Midsomer Dental Care Limited

Midsomer Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 23 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Midsomer Dental Care Limited is a dental practice providing predominantly NHS treatment for adults and children. They also provide some private treatment. Midsomer Dental Care was established in Midsomer Norton over 50 years ago. The practice is an adapted modern premises with treatment rooms all located on the ground floor. There is car parking close to the practice and the practice is wheelchair accessible to all patient areas.

The practice employs five dentists, one hygienist, eight dental nurses (who also cover reception duties and have lead roles for other specific areas) and a cleaner.

Treatment fees are displayed on the practice website and in the surgery.

The practice opens Monday 08.30-17.00, Tuesday 08.30-19.00, Wednesday 09.00-17.30, Thursday 09.00-17.00, Friday 09.00 with a variable closing time. The practice seeks to see patients in need or emergency dental treatment within 24 hours. There are arrangements in place to ensure patients receive urgent dental assistance when the practice is closed. This is provided by an out-of-hours service. Out of Hours instructions for emergency dental care can be found on the practice website, via the practice answerphone or by calling NHS 111 (if not registered with practice).

One of the two principal dentists is also the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 was carried out by a lead inspector and a dental specialist advisor.

Before the inspection, we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice.

We received feedback from 47 patients. In addition we spoke with two patients on the day of our inspection. Feedback from patients was positive about the quality of care, the caring nature of all staff and the overall high quality of customer care. They commented that staff put them at ease and listened to their concerns. They also reported they felt proposed treatments were fully explained them so they could make an informed decision which gave them confidence in the care provided.

Our key findings were:

- We found that the practice ethos was to provide patient centred dental care in a relaxed and friendly environment.
- Effective leadership was provided by the two principal dentists.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- Premises appeared well maintained and visibly clean.
- Good cleaning and infection control systems were in place and the practice followed published guidance.
- The treatment rooms were well organised and equipped, with good light and ventilation.
- There were systems in place to check all equipment had been serviced regularly, including the autoclaves and the X-ray equipment.
- The practice had a safeguarding lead professional and effective processes in place for safeguarding adults and children.
- There was a policy and procedure in place for recording adverse incidents and accidents.
- The dentists and dental hygienist provided dental care in accordance with current professional and National Institute for Care Excellence (NICE) guidelines.
- The dentist used Loupes – these enable the clinician to have a magnified view of the operation site thus enabling accuracy of treatment.
- The practice had a system to monitor and continually improve the quality of the service; including through a programme of clinical and non-clinical audits.
- Patients could access treatment and urgent and emergency care when required.
- Staff had received training appropriate to their roles and were supported in their continuing professional development by the practice owners.
- Staff we spoke with felt well supported by the practice owners and were committed to providing a quality service to their patients.
- Information from 47 completed Care Quality Commission (CQC) comment cards and speaking to patients gave us a positive picture of a friendly, caring, professional and quality service.
- The practice reviewed and dealt with complaints according to their practice policy.

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

- Review the sterilisation of dental equipment in line with current HTM 01 05 guidelines Review the manual dismantling of syringes and consider changing to a safer sharps system.
- Review arrangements for the management of privacy and dignity for surgery three and consider the provision of an entry door.
- Review the arrangements for the storage of local anaesthetic in treatment rooms so that is maintained in the original packaging until use.
- Review the labelling and use of appropriate colour coded clinical waste bags under sinks in treatment rooms.
- Review the arrangements for the decanting of items such as amalgam or composite capsules so that expiry dates are present in the treatment rooms.
- Review the arrangements for stock rotation to ensure that no out of date stock or products are available in treatment rooms.
- Review the access arrangements for the emergency oxygen and readiness for immediate use.
- Review the need for marking a radiation designated 'safe zone' area in the passage outside of surgeries three and four.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had effective arrangements in place to help ensure the safety of staff and patients. This included for essential areas such as infection control and the management of medical emergencies and dental radiography (X-rays) although we noted that there was no designated 'safe zone' area marked on the floor outside of surgeries three and four.

