Petrie Tucker and Partners Limited

Mydentist - Old Road - Clacton-on-Sea

Inspection Report

129 Old Road
Clacton On Sea
Essex
CO15 3AW
Tel: 01255 222223
Website: www.idhgroup.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 16 July 2015 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.

The practice employs six dentists who undertake mainly NHS treatments with a small amount of private dental treatment. The practice offers conscious sedation for nervous patients.

The dentists are supported by a clinical support team consisting of seven dental nurses, four trainee dental nurses and two orthodontists. There is a practice manager, assistant practice manager, a reception manager and several receptionists. The practice has six surgeries, a dedicated decontamination room and several X-ray suites.

The practice is open Monday to Thursday between the hours of 8am and 8pm and Fridays between the hours of 8am until 5pm. They are also open Saturdays between 9am and 2pm.

We spoke with four patients during the inspection. They told us that they were very satisfied with the services provided, that the staff treated them with dignity and respect and the dentists provided them with a clear explanation of treatment including options and associated costs. They also commented positively on the efficiency of the nursing and reception staff.

We viewed CQC comment cards that had been left for patients to complete, prior to our visit, about the services

Summary of findings

provided. There were 40 completed comment cards and all of them reflected positive comments about the staff and the services provided, describing the clinical and support staff as kind and caring. The comments made in the CQC cards reflected that patients were extremely satisfied overall with the services provided at the practice. There was only one negative comment made and this related to a minor issue about the frequency of a follow-up visit.

The provider was providing care which was safe, effective, caring, responsive and well-led and the regulations were being met.

Our key findings were:

- The practice recorded and analysed significant events and complaints and cascaded learning to staff.
- Where mistakes had been made patients were notified about the outcome of any investigation and given a suitable apology.
- Staff had received safeguarding training and knew the processes to follow to raise any concerns.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment were readily available.
- Infection control procedures were effective and instruments cleaned and sterilised in line with published guidance. Infection control audits reflected that systems were robust.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- There was an effective complaints system and the practice displayed a duty of candour.
- The practice was well-led and staff felt involved and worked as a team.
- Governance systems were effective and there was a range of clinical and non-clinical audits to monitor the quality of services.
- The practice sought feedback from staff and patients about the services they provided.
- There was a consistent approach to learning from all the staff at the practice.

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 care which was safe in accordance with the relevant regulations. The practice had effective systems and processes in place to ensure all care and treatment was carried out safely. There were systems in place to record and analyse significant events and meetings were used to share learning with staff. All staff were aware of the procedures to follow and were encouraged to report them. Where mistakes had been made patients were offered suitable explanations and apologies. National patient safety and medicines alerts were acted upon in a timely manner and relevant staff advised of them accordingly. Staff had received training that met the needs of patients and an effective system was in place to monitor that it was being undertaken. Staff numbers were sufficient for the smooth running of the practice. Procedures for undertaking conscious sedation on nervous patients were safe and effective and subject to additional levels of training for staff carrying them out. Infection control procedures were robust and staff had received training. Infection control audits took place at intervals in line with guidance and reflected that procedures were effective. The systems for cleaning and sterilising dental instruments met Department of Health guidelines. Radiation equipment was suitably sited, maintained and used by trained staff only. Emergency medicines in use at the practice were stored safely and checked to ensure they did not go beyond their expiry dates. Fridges in use were monitored to ensure medicines in use were stored at the correct temperatures. Sufficient quantities of equipment were in use at the practice and serviced and maintained at regular intervals. The practice was able to respond to emergencies.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations. Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE). The dentists were all up to date with current dental guidelines. Patients received a comprehensive assessment of their dental needs including updating a medical history and monitoring gum conditions. Visual aids were shown to patients to support their understanding of oral health issues. Explanations were given to patients in a way they understood and treatment options were discussed and supported by written treatment plans. Nervous patients requiring conscious sedation received full explanations about the risks of the procedure and were allowed time to consider the procedure before consenting. Written information about the procedure was supplied to them. Staff were supported through training and annual appraisals. Dentists were the subject of peer review by a clinical support/ practice manager to ensure standards were being maintained and these were monitored. Patients were referred to other services in a timely way. Staff had an understanding of the Mental Capacity Act and Gillick competency in relation to children under the age of 16 years.

Are services caring?

