Woodcote Dental Practice Limited

Woodcote Dental Practice

Inspection Report

7 Surrey Court
55 Woodcote Road
Wallington
Surrey
SM6 0PN
Tel: 020 8647 1081
Website: http://www.woodcotedental.co.uk

Date of inspection visit: 3 March 2016
Date of publication: 08/04/2016

Overall summary

We carried out an announced comprehensive inspection on 3 March 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

The Woodcote Dental Practice is located in the London Borough of Sutton. The premises are situated on the ground floor beneath a block of flats. There are two treatment rooms, an autoclave room, waiting room, administrative office, and a patient toilet.

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

The staff structure of the practice consists of a principal dentist, an hygienist, two dental nurses and a receptionist.

The practice opening hours are from Monday to Friday from 9.00am to 5.00pm.

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

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

Summary of findings

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

Our key findings were:

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff knew how to report incidents and how to record details of these so that the practice could use this information for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced. However, we found that the oxygen cylinder for use during medical emergencies was out of date and needed replacing.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- Staff were working towards completing continuing professional development (CPD) standards set by the General Dental Council (GDC). However, improvements could be made to ensure that all staff were up to date with training in responding to medical emergencies and safeguarding vulnerable adults and children.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements were in place for the smooth running of the practice; however the practice had not carried out a recent audit of infection control protocols in line with national guidance.

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

- Review the availability of equipment, and the frequency of staff training, for managing medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review staff training to ensure that all of the staff had undergone relevant training, to an appropriate level, in the safeguarding of children and vulnerable adults.
- Review staff awareness of Gillick competency and ensure all staff are aware of their responsibilities.
- Review the practices' current Legionella risk assessment and implement the required actions 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'
- Review the practice's audit protocols, such as those for infection control and dental care records, with a view to monitoring and improving the quality of service. The practice should also check that where appropriate, audits have documented learning points, which are shared with all staff, and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of infection control and medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse.

There were some areas where improvements could be made to safety systems. For example, some items of equipment required for use in medical emergencies needed renewing. The Legionella risk assessment also needed to be reviewed to understand the wider implications of shared plumbing at the location.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. The practice maintained appropriate dental care records and details were updated appropriately. The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Clinical staff worked towards meeting professional standards and had engaged in some continuing professional development (CPD) training. Staff told us they were well-supported by the principal dentist through informal supervision and ad hoc staff training meetings. However, improvements could be made to ensure that all staff were up to date with some key training topics, including responding to medical emergencies and safeguarding vulnerable adults and children.

Are services caring?

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

We received positive feedback from patients through comment cards and by speaking with patients on the day of the inspection. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all. For example, the practice had made arrangements to ensure that it could be accessed by people using wheelchairs through the use of a portable ramp.

There was a complaints policy in place; we were told no complaints had been received in the past year. Patient feedback, through the use of a quarterly annual patient satisfaction survey, was used to improve the quality of the service provided.

Summary of findings

Are services well-led?

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

The practice had clinical governance and risk management structures in place. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose. However, improvements could be made to strengthen the governance structures and protocols, for example, by ensuring staff training needs were reviewed and infection control audits were carried out in line with published guidance.

Woodcote Dental Practice

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 3 March 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

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

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was a system in place for reporting and learning from incidents. There had not been any significant events related to patients in the past year. There was a written policy which described what types of events might need to be recorded and investigated. We discussed the investigation of incident with the principal dentist. They confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any accidents recorded in the past 12 months.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for children and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a safeguarding policy which referred to national guidance. However, information about the local authority contacts for safeguarding concerns were not held at the practice. We discussed potential safeguarding scenarios with all members of staff. They all demonstrated a good working knowledge of what types of concerns would need to be raised and investigated.

The hygienist had completed safeguarding training, to an appropriate level, in 2015. The principal dentist and one of the dental nurses had completed safeguarding training in 2012 and 2013 respectively. They were aware that this training now needed renewing. The receptionist also told us that they had recently discussed the need to complete Level 1 training in safeguarding children with the principal dentist, but that they had yet to do this.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of sharps injuries. Local anaesthetic was administered using a small, computer-controlled handpiece for delivering local anaesthetic. The dentist used a new needle and tubing for each patient. After use, the dentist disposed of the equipment directly into a sharps bin. We were told that the system prevented the need for resheathing needles during the delivery of local anaesthetics and thus helped minimise the risks to staff associated with the procedure.