We found all the equipment used in the dental practice was well maintained.

The practice took their responsibilities for patient safety seriously and staff were aware of the importance of identifying and investigating patient safety incidents.

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

The practice carried out and reviewed risk assessments to identify and manage risks.

The practice used a system whereby syringes were manually dismantled following administration of a local anaesthetic to a patient. Although a sharp safety risk assessment had been carried out the practice had not yet changed to a safe sharps system.

There were clear procedures regarding the maintenance of equipment and the storage of medicines in order to deliver care safely and in an emergency but we found that access to the emergency oxygen was impeded.

We found in treatment rooms some phials of local anaesthetic that were not stored in their original packaging but were loose in drawers; some out of date stock items that were no longer used were still available in the treatment room. We observed amalgam and composite capsules in the treatment rooms did not display an expiry date.

We noted that in the treatment rooms, clinical waste bins were not labelled or clinical waste put in yellow bags under sinks.

Are services effective?

No action

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

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

We saw examples of positive teamwork within the practice and evidenced good communication. The staff received professional training and development appropriate to their roles and learning needs. Staff we spoke with told us they had accessed specific training in the last 12 months in line with their professional development plan and in line with General Dental Council (GDC) requirements for registrants. However performance review / appraisal of dental associates and the hygienist was not taking place.

Summary of findings

Staff where appropriate were registered with the GDC and were meeting the requirements of their professional Registration. They monitored any changes in the patient's oral health and made referrals as appropriate to other primary and secondary care providers such as for specialist orthodontic treatment or hospital services for further investigations or treatment as required.

The practice was proactive in providing patients with advice about preventative care and supported patients to ensure better oral health in line with Public Health England publication 'Delivering Better Oral Health 3rd edition. (DBOH).

Are services caring?

No action

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

We reviewed 47 completed CQC comments and received feedback on the day of the inspection from three patients about the care and treatment they received at the practice.

Patients commented the quality of care was very good. Patients commented on the friendliness and helpfulness of the staff and told us dentists were good at explaining the treatment that was proposed.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Policies and procedures in relation to data protection and security and confidentiality were in place and staff were aware of these. However, we noted that surgery three, which was located at the end of a corridor, did not have an entry door. Whilst conversations between patient and dentist could not be overheard by other patients unless they stood outside the entry to the room, this arrangement could compromise patient privacy and dignity and should be remedied.

Are services responsive to people's needs?

No action

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

Patients could access treatment and urgent and emergency care when required. The practice provided patients with written information. The practice had experienced very few requests for treatment by patients whose first language was not English. If required, they could provide information about treatments in another language and access interpreter services for consultations.

There was level access into the building for patients with limited mobility, or those with prams and pushchairs. We observed the reception desk was compliant with the Equality Act 2010. Although there was no hearing loop available, information and forms were available and could be printed in large print when required.

There was a procedure in place for acknowledging, recording, investigating and responding to complaints and concerns made by patients or their carers.

Are services well-led?

No action

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

Summary of findings

We found effective leadership was provided by the two principal dentists. One of the principal dentists was also the practice manager and the other was the registered manager. Staff had an open approach to their work and shared a commitment to continually improving the service they provided. There was a no blame culture in the practice.

The practice maintained a comprehensive system of policies and procedures using a commercially available dental clinical governance system which had recently been introduced. Staff told us they felt well supported and could raise any concerns with the principal dentists. All the staff we met said they were happy in their work and the practice was a good place to work.

The practice assessed risks to patients and staff and carried out a programme of audits as part of a system of continuous improvement and learning. There were clearly defined roles within the practice and staff told us they felt well supported and enjoyed their work.

The practice had systems in place to seek and act upon feedback from patients using the service.

Midsomer Dental Care

Detailed findings

Background to this inspection

This inspection took place on the 23 January 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector, and a dental nurse specialist advisor.

Prior to the inspection we reviewed information we held about the provider. We also reviewed information we asked the provider to send us in advance of the inspection. This included their latest statement of purpose describing their values and objectives, a record of any complaints received in the last 12 months and details of their staff members together with their qualifications and proof of registration with the appropriate professional body.