We found that this practice was caring in accordance with the relevant regulations. Patients were treated with dignity and respect and their privacy maintained. Patient information and data was handled confidentially. Patients told us they were listened to, given time to decide upon treatment options and that treatment was clearly explained. Patients who had dental emergencies were seen in a timely manner, often on the same day. Staff had received training in customer care. CQC comment cards completed by patients rated the practice highly in this area. Patients felt involved in the decisions about their care and treatment and patient records contained details of decisions made. Patients undergoing conscious sedation were monitored closely and then followed up after the procedure to check on their welfare.

Summary of findings

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations. Appointment times met the needs of patients and waiting time was kept to a minimum. The practice remained open at lunchtimes and until 8pm four evenings each week. Saturday appointments were also available. A new telephone system had increased appointment efficiency and a touch screen check-in facility reduced queues at reception. The practice responded to patients in need of emergency dental treatment and saw them the same day when there was a need. The practice had a website which provided information about treatment costs, complaints procedure, opening hours and emergency care. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. Patients who had difficulty understanding care were given adequate support to understand treatment options. The practice handled complaints in an open and transparent way and apologised when things went wrong. The practice acted on patient feedback.

Are services well-led?

We found that this practice was providing care which was well led in accordance with the relevant regulations. The practice provided clear leadership and involved staff in their vision and values. Regional and area managers were visible and ensured that corporate standards were being met. Practice managers led by example, were supportive and took action when under performance was identified. Regular staff meetings took place and staff felt involved in the running of the practice. Meetings were minuted and there were clear audit trails when areas for improvement had been identified. There was a range of software that supported the practice in assessing and monitoring the services they provided. The audit programme and timetable was robust and re-audits reflected that improvements had been maintained. Staff were encouraged to develop and supported to maintain their training. There was candour, openness, honesty and transparency amongst all staff we spoke with. The practice sought the views of staff and patients. Health and safety risks had been identified which were monitored and reviewed regularly.

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Detailed findings

Background to this inspection

The inspection took place on 16 July 2015 and was conducted by a CQC inspector and a specialist dental advisor.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

We also reviewed the information we held about the practice and consulted with other stakeholders, such as NHS England area team / Healthwatch, however we did not receive any information from them.

During the inspection we spoke with two dentists, two dental nurses, the practice manager, the assistant manager, the reception manager and a receptionist. We reviewed policies, procedures and other documents. We also spoke with four patients. We reviewed comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice.

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 maintained clear records of significant events and complaints. Staff we spoke with were aware of the reporting procedures in place and said they were encouraged to bring safety issues to the attention of the practice manager.

We viewed four complaints and four significant events that had occurred in the last 12 months. We found that they had been accurately recorded and the issues were clear. Investigations had been thorough and where learning had been identified this had been cascaded to staff at team meetings or personally if required.

Where appropriate, patients had received and apology and an explanation and it was clear that the practice had displayed a duty of candour.

The practice had a system of managing national patient safety and medicines alerts that affected the dental profession. These were cascaded to clinical staff by email and action taken to identify patients at risk. There was evidence that they had been discussed at clinical meetings and dentists spoken with displayed a working knowledge of the issues raised by the alerts.

One such example was in relation to guidance about the sedation of young children and we saw that appropriate action had been taken.

Records we viewed reflected that the practice was following the guidance in relation to the control of substances hazardous to health (COSHH). Substances in use at the practice had been risk assessed and measures put in place to keep staff and patients safe.

Reliable safety systems and processes (including safeguarding)

Staff at the practice had received safeguarding training for children and vulnerable adults and the leads for safeguarding was one of the dentists and the practice manager. We spoke with several staff members and found that they were knowledgeable about the subject and knew the processes to follow in the event of an issue. Staff were also aware of the procedures to follow and who to contact at the practice or externally if the need arose. They felt confident that incidents they reported would be dealt with professionally.

Patients receiving conscious sedation treatment were required to attend the practice for a detailed consultation several days before receiving it. This consultation checked the patient's medical history and any allergies they may have to ensure it was safe to proceed and gave patients all the information they needed to understand the procedure, including the risks, options and benefits. On the day of our inspection, we spoke with three patients after their consultations and we were satisfied that their safety had been considered and that they had received clear explanations about the procedure.

During the actual procedure patients were monitored throughout by a qualified dentists, nurses and a dedicated anaesthetist who had received specific training in conscious sedation. Emergency medicines were readily available should there be a need and the vital signs of patients were monitored and recorded throughout the procedure. We looked at the records held for one patient and found that a detailed record had been maintained, including the batch number of the anaesthetic used.

Patients were also given post procedure guidance and if they were accompanied by a friend or relative, the after-care advice was also explained to them.