The practice followed other national guidelines on patient safety. For example, the principal dentist told us they used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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. Rubber dams should be used when endodontic treatment is being provided. On the 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 practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as portable suction. (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). However, the oropharyngeal airway equipment was past its use by date and needed replacing, and self-inflating air bags were also not available in line with the Resuscitation Council UK guidelines. We found that the oxygen cylinder was past its use by date (2012) and needed replacing. We discussed this with the principal dentist who assured us these items would be ordered promptly; they confirmed on the day of the inspection that a new oxygen cylinder had been ordered.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff.

The principal dentist and dental nurses had attended training in managing medical emergencies in 2014 and it was valid for three years. We also noted that all staff had reviewed their knowledge of how to respond to medical

emergencies either through the use of an online training course, or at a full day training session, in 2015. Since that time, a new AED had been purchased by the practice. We discussed with the principal dentist the current national recommendations that emergency training be renewed on an annual basis, and the need for staff to be trained in how to use the new AED. They assured us that such training would now be completed.

Staff recruitment

The staff structure of the practice consists of a principal dentist, an hygienist, two dental nurses and a receptionist.

The practice had recruited three new staff members during the past two years. There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

We checked the staff recruitment records and saw that the majority of relevant documents had been suitably obtained prior to staff commencing employment. This included checks of professional registration, immunisation history, and identification. It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of staff prior to employment and periodically thereafter. (The 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). All of the staff recruitment records held information demonstrating that a DBS check had been carried out.

However, not all records contained copies of relevant qualifications, employment history, or references. The principal dentist sent us evidence via email on the day after the inspection demonstrating that a review of qualifications and employment history had been carried out for all members of staff.

The principal dentist told us that two of the newer members of staff were well known to them over a number of years through either work or educational settings and that therefore they had not sought references for them. We noted that written references had been obtained for one other newly recruited staff member.

Monitoring health & safety and responding to risks

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

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

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

There was an arrangement in place to direct patients to another local practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts in the local area were kept up to date at the reception desk in the event that a maintenance problem occurred at the premises.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The principal dentist was the infection control lead. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste.

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment room, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked one of the dental nurses to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had followed the guidance on decontamination

and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

The practice used an autoclave room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually cleaned in one of the treatment rooms. Cleaned instruments were inspected under a light magnification device and then placed in a lidded, transportation box. Items were then transported to the dirty area in the autoclave (steriliser) room and placed in the autoclave. When instruments had been sterilized, they were placed in another ('clean') lidded box, transported back to the treatment room, and pouched and stored appropriately, until required. All of the pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclave was working effectively. These included, for example, the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location outside the practice prior to collection by the contractor. Waste consignment notices were available for inspection. Environmental cleaning was carried out using cleaning equipment in accordance with the national colour coding scheme.

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. (People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.)

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by principal dentist within the past two years. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis. However, we noted that the practice was located within a larger building with some shared plumbing systems. The Legionella risk assessment had not taken into account these additional systems. We discussed this with the principal dentist who assured us they would investigate the implication of the shared plumbing for their risk mitigation processes.

We also found that the practice had not carried out practice-wide infection control audits every six months in line with HTM 01-05 guidance. We spoke with the principal dentist about this issue and they told us that this audit would now be carried out.

Equipment and medicines

We found that the majority of the equipment used at the practice, was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced.

Are services safe?

We noted that the practice had carried out an in-house inspection of their portable appliances (Portable appliance testing; PAT), although staff had not been trained in carrying out these types of testing procedures. (PAT is the name of a process during which electrical appliances are routinely checked for safety)

The expiry dates of medicines and equipment were monitored using monthly check sheets which enabled the staff to replace out-of-date drugs and equipment promptly. However, the oxygen cylinder was past its use by date and had not been replaced. . The current equipment checking system had not identified this issue.

Radiography (X-rays)

There was a radiation protection file in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules. We also saw evidence that staff had completed radiography and radiation protection training. Audits on X-ray quality were undertaken at regular intervals.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed 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 were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). These were carried out, where appropriate, during a dental health assessment.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The principal dentist told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice for the maintenance of good oral health. They were aware of the need to discuss a general preventive agenda with their patients including, where appropriate, smoking cessation and sensible alcohol use. The dentist also carried out examinations to check for the early signs of oral cancer.

There was a hygienist working at the practice. Where required, the dentist referred patients to the hygienist to further address oral hygiene concerns.