We informed the NHS England area team we were inspecting the practice and we did not receive any information from them.

During the inspection, we spoke with both principal dentists, dental nurses and dental hygienist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment.

We were shown the decontamination procedures for dental instruments and the computer system that supported the patient dental care records.

We also reviewed policies, procedures and other documents. We reviewed 47comment 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 had a system in place for reporting and learning from significant incidents. Accidents would be recorded in an accident / incident book. The practice was aware of their responsibilities in relation to the Reporting of Injuries Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). RIDDOR is managed by the Health and Safety Executive (HSE).

Procedures were in place for reporting adverse drug reactions and medicines related adverse events and errors.

The provider had an understanding of their duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

There was a procedure for when and how to notify CQC of incidents which cause harm. Staff reported there was an open and transparent culture at the practice which encouraged candour and honesty.

The practice received national patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England). Where relevant these alerts were shared with all staff and filed.

Reliable safety systems and processes (including safeguarding)

The practice had safety systems in place to help ensure the safety of staff and patients. These included clear guidelines about responding to a sharps injury (needles and sharp instruments).

We spoke with a dental nurse and one of the principal dentists about the prevention of needle stick injuries. They explained the treatment of sharps and sharps waste.

The practice used a system whereby syringes were manually dismantled following administration of a local anaesthetic to a patient and did not use a special safety syringe for the administration of dental local anaesthetics to prevent needle stick injuries from occurring. The dentist and the dental hygienist were responsible for the disposal of used sharps and needles. A practice protocol was in place should a needle stick injury occur. The systems and processes we observed were in line with the current regulations about the safer use of sharps. A safer sharps risk assessment had been carried out and identified that only the dentist or hygeinist may manually dismantle a syringe. The practice could consider changing to a safer sharps system.

We asked how the practice treated the use of instruments that were used during root canal treatment. They explained these instruments were single use only. They also explained that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients can be assured the practice followed appropriate guidance issued by the British Endodontic Society in relation to the use of the rubber dam.

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies including the Care Quality Commission.

One of the principal dentists was the lead professional and point of referral should members of staff encounter a child or adult safeguarding issue. Training records showed staff had received appropriate safeguarding training for both vulnerable adults and children. All staff had been trained to Level 2 in child safeguarding. The practice reported there had been no safeguarding incidents that required further investigation by appropriate authorities.

Staff files contained evidence of immunisation as recommended by Public Health England (PHE). For example, against Hepatitis B (a virus contracted through bodily fluids such as; blood and saliva). Staff 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. There were adequate supplies of personal protective equipment (PPE) such as face visors, gloves and aprons to ensure the safety of patients and staff.

Are services safe?

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment.

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to medical oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen we saw were all in date. However we found the oxygen cylinder / tubing was stored in a cupboard where access was impeded by other items. Oxygen tubing was not attached / located, for immediate use. We discussed this with the provider who confirmed they would remedy this without delay.

The practice held training sessions each year so staff could maintain their competence in dealing with medical emergencies. We saw documentary evidence which demonstrated regular checks were carried out to ensure the equipment and emergency medicines were in date and safe to use. Records showed all staff had completed training in emergency resuscitation and basic life support. Staff spoken with demonstrated they knew how to respond in the event of a medical emergency.

Staff recruitment

The practice had systems in place for the safe recruitment of staff which included seeking references, proof of identity and checking qualifications, immunisation status and professional registration. The practice had evidence of Disclosure and Barring service (DBS) checks for clinical staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We spoke with staff who confirmed that newly employed staff had been taken through an induction process to ensure they were familiarised with the way the practice operated. This was corroborated with documentary evidence which had been signed to demonstrate completion of the process.

The practice had a system in place for monitoring staff had up to date indemnity insurance and professional registration with the General Dental Council (GDC) The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Records we looked at confirmed these were up to date and ongoing.

The provider had a current certificate of employer's liability insurance displayed in the reception.