The dentists who we spoke with on the day all used non-latex rubber dam for endodontic procedures. A rubber dam is a thin, rectangular sheet of rubber, used in dentistry to isolate the operative site from the rest of the mouth. This prevents inhalation of small instruments during treatment. It was practice policy not to re-use rubber dams and dentists spoken with were aware of this requirement.

Patients attending for their consultation had their medical history reviewed on each occasion to ensure that any health conditions or medicines being taken could be considered before receiving care or treatment. Patients were asked to update their medical history forms when they attended for their appointments and these were checked by the dentist during the consultation.

Medical emergencies

Emergency medicines, a first aid kit and oxygen were readily available if required. The practice also had a

Are services safe?

defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), and all staff had been trained to operate it. The emergency equipment in use was in line with the 'Resuscitation Council UK' and 'British National Formulary' guidelines.

All staff had been trained in basic life support and were able to respond to a medical emergency. All emergency equipment was readily available and staff knew how to access it. Staff spoken with told us that mock emergency incidents had taken place periodically so that they could familiarise themselves with procedures.

We checked the emergency medicines and found that they were of the recommended type. All medicines were in date and monitored daily to ensure they did not go out of date or that stocks ran low. Records were being kept.

We were told that the practice had recently dealt with a serious medical emergency and had saved the life of a patient. This had involved the use of their emergency equipment and this incident reflected that they were prepared and able to deal with a medical emergency.

Staff recruitment

The practice had a recruitment policy that described the process when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant and the taking of references. It was practice policy to undertake Disclosure and Barring Service checks on all staff and personnel records we viewed confirmed this had taken place.

We looked at four staff files and found that the recruitment policy had been followed and all documentation had been obtained from new employees. New staff had been interviewed by the practice manager and/or the assistant practice manager and records of those interviews were available to view.

We spoke to the newest member of staff who confirmed with us that they had been required to provide relevant documents prior to being accepted for the role and that an interview had taken place. Recruiting procedures were robust and also monitored from the head office.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred, staff were contacted to attend the practice and cover for their colleagues. Where this was not possible agency staff, or qualified casual workers were used. Their qualifications, skills and experience were confirmed before being allowed to work at the practice.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This identified the risks to patients and staff who attended the practice. A regular health and safety audit took place at the practice to ensure the environment was safe for both patients and staff. Where issues had been identified remedial action had been taken in a timely manner.

There were a range of other policies in place at the practice to manage risks. These included infection prevention and control, a legionella risk assessment, fire evacuation procedures and the risks associated with Hepatitis B. Processes were in place to monitor and reduce these risks so that staff and patients were safe. The practice had an induction process for all new staff members and this included familiarisation with health and safety issues.

The practice was also able to demonstrate that they took immediate action when they identified a risk. One such occasion occurred recently when they had made use of the defibrillator in a medical emergency but did not have replacement adult chest pads. The practice realised that their defibrillator could not be used on an adult in an emergency until additional chest pads had been sourced. As a result of this they risk assessed their patient list to identify any patients who might have a heart condition. They then offered them an alternative appointment, an explanation and re-arranged their appointment. This was excellent practise and protected patients who might have had a health condition that made them vulnerable.

The practice had a business continuity plan that outlined the procedures to follow in the event that services were disrupted. This identified the steps to take so that the practice could maintain a level of service for the patients.

Infection control

Are services safe?

The practice was visibly clean, tidy and uncluttered. An infection control policy was in place and a lead had been identified. The policy included guidance on needle stick injuries, inoculations against Hepatitis B and the handling of clinical waste.

The policy also clearly described how cleaning was to be undertaken at the premises. Check lists were made available to support staff and the contract cleaner ensured each area of the practice was cleaned appropriately. The policy explained the types of cleaning and the frequency. Records held reflected that the quality of the cleaning was being monitored and feedback given accordingly and checklists were being completed.

During our inspection we visited three surgeries and found them to be visibly clean and tidy. The daily cleaning of each surgery was the responsibility of the dental nurses and they completed checklists to reflect that appropriate tasks had been undertaken. Dental nurses spoken with were aware of the infection control procedures in place and had received training. Sufficient quantities of personal protective equipment were available for clinical staff and we were told that clean surgical gloves and masks were worn for each patient.

Infection control audits had been carried out every six months and the results of these reflected that robust processes were in place. Where areas for improvement had been identified, these had been recorded then actioned. Appropriate staff had received infection control training and this was strictly monitored.

We found that there were adequate supplies of liquid soaps and hand towels throughout the premises and hand washing techniques were displayed. Sharps bins were properly located, signed and dated and not overfilled. A clinical waste contract was in place and this was stored securely until collection.

