significant events in place which helped to identify any themes or trends.

The practice manager had an awareness of the Duty of Candour and this was encouraged through the significant event reporting and complaint handling process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

We discussed with the practice manager their responsibility in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice were aware of when a report should be made and accident forms were available which aided staff to consider when a report was necessary.

The practice did not have a system to receive alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Following our inspection the practice manager provided evidence that they had taken action to address this and had implemented a system to log and action any alerts received.

Reliable safety systems and processes (including safeguarding)
The practice had policies in place for safeguarding children and vulnerable adults which were dated August 2016. These identified the practice manager as the safeguarding lead for the practice and gave guidance to staff on safeguarding issues. It also contained relevant local contact details needed to raise a concern outside of the practice with the appropriate authority.

We saw evidence that all staff had received safeguarding training to the appropriate level for their role and minutes of practice meetings showed that the principal dentist had discussed safeguarding with staff, including how to identify safeguarding concerns.

The practice had an up to date annual employers' liability insurance certificate, which was displayed in the practice. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Discussions with dentists identified the dentists were using rubber dams when providing root canal treatment to patients. This was in line with guidance from the British Endodontic Society. A rubber dam is a thin, square 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 (treatment involving the root canal of the tooth) 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.

We spoke with staff about the procedures to reduce the risk of sharps injury in the practice. The infection control lead had carried out a risk assessment in August relating to the type of sharps used. This identified the need to use 'safer sharps' in line with the requirements of the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation. We saw evidence that the practice were in the process of ordering new sharps to comply with this.

Medical emergencies
The dental practice had medicines and equipment in place to manage medical emergencies. These were stored securely and staff we spoke with were aware how to access them. Emergency medicines were available in line with national guidance.

Equipment for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). 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.

There was a system in place to ensure that all medicines and equipment were checked on a monthly basis to confirm they were in date and serviceable should they be required. We pointed out that national guidance recommended that these checks were made weekly and the practice manager advised us that they would put this in place.

All staff had undertaken basic life support training at appropriate intervals and the staff also undertook sessions within the practice to carry out role play of emergency situations in order to refresh their training. To facilitate this training the practice kept a spare kit of equipment.

We found the airways which were part of the emergency equipment were out of date but it transpired that they were the airways from the practice kit and they had accidentally been mixed up. This was rectified immediately.

Staff recruitment

We reviewed four staff recruitment files and found that some recruitment checks had been undertaken prior to employment. Files did not consistently contain references, qualifications or photographic proof of identification. However all files contained registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. (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). The practice had introduced a new recruitment policy in September 2016 which outlined that going forward for any newly recruited members of staff the appropriate documentation would be sought. Following our inspection the practice provided evidence that they now held photographic identification for all staff members.

Monitoring health & safety and responding to risks

The practice had systems in place to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had a health and safety policy which was dated September 2016. This was displayed in the staff room and had been signed by all staff to acknowledge that they had read and understood it. The practice had a health and safety law poster on display in the staff room.

Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

A health and safety risk assessment had been carried out in September 2016 and included risk assessments for slips, trips and falls, blood and saliva, sharps, clinical waste disposal, the autoclave and radiation.

We found that no fire risk assessments had been undertaken by the practice. However following our inspection the practice provided us with evidence that a fire risk assessment had been undertaken. No actions were identified as a result of this. Staff had received in house fire safety training and there were appointed fire marshals. We saw that a fire drill had last been undertaken in July 2016 and these were scheduled to take place twice a year. There was evidence of annual servicing of the fire alarm system and equipment and records of weekly tests of the emergency lighting and the fire alarm.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a comprehensive file of information pertaining to the hazardous substances used in the practice with a COSHH policy, risk assessments and safety data sheets for each product which detailed actions required to minimise risk to patients, staff and visitors.

The practice had a limited business continuity plan in place. It did not give guidance in the event of a major incident such as computer loss, power failure or flood and did not include staff details or contact numbers for contractors which may have been required in the event of an incident. Following our inspection the practice provided a revised continuity plan which included these details.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

Are services safe?