Monitoring health & safety and responding to risks

The practice had systems to monitor health and safety and deal with foreseeable emergencies. There were comprehensive health and safety policies and procedures in place to support staff, including for the risk of fire and patient safety. Records showed that fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly checked.

The practice had a risk management process, including a detailed log of all risks identified, to ensure the safety of patients and staff members. For example, the practice had a comprehensive file relating to the Control of Substances Hazardous to Health (COSHH) Regulations 2002, including substances such as ionising radiation, amalgam and disinfection substances. This file contained details of the way substances and materials used in dentistry should be handled and the precautions taken to prevent harm to staff and patients.

The practice had a detailed business continuity plan to support staff to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

Infection control

There were effective systems in place to reduce the risk and spread of infection. There was a documented infection control policy which was reviewed and included minimising the risk of blood-borne virus transmission and the possibility of sharps injuries, decontamination of dental instruments, hand hygiene, segregation and disposal of clinical waste.

It was demonstrated through direct observation of the cleaning process and a review of practice protocols that the practice had followed the guidance about decontamination and infection control issued by the Department of Health, the 'Health Technical Memorandum

Are services safe?

01-05 decontamination in primary care dental practices (HTM01-05).' We observed the essential quality requirements for infection control set out in HTM 01-05 were being met. We were shown the audit of infection control processes carried out in August 2016 which confirmed compliance with HTM 01-05 guidelines with three outstanding actions to follow up. We saw an Infection Prevention Annual Statement and Annual Review both dated January 2017.

We observed that bur blocks were in use. Bur blocks are used for holding and organising dental instruments for sterilisation. We found diamond burs were re-used. To maintain sterility of the device , these should be sterilised in individual steribags. The provider agreed to do this.

We saw four dental treatment rooms in use. The waiting areas, reception, toothbrushing room and toilets were visibly clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms and bare below the elbow working was observed.

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

The dental nurses we spoke with described to us the end-to-end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient. They demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria in line with current HTM 01 05 guidelines. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We saw a Legionella risk assessment had been carried out at the practice by a competent person in 2015. The recommended procedures contained in the report were carried out and logged appropriately. These included the monitoring of water temperatures and microbiological testing of samples of the water supply. These measures ensured patients and staff were protected from the risk of infection due to Legionella.

The practice had a separate decontamination area for instrument processing, packaging and storage of processed instruments. The dental nurse we spoke with demonstrated the process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a system of manual scrubbing using the two sinks method and an ultrasonic bath for the initial cleaning process. Following inspection with an illuminated magnifier the instruments were placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilised, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines.. However, on the day of the inspection both the washer disinfector and vacuum sterilser (used to sterilise items within the pouches) were out of order and waiting for repair/replacement. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always completed and up to date. Effective performance was monitored by indicator tape (because although the machines that were out of order were equipped with data loggers, they were not available on the day of inspection). We also noted the essential validation checks for the ultrasonic baths including the residual protein test and foil tests were carried out and the results recorded.

We observed sharps containers and municipal waste were properly maintained and was in accordance with current guidelines. However we noted that in the treatment rooms, clinical waste bins were not all labelled or clinical waste put directly in yellow bags under sinks. The practice used an appropriate contractor to remove clinical waste from the practice. Clinical waste was stored either in a locked yellow bin outside of the practice which was inaccessible to the public, or in a locked room within the practice, prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients' could be assured they were protected from the risk of infection from contaminated dental waste.

We also saw general environmental cleaning was carried out according to a cleaning plan developed by the practice. Cleaning materials and equipment were stored in accordance with current national guidelines.

Are services safe?

Equipment and medicines

There were systems in place to check all equipment had been serviced. Records seen showed contracts were in place to ensure annual servicing and routine maintenance. Equipment checks were carried out in line with the manufacturer's recommendations. For example, the autoclave had been serviced and calibrated in January 2017. The practice X-ray machines had been serviced and calibrated as specified under current national regulations in July 2015. Portable appliance testing (PAT) had been carried out in June 2016.