We looked at the procedures in place for the decontamination of used dental instruments. The practice had a dedicated decontamination room that was set out according to the

Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05):

Decontamination in primary care dental practices.

We found that instruments were being cleaned and sterilised in line with published guidance (HTM 01-05). On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures.

The practice cleaned their instruments using a washer/ disinfector, examined the instruments with a magnifying glass then sterilised them in an autoclave. At the end of the sterilising procedure the instruments were correctly packaged, sealed, stored and dated with an expiry date. We looked at the sealed instruments in the surgeries and found that they all contained an expiry date that met the recommendations from the Department of Health. Instruments designed for single use only were disposed of after use.

The decontamination room had clearly defined dirty and clean zones in operation to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

The equipment used for cleaning and sterilising was maintained and serviced as set out by the manufacturers. Daily, weekly and monthly records were kept of decontamination cycles and tests and when we checked those records it was evident that the equipment was in good working order and being effectively maintained. Dental unit water lines (used for connecting the dentist's drills and other devices to the dental unit on a dental chair), were flushed and decontaminated regularly to reduce the risk of the legionella bacteria (a term for particular bacteria which can contaminate water systems in buildings).

Staff were well presented and told us they wore clean uniforms daily and this included reception staff. They also told us that they wore personal protective equipment when cleaning instruments and treating people who used the service. Staff files reflected that staff had received inoculations against Hepatitis B and received blood tests to check the effectiveness of that inoculation. We were told that all staff at the practice were not permitted to wear their uniforms outside of the practice to reduce the risk of cross contamination.

Patients we spoke with always said that the dentist and the dental nurse always wore protective glasses, visors and gloves while undertaking treatment or examinations.

Are services safe?

The practice had undertaken a legionella risk assessment in July 2014, monthly checks were in place and records were being kept.

Equipment and medicines

Records we viewed reflected that equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Some equipment was less than 12 months old so had not required an annual service or testing but a system was in place for the future. Fire extinguishers were in place throughout the practice and they had been checked and serviced regularly by an external company. Staff had been trained in the use of equipment and evacuation procedures.

X-ray machines were the subject of regular visible checks and records had been kept. The X-ray equipment was only 12 months old and not yet due for servicing or critical examinations to ensure they were emitting the correct levels of radiation. The practice had identified an appropriate company to carry these checks out when they were due.

All equipment used for the cleaning and sterilising of medical instruments had been serviced and maintained regularly. Records reflected that it was in working order at the time of the inspection.

Medicines in use at the practice were stored and disposed of in line with published guidance. We checked the medicines in use and found them to be in date and in sufficient quantity. Records were maintained for patients receiving anaesthetic during conscious sedation procedures. Clinical records showed the dose, batch number and expiry date of each local anaesthetic administered. There were sufficient stocks available for use and these were rotated regularly. The ordering system was effective. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Some medicines were stored in a fridge at the practice and temperatures were being monitored to ensure the medicines remained effective. Records had been kept.

Radiography (X-rays)

X-ray equipment was situated in suitable areas and X-rays were carried out safely and in line with local rules that were relevant to the practice and equipment. These rules described the safe use of X-rays and the procedures to follow if the X-ray equipment failed to operate properly. The local rules were clearly displayed in each surgery.

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. The equipment had been installed approximately 12 months ago and a prior risk assessment had taken place, including detailed plans about the location of the X-ray equipment to reduce the risk of radiation exposure to patients.

The practice's radiation protection file contained the necessary documentation covering the names and the qualifications of those permitted to use the equipment. Other staff had signed the procedures section to demonstrate that they understood the regulations for the safe use of the equipment.

All staff who were involved in taking X-rays were suitably trained and qualified and had received up to date training in relation to dental radiography. Dental nurses and other staff we spoke with were aware of the safety procedures to follow and where to stand when a patient received an X-ray.

The practice audited the quality of the X-rays on a six monthly basis and records were being maintained. Any learning identified was shared with other staff. This ensured that they were of the required standard and reduced the risk of patients being subjected to further unnecessary X-rays.

Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays. This included identifying where patients might be pregnant. Signs were displayed requesting patients who were or might be pregnant, to notify the dentist.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations and assessments in line with recognised guidance from the National Institute for Health and Care Excellence (NICE) and General Dental Council (GDC) guidelines.