The practice had an up to date infection control policy in place which gave guidance on areas which included the decontamination of instruments and equipment, hand hygiene, sharps, waste disposal and environmental cleaning of the premises.

The decontamination process was performed in two dedicated decontamination rooms, one on the ground floor and another on the first floor. We observed the process being carried out by a dental nurse. The decontamination room on the first floor was small and there was not room for a handwashing sink as well as a sink for washing instruments. This was not in line with HTM 01-05. This was managed by using the hand wash sink in the treatment room. Following our inspection the principal dentist provided us with a risk assessment relating to the current arrangements for hand hygiene and possible contamination of sterilised instruments. They also provided a new protocol which incorporated the management of hand hygiene in this area.

Instruments were cleaned manually in a dedicated sink before being further cleaned in an ultrasonic bath (this is designed to clean dental instruments by passing ultrasonic waves through a liquid). Instruments were sterilised in an autoclave and then inspected under an illuminated magnifier. HTM 01-05 recommends the use of an illuminated magnifier to see residual contamination, debris or damage, prior to sterilisation. We pointed this out to the dental nurse and they immediately put a process in place to rectify this. The practice manager told us they would review their protocol and ensure that the correct process was followed. After sterilisation the instruments were either packaged, sealed and dated or returned to the surgery in a coded, sealed box if they were for use that day. The practice checked the dates on packaged instruments every six months to ensure the dates had not been exceeded. We saw that the required personal protective equipment was available and worn throughout the process.

The practice had a policy in place for dealing with blood borne viruses. We saw records which showed that clinical staff had received inoculations against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact) and had received blood tests to check the inoculation was effective. 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.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health publication, Health Technical Memorandum: (HTM 07-01) Safe Management of Healthcare Waste. We observed that sharps containers, clinical waste bags and general waste were used and stored in accordance with current guidelines, with the exception that one sharps container which was not signed and dated. The National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care' advise – "sharps boxes should be replaced every three months even if not full." Signing and dating would allow the three month expiry date to be identified.

The practice manager told us they would ensure this was rectified.

The practice used an appropriate contractor to remove clinical waste from the practice. This was stored securely at the rear of the premises prior to collection by the waste contractor. We saw the appropriate waste consignment notes. (When hazardous waste is moved it must be accompanied by correctly completed paperwork called a consignment note.)

Practice staff told us how the dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. We saw that a Legionella risk assessment had been carried out by an external contractor and this had last been reviewed by the practice in October 2015. The recommended procedures contained in the report were carried out and logged appropriately. Control measures such as running the shower on a weekly basis and monthly water monitoring checks were carried out. The monthly water checks had identified that the temperatures were sometimes out of range and the practice had taken steps to address this.

We saw that the three dental treatment rooms, waiting areas, reception and toilets were clean, tidy and clutter free. Hand washing facilities were available including liquid

soap and paper towel dispensers in each of the treatment rooms, one of the decontamination rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice.

Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The practice had contracted with a cleaning company to carry out daily cleaning tasks in line with their cleaning schedule and used a colour coding system for cleaning equipment which conformed with national guidance. The practice manager told us that the cleaning company carried out cleaning of the carpets in the practice but this was not reflected in the cleaning schedule. The practice manager added this to the cleaning schedule, with a deep clean to be carried out on a six monthly basis.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in accordance with the Pressure Vessel Regulations 2000. The practices' X-ray machines had been serviced and calibrated as specified under current national regulations. Portable appliance testing (PAT) had been carried out in June 2016.

The practice had maintenance contracts in place to ensure equipment was maintained, serviced and tested at the appropriate intervals.

We found that the glucagon which the practice held for emergencies was being stored in the refrigerator. (Glucagon is a hormone which helps to raise blood glucose levels. A glucagon injection kit is used to treat episodes of severe hypoglycemia, where a patient is either unable to treat themselves or treatment by mouth has not been successful). However the temperature of the refrigerator was not being monitored to ensure a temperature of 2-8o C was being maintained. Glucagon can be stored outside of a refrigerator but with a shortened expiry date of 18 months. Following our inspection the practice provided evidence that a refrigerator thermometer had been purchased in order to monitor the temperature.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice had an intra-oral X-ray machine in each of the two treatment rooms; these can take an image of one or a few teeth at a time. The practice displayed the 'local rules' of the X-ray machine in the room where each X ray machine was located.