The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. However, these medicines were not stored appropriately in treatment rooms. We found phials of local anaesthetic were not stored in their original packaging but were loose in the drawer instead of being maintained in the original packaging to prevent cross contamination from handling or the aerosol area.

We also found a small supply of out of date Thermafil, a product no longer used by the practice which should have been removed from the treatment room and destroyed. We also found that amalgam and composite capsules in the treatment room did not have expiry dates in line with good practice guidance.

We observed the practice had equipment to deal with minor first aid problems such as minor eye problems and body fluid and mercury spillage.

The practice had in place a system to account for the prescriptions issued to prevent inappropriate prescribing or loss of prescriptions. We saw evidence of prescription numbers annotated in the patient electronic record. Prescription pads were stored in a lockable cabinet overnight to prevent theft or misuse by staff or unauthorised persons.

Radiography (X-rays)

The practice used digital X-rays. We were shown documentation in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). The file reviewed contained the names of the Radiation Protection Advisor (RPA) and the Radiation Protection Supervisor (RPS) and the necessary documentation pertaining to the maintenance of the X-ray equipment. We noted that there were three people designated as an RPS. It was confirmed that one of the two principal dentists was the main RPS but the two associates were also qualified to perform this role should it be required.

Included in the documentation were the three yearly maintenance logs and a copy of the local rules. The local rules must contain the name of the appointed Radiation Protection Advisor, the identification and description of each controlled area and a summary of the arrangements for restriction access. Additionally, they must summarise the working instructions, any contingency arrangements and the dose investigation level. We saw there was an audit of equipment in January 2017.

We saw a radiological audit for each dentist had been carried out in July 2016. Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported upon and quality assured. These findings showed the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation. We saw training records that showed staff, where appropriate, had received training for core radiological knowledge under IRMER 2000 Regulations.

At the last critical examination of the X-ray machines in treatment rooms three and four the safe operator position was identified by the Laser Protection Advisor. However where this was outside of the treatment room, the designated area was not marked to reflect this and control entry while exposure was taking place.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines. The three dentists we spoke with described to us how they carried out their assessment of patients for routine care.

The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence 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 then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment, the diagnosis was discussed with the patient and treatment options explained.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general oral hygiene instruction such as tooth brushing techniques or recommended tooth care products. The patient 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 the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records seen demonstrated the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. These were carried out where appropriate during a dental health assessment.

The practice also sought to ensure best practice and patient safety through the use of 'Loupes'. These enable the clinician to have a magnified view of the tooth thus enabling greater precision of treatment.

Health promotion & prevention

The practice was focussed on the prevention of dental disease and the maintenance of good oral health. To facilitate this the practice appointed a dental hygienist to work alongside of the dentist in delivering preventative dental care. In addition, one of the dental nurses was an oral health educator and provided 30 minute sessions about oral health topics free of charge. This was mainly for children and included visits to local schools. Free oral health kits were offered to children when sessions in schools were provided. The practice also had a dedicated tooth brushing room for use by any patient or patients being offered oral health education on a one to one basis.

The dentist explained that children at high risk of tooth decay were identified and were offered fluoride varnish applications or the prescription of high concentrated fluoride tooth paste to keep their teeth in a healthy condition. They also placed fissure sealants (special plastic coatings on the biting surfaces of permanent back teeth) in children who were particularly vulnerable to dental decay. Other preventative advice included tooth brushing techniques explained to patients in a way they understood and dietary, smoking and alcohol advice was given to them where appropriate. This was in line with the Department of Health guidelines about prevention of dental decay, known as 'Delivering Better Oral Health'. (Delivering Better Oral Health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health published by Public Health England).

Dental care records we observed demonstrated the dentist and hygienist had given oral health advice to patients.

The waiting room and reception area at the practice contained leaflets that explained the services offered at the practice. This included information about how to carry out effective dental hygiene and how to reduce the risk of poor dental health. There was also information about making patients aware of the early detection of oral cancer. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums. These were available in the reception area. The practice web site also provided information and advice to patients about how to maintain healthy teeth and gums.