The head office of the practice provided updates on NICE and dentistry guidance and a system was in place to disseminate them to clinical staff working at the practice. Dentists we spoke with were aware of the latest NICE guidelines and the preventative care and advice known as "Delivering Better Oral Health Toolkit". This involved identifying patients at high risk of tooth decay and then applying fluoride varnish to the teeth at specific intervals. High fluoride toothpastes were also prescribed for patients who had a high risk of tooth decay.

Each patient received an oral examination prior to deciding whether further care and treatment was required. This assessment included an examination covering the condition of a patient's teeth, gums and soft tissue and whether there were any signs of mouth cancer. Patients were then made aware of the condition of their oral health and treatment discussed with them.

At each visit, patients were required to complete a medical history questionnaire. This was checked and updated each time they attended the practice. A hard copy was maintained, which the dentist checked with the patient, then it was transferred to the patient records on their computerised record system.

Following the consultation X-rays were taken in line with Faculty of General Dental Practice (FGDP) guidelines. This identifies patient's risk factors and gives suggested intervals to take X-rays in order to diagnose or monitor tooth decay. All X-rays taken were justified, graded and reported on and recorded in the clinical records. A diagnosis was then discussed with the patient and appropriate treatment was planned. Care was taken to ensure X-rays were not taken on any patients who were or maybe pregnant.

There was evidence that recall intervals were adjusted to an individual patient's needs. This was in line with NICE guidelines. This recall interval was based on risk factors including tooth decay, gum disease, medical history and soft tissue condition. These recall intervals were discussed with the patients and an explanation given. Recall intervals were monitored at their head office and locally to ensure patients were recalled on the risk rather than a time factor, to reduce the need for unnecessary visits to the dentist.

We saw evidence that all patients who required treatment were given a written treatment plan which included details of the treatment required. This also included the costs associated with the treatment.

Health promotion & prevention

The waiting room and reception area at the practice contained a range of posters that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health.

These included dietary, alcohol and smoking information and the effect they have on maintaining good oral health. There was information for parents to encourage and promote their children to maintain healthy teeth. The dentists we spoke with confirmed that adults and children attending the practice were advised during their consultation of steps to take to prevent tooth decay and this was monitored at subsequent visits to ensure it had been effective. Smoking cessation and lifestyle advice were given to patients where appropriate.

Patients were recalled at appropriate intervals to check on their teeth to ensure that prevention methods were effective.

Staffing

The practice employed six dentists all supported by dental nurses. The ratio of dentists to dental nurses was one to one. The practice also provided conscious sedation for nervous patients and when this took place a dental nurse was available for the patient to support them and help them to recover after the procedure.

The practice had a practice manager and an assistant practice manager. They managed the day to day running of the practice. They were supported by a regional and an area manager that attended periodically to monitor performance and conduct appraisals. They also attended some team meetings.

Are services effective?

(for example, treatment is effective)

There was a reception manager and a number of receptionists all working a variety of hours. One of the receptionists was waiting to undergo training to become a dental nurse.

All staff at the practice had received annual appraisals and staff spoken with felt supported and involved in the process and were given time to prepare for their appraisal. They told us that they were provided with opportunities for training and development and these were discussed with them at their appraisal meeting. Staff spoken with felt the process was meaningful, fair and they felt valued. They told us that managers were supportive and always available for advice and guidance.

The clinical support/practice manager also conducted peer reviews on the dentists at the practice. Prior to the review, the dentists were sent information about their performance in line with the objectives and standards set for them, then this was discussed at a face to face meeting. This was documented and where improvements were required they were set an action plan and timescale for completion and this was followed up in due course. Dentists spoken with felt supported.

The practice manager told us that they were supported by their regional and area manager and they were available when required, for advice and guidance.

Staff training records were well organised and staff training was up to date. The practice had identified the types of training that were mandatory and records we viewed confirmed that this was being monitored by managers.

The practice had their own training resources and these included on-line training and face to face training. Each staff member had their own personal account and training reminders were sent to them. Compliance with this training was monitored both locally and centrally and it was effective.

We looked at the staff files for a number of the clinical staff working there and found that they were appropriately trained and registered with their professional body and this was checked annually. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. Where training courses had been attended, relevant certificates were contained within their personal files.

Staff new to the practice went through a role specific induction process. The induction included familiarisation with health and safety procedures and how the practice was managed. New staff received mentoring from a more senior colleague. We spoke with the newest member of staff who told us that the support they had received had been excellent. They had been given clear guidance on the day to day procedures to follow, had been given the opportunity to develop within the practice and had been supervised until it was felt they were competent to work unsupervised.