The practice used exclusively digital X-rays, which were available to view almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

The practice kept a well maintained radiation protection file which contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor. The records demonstrated that the X-ray machines had undergone testing and servicing in line with current regulation.

Clinical staff were up to date with radiation training as specified by the General Dental Council. The justification for taking an X-ray as well as the quality grade, and a report on the findings of that X-ray were documented in the dental care record.

We saw evidence of detailed rolling audits which had been discussed and action plans agreed in order to monitor and improve quality.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with both dentists who demonstrated their awareness of National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines in relation to lower wisdom tooth removal. However one of the dentists did not appear to be aware of the NICE guidance in relation to dental recall intervals between oral health reviews which recommends that intervals should be determined specifically based on risk for each patient. Their recall intervals between recalls tended to be a standard six months.

The dentists we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentists described and showed us records which confirmed how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire and we noted that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

Patients were presented with clear treatment options and we saw evidence of the advantages, disadvantages and costs being explained. Patient choice was respected.

Dental care records that were shown demonstrated that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).

We saw that patients considering implants were offered alternative options, costs were clearly explained and patients were given the right information both before and after the treatment post and preoperative guidance was robust.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive. A justification, grade of quality and report of the X-ray taken was documented in the dental care record.

Health promotion & prevention

The practice was committed to and focussed on the prevention of dental disease and the maintenance of good oral health and actively promoted this. One of the dentists was not aware of the Department of Health guidelines on prevention known as 'Delivering Better Oral Health: an evidence based toolkit for prevention.' This is used by dental teams for the prevention of dental disease in a primary and secondary care setting. However the records we reviewed indicated they were practicing in line with the guidance.

Appointments were available with a hygienist in the practice four days a week to support the dentists in delivering preventative dental care. We saw there was good communication between the dentists and the hygienist.

We saw evidence of dentists providing fluoride varnish applications for children (Fluoride varnish is a material that is painted on teeth to prevent cavities or help stop cavities that have already started). High concentration fluoride toothpaste was prescribed to high risk patients.

Smoking and alcohol use were recorded on medical history forms and oral hygiene assessments were made during examinations. Clinicians used this information to discuss oral health, the effects of alcohol consumption and referrals to smoking cessation services were offered. A wide range of health promotion leaflets and information was available in both waiting rooms.

We reviewed a sample of dental care records which demonstrated dentists had given appropriate oral health advice to patients. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the waiting room.

Staffing

The practice was staffed by two dentists, one of whom was full time and the principal dentist who worked clinically four days a week ; They were supported by a dental hygienist four days a week, three qualified dental nurses, a trainee dental nurse, a dedicated receptionist and a practice manager. Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). On the day of our inspection we also saw evidence of current professional indemnity cover for all relevant staff.

Are services effective?

(for example, treatment is effective)

Staff turnover was low and patients commented on how staff put them at their ease as well as being professional. We found that staff had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dental professionals.

Clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding. Staff had been encouraged to undertake extended duties. For example the lead dental nurse had undertaken an impression taking course, X-ray training and was an oral health educator.

Working with other services

The practice had an effective system in place to accept referrals for endodontic treatment and implants. The dentists were also able to refer patients to a range of specialists in primary and secondary services if the treatment required was not available in the practice. We found there was good communication between the practice and other providers to whom they made referrals.

The practice also had a system in place to track and follow up urgent referrals to ensure patients were seen in a timely manner.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The MCA had been discussed in practice meetings and the practice manager told us they planned to arrange online training regarding the MCA. Staff demonstrated an understanding of the MCA and how this applied in considering whether or not patients had the capacity to consent to dental treatment.