We observed that there were health promotion materials displayed in the waiting room, administrative office and treatment rooms. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the training records of all staff and saw that all staff had engaged in continuing professional development (CPD) with a view to meeting the requirements of the General Dental Council. This included responding to emergencies, infection control, safeguarding training and radiography and radiation protection training. However, we noted that some training required renewing, including training in safeguarding and use of the automated external defibrillator (AED). The principal dentist was aware of these issues and assured us that such training would be completed as soon as possible.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

The principal dentist held regular supervision and review meetings with each member of staff. This provided staff with an opportunity to discuss their current performance as well as their career aspirations. Notes from these meetings were kept in each staff member's file.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The principal dentist explained how they worked with other services, when required. The dentist was able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice made referrals to other specialists for more complicated extractions and for orthodontic treatments.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral form was prepared and sent to the hospital with full details of the dentist's

Are services effective?

(for example, treatment is effective)

findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. A copy of the referral form was always available to the patient if they wanted this for their records. The principal dentist told us that they had not had any patients report difficulties with accessing services that they had been referred to; the practice therefore had not proactively monitored referral times for patient. However, the principal dentist assured us that the outcomes of treatments received by their patients at other services were reviewed with the patient when they next visited the practice.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke to the principal dentist about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

All of the staff we spoke with were aware of the Mental Capacity Act 2005. (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 principal dentist could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met. However, improvements could be made to ensure increased staff awareness of the Gillick competence test for young people, under the age of 16 years, who may wish to access dental care services without being accompanied by an adult.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received, and the patients we spoke with, all made positive remarks about the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the waiting room and administrative office. We saw that the doors were closed at all times when patients were having treatment. Conversations between patients and the dentist could not be heard from outside the rooms, which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received in-house training in information governance. Patients' dental care records were stored in a paper format in locked filing cabinets.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area and on its website which gave details of the private dental charges or fees.

We spoke with the principal dentist, hygienist, dental nurse and the reception staff on the day of our inspection. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentist recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, and through speaking with patients on the day of the inspection, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' dental needs. The principal dentist decided on the length of time needed for their patient's consultation and treatment. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting room displayed a variety of information including opening hours and guides to different types of dental treatments. The practice had a website which reinforced this information. New patients were given a practice leaflet which included advice about appointments, opening hours and the types of services that were on offer.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Reception staff told us they supported people to access the service and encouraged people to tell them what additional support they might need. They could provide written information for people who were hard of hearing and use large print documents for patients with some visual impairment.

The practice used a portable ramp to ensure that the treatment rooms could be accessed by patients in wheelchairs. There was also a handrail at the main entrance and in the patient toilet to support people with more limited mobility. The practice had explored the possibility of making further adjustments to improve access, but the landlord had not agreed that any further proposed changes were reasonable.

Access to the service

The practice opening hours are from Monday to Friday from 9.00am to 5.00pm.

We asked the receptionist and the principal dentist about access to the service in an emergency or outside of normal opening hours. They told us that any messages left on the answerphone were directed to the principal dentists' mobile phone so that they could call the patient back and determine their level of need. The dentist then either arranged to see the patient, or referred them to another service, depending on the outcome of their telephone assessment.

The reception staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had not been any complaints recorded in the past year.

Patients were also invited to give feedback through a quarterly patient satisfaction survey, a comments book and a suggestions box in the waiting room. The information received demonstrated that patients were satisfied with the care they received.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them. Records, including those related to patient care and treatment, as well as staff employment, were kept accurately.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes.

Staff told us that if any governance issues arose then these were dealt with promptly by convening an in-house training session to review protocols and improve the quality of the service. We saw notes kept from these meetings which showed that a range of issues had been discussed; these included the outcomes of patient surveys and audits as well as reviews of topics such as mental capacity and infection control.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. All of the staff we spoke with said that they felt comfortable about raising concerns with the principal dentist and that they were listened to and responded to when they did so. We found staff to be hard working, caring and committed.

We found staff to be hard working, caring and committed to their work and overall there was a sense that staff worked together as a team. There was a system of yearly staff appraisals to support staff in carrying out their roles to a high standard. Notes from these appraisals demonstrated that they identified staff's training and career goals.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for clinical record keeping and X-ray quality. The audits demonstrated a generally high standard of work with only small improvements required. We saw notes from meetings which showed that results of audits were discussed in order to share achievements or action plans for improving performance. However, although the practice used a daily checklist to monitor infection control processes, they had not carried out full infection control audits at the recommended six-monthly intervals. We raised this with the principal dentist who told us that these audits would now be implemented.

Staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC). . We found that some staff needed additional safeguarding training and all staff now needed training in use of the automated external defibrillator (AED). The principal dentist confirmed that the training needs of staff would be fully reviewed and any new training courses required would be identified and booked.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey, a suggestions box and comments book. The majority of feedback had been positive. However, we noted that the practice acted on feedback from patients where they could. For example, some people had made a suggestion regarding the provision of water in the waiting room. The principal dentist had taken action and drinking water was now available.

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