Staff numbers were monitored by the practice manager and identified staff shortages were planned for in advance wherever possible. Where it was necessary to obtain staff from a locum agency, there was a system was in place to check their registration with their professional body, qualifications, skills and experience before using them.

Staff had ready access to the procedures and policies of the practice which contained information that further supported them in the workplace.

Working with other services

The practice had systems in place to refer patients for specialist treatment if it was required. Records we viewed reflected that relevant information was recorded and sent with the referral that identified the reason and the symptoms necessitating the referral including copies of X-rays if relevant. We found that there was no backlog and that referrals were sent within two weeks, but often on the same day.

Consent to care and treatment

Staff spoken with had a clear understanding of consent issues in relation to children, adults and vulnerable persons. They understood that consent could be withdrawn by a patient at any time. The practice had a consent policy in place to support staff.

Staff were aware about consent in relation to children under the age of 16 years who attended for treatment without a parent or guardian. This is known as Gillick competence. They told us that children of this age attending the practice would be referred to one of the dentists if they did not wish to be accompanied by a parent or guardian. Dentists spoken with were also aware of this

Are services effective?

(for example, treatment is effective)

consent issue and told us that they would ask the child questions to ensure they understood the care and treatment proposed before providing it. This is known as the Gillick competency test.

The dentists we spoke with displayed knowledge of the guidelines of the Mental Capacity Act 2005 and explained how they would take consent from a patient if their mental capacity was such that they might be unable to fully understand the implications of their treatment. They told us that they would involve careers or family members to help decide on the best treatment for the patient if they were not capable of providing informed consent themselves. This followed published guidance.

The dentists obtained written and verbal consent from all patients. Written consent was always obtained for any invasive procedure such as fillings, extractions or crowns.

This was documented in the clinical records. Patients signed a written treatment plan which included the costs of the treatment. Patients were made aware that consent could be withdrawn at any time.

Patients undergoing conscious sedation were given a time period to fully understand the implications of the treatment before providing consent. The explanations, risks and options were given to them verbally and in written form. When they returned to the practice and invited to consent, the explanations were repeated to ensure they fully understood the procedures.

There was evidence that discussion had taken place with patients about which treatment would be the most appropriate. This included documentation of discussion of risks and benefits of each treatment available.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We found that staff at the practice treated patients with dignity and respect and maintained their privacy. The reception area was open plan but if a confidential matter arose, a private room was available for use.

Reception staff spoken with had received training in providing customer service and further development and training had been planned for the near future. It was clear from staff spoken with that patient care was at the centre of their work.

Patients we spoke with told us that practice staff were kind and caring and treated them with dignity and respect. The patients we spoke with told us that they would be happy to recommend the practice to family and friends and that all staff were polite and caring. The comment cards we reviewed reflected that patients were extremely satisfied with the way they were treated at the practice by clinical and non-clinical staff.

A data protection and confidentiality policy was in place of which staff were aware. This covered disclosure of patient information and the secure handling of patient information. We observed the interaction between staff and patients and found that confidentiality was being maintained. Records were held securely in a password protected computer system.

We were told by staff that when patients had received more complex treatments, such as implants, their welfare was checked the day after the procedure to ensure that they were not suffering any pain or side effects.

The patient record of those patients identified as being nervous, were flagged accordingly so that reception and clinical staff could offer them support and reassurance if required.

Patients who had undergone conscious sedation treatment were supported to recover after the procedure by a dental nurse. Once fully recovered they would return home after being given after-care guidance and advice which was also given to anyone accompanying them. Patients were then followed up later on that day or the next with a phone call to check on their welfare.

Involvement in decisions about care and treatment

Patients we spoke with and comment cards we viewed reflected that patients felt that the dentists listened to them and involved them in the decisions about their care and treatment. They told us that consultations and treatment options were clearly explained to them followed up by a written treatment plan that explained the costs involved.

We spoke with three patients that had attended for a conscious sedation consultation and were told that explanations were clear and they were involved in the decisions about the care and treatment proposed.

We looked at some examples of written treatment plans and found that they explained the treatment required and outlined the costs involved. Dentists spoken with explained that they took care to outline the options, risks and benefits of treatment and recorded these in the patient record. This was the subject of quality monitoring by the head office of the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice offered mainly NHS treatment but also private treatment and the costs of each were clearly displayed in the practice and on their website. The website contained information that described the different types of services that patients could receive and a description of the treatment that would take place. This included information for new patients about the initial assessment of their oral health to identify any relevant issues or treatment that might be required.