There was a consent policy in place dated August 2016. We found that the dentists had a clear understanding of consent issues and that they explained different treatment options and gave the patient the opportunity to ask questions before giving consent. Staff we spoke with also demonstrated their understanding regarding Gillick competence which relates to children under the age of 16 being able to consent to treatment if they are deemed competent.

We found that in the case of complicated procedures the dentists gained written consent, gave lengthy explanations to inform the patient's choice and allowed a period of time for the patient to consider their decision. Leaflets were also available relating to certain treatments which patients could take away to further inform their decision in their own time.

Are services caring?

Our findings

Respect, dignity, compassion & empathy
Before our inspection, Care Quality Commission (CQC) comment cards were left at the practice to enable patients to tell us about their experience. We also spoke with patients on the day of our inspection and in total received feedback from 43 patients. The feedback gave a wholly positive view of the service provided by the practice. Patients told us they were extremely satisfied with the quality of care they had received and commented that all staff treated them with dignity and respect. Staff were described as kind, sensitive, welcoming and caring. During the course of our inspection we observed staff interacting with patients and noted that they were caring and respectful.

On the day of our inspection we saw that surgery doors were left open during consultations and patients we spoke with commented that this was their preference. Staff told us that patients were always asked whether they preferred to have the door open or closed during their treatment.

The confidentiality of patients' private information was maintained as patient care records were computerised and all the computers were password protected. Paper records were kept securely. Practice computer screens were not visible at reception which ensured patients' confidential information could not be seen.

The practice had considered the issue of confidentiality at the reception desk and told us that patients were advised they could have a private conversation in another room if required.

We were given examples of when the practice had sent cards to patients following events such as bereavement or the birth of children.

The practice manager called patients as a matter of course following any complicated treatment or for anxious patients who had received treatment.

Involvement in decisions about care and treatment
From our discussions with dentists, extracts of dental care records we were shown and feedback from patients it was apparent that patients were given clear treatment plans which contained details of treatment options and the associated cost.

A comprehensive price list of treatments was available in the patient information folders in the waiting rooms and this was also available on the practice website.

Patients we spoke with and those who completed comments cards were positive about their involvement in their care and treatment. Comments included that they were never rushed; felt listened to and had the right information and sufficient time to make an informed decision about their treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we toured the premises and found that the practice had appropriate facilities and was well equipped to treat patients and meet their needs.

We looked at the variety of information available to patients. We saw that the practice waiting areas displayed a range of information in the patient information folders as well as in leaflet form which patients could take away with them. Information was also available on the practice website. This included the services offered by the practice, health promotion, complaints information and the cost of treatments, opening hours and emergency arrangements for both when the practice was open and when it was closed. The practice website also contained comprehensive information for patients about different types of treatments available at the practice.

We reviewed the appointment system and saw that sufficient time was given for each type of appointment to allow for adequate assessment and discussion of patients' needs.

Patients commented that they were able to get appointments easily; they did not usually have to wait to be seen beyond their appointment time and were seen on the same day if their need was urgent.

The practice had links with the local university and treated their overseas students.

Tackling inequity and promoting equality

Practice staff told us that they treated all patients equally while accommodating their individual needs.

Staff we spoke with were able to give us examples of how the practice had made reasonable adjustments to enable patients such as those with limited mobility or other issues to access their services. There was a small step at the entrance of the premises. We saw that there was a removable ramp available should it be required. Additionally any patients who needed to use the ramp were identified on their patient record which enabled staff to have the ramp ready when the patient was due to arrive for their appointment. There was a window in front of the reception desk which allowed the receptionist to see patients approaching the entrance and provide assistance if required.

Patient records identified requirements such as the need to be seen in the ground floor treatment room for patients who had difficulty using the stairs to the first floor. Appointments were booked accordingly in the ground floor treatment room for these patients.

The practice had access to an interpreting service to support patients whose first language was not English, but had not yet had to use this facility. The practice did not have an induction hearing loop to assist hearing aid users. However following our inspection we saw evidence that a hearing loop had been purchased by the practice.

The practice manager gave us an example of how they had attended a hospital dental appointment to support a patient with a disability. The patient was anxious as they were unable to have their treatment at the practice due to their condition.