Patients reported they felt well informed about their dental care and treatment pertaining to the health of their teeth and dental needs.

Are services effective?

(for example, treatment is effective)

Staffing

We observed a friendly atmosphere at the practice. All clinical staff had current registration with their professional body, the General Dental Council.

The practice had four dentists who were supported by eight dental nurses and s dental hygienist. The practice employed their own cleaner.

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. There was a structured induction programme in place for new members of staff. We were shown evidence of completed induction and training carried out. A record of all training completed by staff was available in staff files. Training was individual to their identified development needs to ensure they had the right skills to carry out their work. Mandatory training included basic life support and infection prevention and control.

Staff had access to policies which contained information that further supported them in the workplace. All clinical staff were required to maintain an on-going programme of continuing professional development as part of their registration with the General Dental Council. Records showed professional registration was up to date for all staff.

There was an effective appraisal system which had been recently implemented and was used to identify training and development needs for the dental nurses. However there were no clear arrangements currently in place for performance review / appraisal of dental associates and the hygienist.

Staff we spoke with told us they had accessed specific training in the last six months in line with their professional needs and we saw evidence to support this. Dental nurses were also part of a Clinical Commissioning Group (CCG) cluster group which met regularly to share experiences and identify local training needs.

Working with other services

The dentists could refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by them. The dentists used referral criteria and referral forms to refer to other primary and secondary care providers such as oral surgery, special care dentistry and orthodontic providers.

Consent to care and treatment

We spoke with the dentists about how they implemented the principles of informed consent; they had a clear understanding of consent issues. They explained how 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 understood their treatment options. The dentist told us patients should be given time to think about the treatment options presented to them and explained that in certain situations patients would be brought back to the practice to discuss complex treatment options. This process made it clear that a patient could withdraw consent at any time.

The dentists explained how they would obtain consent from a patient who suffered with any cognitive impairment that may mean they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16 years. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The practice consent policy provided staff with guidance and information about when consent was required and how it should be recorded.

We reviewed dental care records to corroborate our information. Feedback in CQC comment cards confirmed patients were provided with sufficient information to make decisions about the treatment they received.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We obtained the views of two patients on the day of our visit. These provided a positive view of the service the practice provided. During the inspection, we observed staff in the reception area, they were polite and helpful towards patients and the general atmosphere was welcoming and friendly. Patients commented they were treated with respect and dignity and that staff were friendly and reassuring. We observed positive interactions between staff and patients during the inspection.

Treatment rooms were situated away from the main waiting areas and we saw doors (with the exception of surgery three), were always closed when patients were receiving or discussing treatment during consultations. Surgery three had no door at the time of the inspection. Patients' clinical records were stored on a secure system. The practice aimed to be a paperless practice with all patient records being stored in digital format. Treatment plans were scanned and only saved electronically. Computers were password protected and regularly backed up to secure storage with paper records stored in a secure room not accessible by the public. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception.

Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality.

The provider told us they would act upon any concerns raised by patients regarding their experience of attending the practice.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS costs was displayed in the waiting area. The practice website also gave details of the cost of treatment.

The dentists we spoke with paid attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them. Patients were given time to consider options before returning to have their treatment. Patients signed their treatment plan before treatment began.

The practice provided patients with information to enable them to make informed choices. Patients commented they felt fully involved in making decisions about their treatment, were at ease speaking with the dentists and felt listened to and respected.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in the practice leaflet and on their website.

Patients' feedback demonstrated they had flexibility and choice to arrange appointments in line with other commitments. Patients booked in with the receptionist on arrival and they kept patients informed if there were any delays to appointment times.

During our inspection, we looked at examples of information available to patients. We saw the practice waiting area displayed a variety of information. These explained opening hours, emergency 'out of hours' contact details, arrangements about how to make a complaint, provide feedback about services and information about maintaining good oral health. We observed the appointment system provided capacity each day for patients with urgent treatment needs to be fitted into slots for the dentist.