The practice offered conscious sedation for patients who were nervous. Prior to the treatment patients were assessed and invited in to the practice for a detailed explanation about the procedure. We found that the procedures followed met the needs of patients, including the after care provided by a nurse who helped patients recover after the procedure.

The practice monitored the number of patients that failed to attend for their appointments. They had taken steps to reduce the frequency of those that did not attend through text message reminders and patient education on the impact of their non-attendance on other patients.

The practice had a suggestion box in reception and sought feedback from patients twice annually and responded to patient feedback when relevant.

Tackling inequity and promoting equality

The practice was accessible for those patients with mobility issues, using wheelchairs or mobility scooters and had made reasonable adjustments to accommodate them. The front door to the premises opened automatically at the touch of a button and the waiting room area was spacious.

All surgeries were on the ground floor and accessible to all patients. The practice had a toilet for the disabled and for mothers and babies. Patients with mobility issues were supported by staff when they needed it. A hearing loop was available at reception to support patients with hearing difficulties.

The practice had a small number of vulnerable patients and they were aware of their support needs when attending the practice. These had been recorded in their patient record system.

Access to the service

Appointment times and availability met the needs of patients. The practice was open Monday to Thursday between the hours of 8am and 8pm and Fridays between the hours of 8am and 5pm. The practice did not close during the lunch period. They also opened on Saturdays between 9am and 2pm. Information about opening times was displayed for patients to read.

Patients needing an appointment called a central number rather than the practice and they were allocated an appointment time. This was a new system that had been introduced due to the volume of calls received at the practice and as a result of concerns raised by patients. This improved the patient experience as we were told it was now much easier to get through on the phone. Patients had provided positive feedback about the new system on the comment cards we left them to complete prior to the inspection. Patients were also able to book online on the practice website.

Patients with emergencies could usually get an appointment on the same day or sit and wait to be seen if one was not available. Some emergency appointments were made available each day.

The practice had recognised that a high number of patients did not attend for their appointment. This was monitored centrally and the practice kept informed of the frequency of this issue. Measures had been put in place to reduce the frequency and as a result, every patient was called 24 hours before their scheduled time to confirm that they would still be attending.

The practice also monitored the waiting times of patients throughout each day. Computer software supported staff in identifying how long patients were being kept waiting and dentists were updated accordingly to try and keep patients waiting to a minimum. Where appropriate patients who were kept waiting were informed if their appointment was running late. This was also being monitored for efficiency and customer satisfaction purposes.

Patients that completed CQC comment cards prior to our inspection stated that they were satisfied with the appointment system and that they were rarely kept waiting.

Are services responsive to people's needs?

(for example, to feedback?)

A touch screen check-in system was available for patients to use when they arrived at the practice for their appointment. We were told that this had been introduced due to queuing at reception when arriving for appointments and this had alleviated that problem.

Concerns & complaints

The practice had a complaint procedure that was advertised in the reception area and in their practice leaflet. Complaints could also be made through the submission of a website form. Staff we spoke with were aware of the procedure to follow if they received a complaint and forms were available for the purpose.

The procedure explained to patients the process to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact. The practice manager took responsibility for all complaints and there was oversight centrally from other managers.

The practice manager dealt with the complaint in the first instance and then wrote to the complainant acknowledging the concern. If it was a clinical matter, the dentist concerned was required to write a report about the matter and return it to the practice manager. This was analysed and investigated. The complainant was then written to and an explanation and an apology offered where relevant. The more serious complaints were reviewed by a senior manager before approval was granted to send a reply.

We looked at the four complaints that the practice had received in the last 12 months. We found that they had been investigated appropriately and learning identified. Replies sent to complainants reflected that the practice had displayed a duty of candour by offering the patient an explanation and an apology and remedied the concern to their satisfaction. It was evident from the record of the complaints that the practice had been open and transparent and taken the matter seriously.

Where learning had been identified this was highlighted in the complaint record and action taken. One of the complaints reviewed suggested further training for a member of staff and this had been actioned.

Patients we spoke with on the day of our inspection had not had any cause to complain and were satisfied with the services provided. They felt that staff at the practice would treat any matter professionally. CQC comment cards reflected that patients were highly satisfied with the services provided.

Are services well-led?

Our findings

Governance arrangements

The practice manager was responsible for all matters relating to governance, supported by an assistant practice manager. We were told by the practice manager that they were supported by more senior managers and there was oversight of governance generally.

The practice benefited from following an organised system of governance supported by computer software. There were clear standards set to ensure that governance procedures were robust. The practice manager was required to submit monthly returns on performance and these were monitored centrally. This involved the use of a system that highlighted the practice performance and whether improvements were required to meet the standards set.