Access to the service

The practice was open from 8.45am to 5.30pm Monday to Friday and closed for lunch each day from 1.00pm to 1.45pm.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised on the practice website and through the telephone answering service when the practice was closed.

The practice manager told us they would always arrange to see a patient on the same day if they were in pain or it was considered urgent. Many comments from patients reflected this and described how the practice went out of their way to accommodate patient's needs.

The practice operated a telephone reminder service for patients the day before their appointment with the dentists.

Concerns & complaints

The practice had an effective system in place for handling complaints and concerns.

The complaints policy and procedures were in line with recognised guidance and contractual obligations for dentists in England. The practice manager was the designated person responsible for handling all complaints in the practice.

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system including advocacy support. This was available in the patient information folders in the waiting rooms. There was no information relating to complaints available on the practice website.

We looked at the one complaint which had been received in the last 12 months and found it had been satisfactorily handled in a timely way. Lessons had been learnt from the complaint and action taken as a result to improve the quality of care. We saw evidence that the complaint had been fully discussed at a practice meeting with all staff present in order to share the learning.

Are services well-led?

Our findings

Governance arrangements
There was a governance framework in place which provided a staffing structure whereby staff were clear about their own roles and responsibilities.

Practice specific policies were available which had been signed by staff to acknowledge they had read and understood them and included review dates. We looked at policies which included those which covered infection control, health and safety, complaints and safeguarding children and vulnerable adults.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. At the time of our inspection the practice did not have a fire risk assessment but this was undertaken after our inspection.

Leadership, openness and transparency
The leadership team within the practice consisted of the principal dentist and the practice manager. Staff told us they felt able to raise concerns. Staff we spoke with told us they felt they made a good team and supported each other. This was apparent in their interactions with each other and attitudes on the day of our inspection.

The practice staff were aware of the Duty of Candour and this was demonstrated in the records we reviewed relating to incidents and complaints. For example the patient who had complained had received an apology.

We saw evidence of monthly staff meetings and clinical meetings which staff were encouraged to participate in fully. There was a system in place whereby any member of staff could add to the meeting agenda on an ongoing basis throughout the month. The meetings had a set agenda, were minuted and were available for staff unable to attend.

Learning and improvement
There was an effective programme of clinical audits in place in order to monitor quality and to make improvements. We reviewed the most recent infection control audit which had been carried out in May 2016. This had identified the need for safer sharps and an action plan had been produced to address this. There was also an audit of clinical record keeping and detailed ongoing audits of X-ray quality. We were shown a waiting time audit which had been carried out in September 2016 reviewing the period from September 2015 to September 2016. The findings showed that on the occasions when a patient had to wait for their appointment the waiting time was no more than seven minutes.

The provider had commissioned an external audit of the whole practice in August 2016 in order to identify any areas for improvement and actions had been implemented as a result. For example, implementing new policies.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that clinical staff were up to date with the recommended CPD requirements of the GDC.

The lead dental nurse had been supported to undertake additional training in order to extend her role.

The practice ensured that all staff underwent regular training in cardio pulmonary resuscitation (CPR), infection control, safeguarding of children and vulnerable adults and dental radiography (X-rays), where appropriate. Staff development was by means of internal training, staff meetings and attendance on external courses.

We were shown evidence that staff had undergone regular appraisal where appropriate, which were used to identify staff learning needs.

Practice seeks and acts on feedback from its patients, the public and staff
The practice participated in the NHS Friends and Family Test, the results of which gave an indication of how well they were performing. We looked at the results from June to September 2016 which indicated that from 55 responses 54 patients said they were extremely likely to recommend the practice. There was also a suggestion box in the waiting area for patients to leave any comments. We were told patients' feedback was discussed and acted upon. There was a book in reception for patients to make comments. These were positive and commented for example on how patients liked the 'open door' system in treatment rooms.

It was apparent from the minutes of practice meetings that staff were able to raise any issues for discussion which were acted upon. Staff were also confident to discuss suggestions informally.