Tackling inequity and promoting equality

The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other barriers which may hamper them from accessing services. The practice could access to interpreter services for consultations, if it became clear that a patient had difficulty in understanding information about their treatment.

The practice did not have access to a 'hearing loop' which would assist patients with hearing issues.

Access to the service

The practice displayed its opening hours on the website, in the waiting room and in leaflets. It was open: Monday to Friday 9am to 5pm with a flexible closing time on a Friday. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

The 47 CQC comment cards seen and two patients spoken with reflected patients felt they had good access to the service and appointments were flexible to meet their needs.

Concerns & complaints

The practice had a complaint policy which provided staff with clear guidance about how to handle a complaint. The policy explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included the Dental Complaints Service. Staff told us if they raised any formal or informal comments or concerns with the practice manager they ensured these were responded to appropriately and in a timely manner.

The practice had received one complaint in the last 12 months. We looked at the practice procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

We found there was a system in place which ensured a timely response, sought to address the concerns promptly and efficiently and effect a satisfactory outcome for the patient. One of the two principal dentists was also the practice manager and told us that complaints made would be investigated and the outcome discussed amongst the team and implemented for the safety and well-being of patients.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. The governance arrangements were managed by one of the principal dentists / practice manager. They were responsible for the day to day running of the practice. The practice maintained a comprehensive system of policies and procedures using a commercially available dental clinical governance system which had recently been introduced. . They explained the company who provided the governance system notified the practice via email when policies and protocols required updating which prevented systems and process from lapsing.

We saw risk assessments and the control measures in place to manage risks, for example infection control and substances hazardous to health. Staff we spoke with were aware of their roles and responsibilities within the practice.

Health and safety and risk management policies were in place including processes to ensure the safety of patients and staff members. We saw risk assessments and the control measures in place to manage those risks for example, use of equipment and infection control. Lead roles, for example in infection control and safeguarding, supported the practice to identify and manage risks and helped ensure information was shared with all team members.

There was a full range of policies and procedures in use at the practice to govern activity and these were accessible to staff on the practice computers and in paper files. Staff were aware of the policies and procedures and acted in line with them.

These included guidance about confidentiality, record keeping, sharps injuries, radiological safety and patient safety. There was a clear process in place to ensure all policies and procedures were reviewed as required to support the safe running of the service. The practice had begun a regular programme of meetings covering a wide range of topics areas. The clinical governance system provided the practice with a list of issues to discuss at staff / team meetings throughout the year. This included audit results. Time was also provided for educational activity. Notes and actions were written up as acted upon appropriately and in a timely manner.

Leadership, openness and transparency

Effective leadership was provided by the principal dentists. The practice ethos focussed on providing patient centred dental care in a relaxed and friendly environment. The comment cards seen and the patients spoken with reflected this approach. The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with the principal dentists.

There was a no blame culture within the practice. They felt they were listened to and responded to when they did raise a concern. All the staff we spoke with demonstrated a firm understanding of the principles of clinical governance in dentistry and were happy with the practice facilities. Staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

The practice had a statement of purpose that described their vision, aims and objectives.

We observed and staff told us the practice was a relaxed and friendly environment to work in and they enjoyed coming to work at the practice. Staff felt well supported by the principal dentists and worked as a team toward the common goal of delivering high quality care and treatment.

The service was aware of and complied with the requirements of the Duty of Candour. Patients were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result.

Learning and improvement

We found there was a rolling programme of clinical and non-clinical audits taking place at the practice. These included infection control; X-ray quality and the quality of clinical record keeping. The audits demonstrated a process where the practice had analysed the results to discuss and identify where improvement actions may be needed, action and share these.

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Records showed professional registrations were up to date for all staff and there was evidence continuing professional development was taking place.

Are services well-led?

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

The practice had systems in place to seek and act upon feedback from patients using the service.

The practice gathered feedback from patients through the NHS Friends and Family Test (FFT), NHS Choices, suggestions box, compliments and complaints. There were feedback comments made on the NHS Choices website since 2014 and all bar one were very positive about their experience at the practice.