The practice also monitored their compliance with the Health and Social Care Act 2008 regulations and it was evident that time and resources had been allocated to achieve compliance with them.

There was a full range of policies and procedures. These included conscious sedation, health and safety, infection prevention control, patient confidentiality and recruitment. Staff were aware of the policies and they were readily available for them to access. Staff spoken with were aware of the content of the policies and they had been signed by staff as having read and understood them.

We found that there were a wide range of clinical and non-clinical audits taking place at the practice that had been undertaken and repeated. Each dentist was separately audited for clinical quality purposes and the results of the audits formed part of their appraisal process. The practice performance as a whole was monitored by head office and it was clear that the practice manager was made aware if improvements were required.

Audits we viewed included patient records, clinical note taking, medical history, consent, oral health assessment, X-rays, infection control, conscious sedation and the appointment system. Records had been maintained to a high standard and reflected a commitment to continued improvement. There was evidence of repeat audits to evidence that improvements had been maintained. There was a clear audit process and timetable and these were monitored centrally.

The practice also used a dental patient computerised record system and all staff had been trained to use it. This enabled dental staff to monitor their systems and processes and to improve performance.

Leadership, openness and transparency

The culture of the practice encouraged, openness, honesty and a duty of candour. The complaint records we viewed reflected that patients had been given explanations and apologies if things went wrong.

There was strong leadership at the practice both at practice manager and head office level. This was reflected in the way the practice was managed and staff told us that support was made available to them. All documents we viewed were clear and concise and of a high standard. Staff were being managed effectively and supervised to ensure standards were being maintained.

Staff spoken with told us that they were encouraged to report safety issues or to raise any concerns they had. They were aware of whom to raise any issue with and told us that the practice manager and dentists would listen to their concerns and act appropriately. They felt confident that issues raised would be dealt with professionally.

Staff told us that team meetings were used to discuss safety issues, concerns and complaints and their ideas for improvement were sought. There were minutes kept of staff meetings and there was a system in place to share them with staff, including those unable to attend. Staff felt part of a team. We were told that there was a no blame culture at the practice and that the delivery of high quality care was part of the practice ethos. Staff told us that they worked in a happy environment and felt supported.

Management lead through learning and improvement

The practice was focused on achieving high standards of clinical excellence and this was monitored by the managers at the practice and from the head office. Staff at the practice were all working towards a common goal to deliver high quality care and treatment.

Staff meetings were held regularly and minutes were recorded. Significant events, safety issues and complaints

Are services well-led?

were discussed at these meetings to cascade learning to staff. Staff spoken with were aware of the learning that had been identified and were involved in identifying and implementing areas for improvement. All staff had access to the minutes of the meetings if absent and were required to read them.

Staff appraisals were used to identify training and development needs that would provide staff with additional skills and to improve the experience of patients at the practice. Staff told us that they were encouraged to undertake their continuous professional development and to develop themselves in other areas of dentistry if they so wished.

The results of audits undertaken at the practice were used to drive performance and this led to improvements that were of benefit to the staff and the patients.

The provider, in conjunction with practice staff, was going through a re-branding process. This involved identifying areas where they could improve the experience of the patient when attending the practice. They were in the process of re-designing their practice leaflet so that it contained more detail that would help patients understand the services they provided. They were also improving staff training so that they could provide better explanations about the services they provided to their patients. This included customer service, the use of welcome emails for new patients and supporting patients who were nervous.

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

The practice acted on feedback from staff through staff meetings, appraisals and informally. Staff spoken with confirmed that they were consulted about safety and general incidents and their ideas for improvement sought.

The practice had a comments/suggestions box in the reception area for patients to use if they wished to do so and patients could provide feedback online via their practice website. Patients were also sent text messages after receiving treatment, requesting their feedback.

Every six months, the practice sought feedback from patients about the services provided, by sending them satisfaction questionnaires to complete. The sample was usually 50 in number. Some forms were also sent out by head office asking patients for their views. They were then analysed and discussed at staff meetings and improvements acted upon where relevant. One such example was patient dissatisfaction about the phone system and the queues experienced at reception. A new phone system and touch screen check-in facility was then put in place which had improved the patient experience.

The practice reviewed the feedback from patients who had cause to complain. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate.

Staff we spoke with told us that they felt part of a team and that their ideas and suggestions were sought and acted upon if relevant to the practice. They were able to provide feedback at appraisals, team meetings and informally to both the lead dentist and the practice manager.