Mr Niloy Karia

Karia Dental - Welling

Inspection Report

61-65 Hadlow Road
Welling
Kent
DA16 1AX
Tel: 0208 311 4095
Website: www.kariadental.co.uk

Date of inspection visit: 04 June 2015
Date of publication: 16/07/2015

Overall summary

We carried out an announced comprehensive inspection on 04 June 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Karia Dental – Welling is located in the London Borough of Bexley. The premises consist of seven treatment rooms, two dedicated decontamination areas and an X-ray room. There are also toilet facilities, a waiting room, a reception area and an administrative office.

The practice provides NHS and private dental services and treats both adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, tooth whitening and oral hygiene.

The staff structure of the practice is comprised of a principal dentist (who is also the owner), eight dentists, seven dental nurses, three hygienists, a practice manager, three receptionists, and one trainee dental nurse. There is also a visiting oral surgeon providing treatment at the practice.

The practice is open Monday to Friday from 8.00am to 5.30pm and on Saturday from 9.00am to 1.00pm.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

This practice was last inspected by CQC in April 2012 and met the required standards at that time. We carried out a new, announced, comprehensive inspection on 04 June 2015. The inspection took place over one day and was carried out by a CQC inspector and dentist specialist advisor.

We received 25 CQC comment cards completed by patients and spoke with two patients in the waiting area. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

We found that this practice was providing safe, effective, caring, and responsive care in accordance with the relevant regulations. However we found that this practice was not providing well-led care in accordance with the relevant regulations.

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).

Summary of findings

- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, oxygen cylinder and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- Patients indicated that they felt they were listened to and that they received good care in a from a helpful and patient practice team.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentists had a clear vision for the practice and staff told us they were well supported by the management team.
- We also found that the governance arrangements and audits were not effective in improving the quality and safety of the services

We identified regulations that were not being met and the provider must**:**

- Review governance arrangements including the effective use of risk assessments, audits, such as those for infection control, and staff meetings for monitoring and improving the quality of the care received.

You can see full details of the regulations not being met at the end of this report.

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

- Review the suitability of all areas where decontamination of used dental instruments is undertaken, and the fixtures and fittings in the treatment rooms giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- Ensure all staff including the domestic staff have received training in infection control processes.
- Review the arrangements for the storage of emergency medicines to reduce the risk that they can be accessed inappropriately by members of the public.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems in place to minimise the risks associated with providing dental services. The practice had policies and protocols related to the safe running of the service. Staff were aware of these and were following them. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. Equipment was well maintained and checked for effectiveness. The practice had an effective recruitment process and staff engaged in on-going training to keep their skills up to date.

The practice had systems in place for the management of infection control and waste disposal, management of medical emergencies and dental radiography. However, there were some areas where the practice could improve. For example, emergency medicines were not securely stored. One of the decontamination areas did not have adequate space to allow for the clear segregation between clean and dirty areas. One of the treatment rooms had not been suitably maintained and posed an infection control risk. The practice recorded incidents but could not demonstrate how they learnt from incidents that occurred.

Are services effective?

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

The practice could demonstrate they followed relevant guidance, for example, issued by the National Institute for Health and Care Excellence (NICE) and The Department of Health (DH). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. There were systems in place for recording written consent for treatments, such as for those involving sedation.

The practice maintained appropriate medical records and details were updated appropriately The practice worked well with other providers and followed patients up to ensure that they received treatment in good time.

Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council (GDC).

Are services caring?

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

We received feedback from patients through comment cards that they were treated with dignity and respect. They noted a positive and caring attitude amongst the staff. We found that patient records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. Members of staff spoke five different languages which supported good communication between staff and patients. The needs of people with disabilities had been considered in terms of accessing the service. Patients were invited to provide feedback via a satisfaction survey, a comments book and a suggestions box situated in the waiting area.

Summary of findings

There was a clear complaints procedure and we saw that the practice responded to complaints in line with the stated policy. However, the outcomes of complaints were not routinely reviewed and discussed at staff meetings in order to identify and share strategies for improving the service.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Governance arrangements were in place to guide the management of the practice. This included having appropriate policies and procedures and staff meetings. However, risk assessments, audits and staff meetings were not being used effectively to monitor and improve the quality of care. We found that the outcomes of risk assessments or audits had either not been reviewed or not been acted on in a timely manner. Staff meetings were infrequent and relevant topics, such as complaints and incidents, had not been discussed in order to share best practice strategies.

Karia Dental - Welling

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 04 June 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. We also informed the NHS England area team and the local Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with seven members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

We reviewed 25 Care Quality Commission (CQC) comment cards completed by patients and spoke with two patients in the waiting area. Patients we spoke with and those who completed comment cards were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. Two significant events related to patients and three staff accidents had been recorded in the past year. The events recorded did not relate to mistakes made by the clinicians which affected individual patients. The practice manager and dentists confirmed that if patients were affected by something that went wrong, they were given an apology and informed of any actions taken as a result.

There was a seven-step protocol for staff to follow in the event of an incident. The practice manager took the lead for investigating and reporting events with input from the clinicians. The practice had dealt effectively with incidents as they occurred. For example, following an incident where the practice's telephones stopped working, the practice manager quickly resolved the problem so that patients' care was not interrupted. However, additional reflection and learning, which could be shared with all staff, following incidents did not take place. The practice meetings had a standard agenda including a section for discussing incidents, but the minutes showed that no such discussions took place related to this incident, or to others as they occurred. This meant that the practice did not use learning from incidents to improve the quality of the care provided or to prevent similar incidents from occurring again.

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

Reliable safety systems and processes (including safeguarding)

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, such as the Care Quality Commission. This information was displayed in each of the treatment rooms so that staff could access the information promptly. These details were also kept with the safeguarding policy.

The registered manager, who was also the principal dentist, was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed safeguarding training and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead. There had been no safeguarding issues reported by the practice to the local safeguarding team.

Staff were aware of the procedures for whistleblowing if they had concerns about another member of staff's performance. Staff told us they were confident about raising such issues with the principal dentist or practice manager.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, a practice-wide risk assessment had been carried out in May 2013 which covered topics such as fire safety, the safe use of X-ray equipment, disposal of waste, and the safe use of sharps (needles and sharp instruments). The practice had then carried out a follow-up risk assessment for each of these issues in March 2015. The most recent risk assessments had identified a number of action points. For example, the fire risk assessment noted that staff may need re-training and that the disposal of paper waste needed to be reviewed. The practice manager told us that these points were due for discussion at the next staff meeting in June 2015 to decide on an implementation strategy.

The practice followed national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. All staff had received training in emergency resuscitation and basic life support. This training was renewed annually. The staff we spoke with were aware of the practice protocols for responding to an emergency.

The practice had suitable emergency equipment in accordance with guidance issued by the Resuscitation Council UK. This included relevant emergency medicines, oxygen and an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life

threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). There were face masks of different sizes for adults and children. The equipment was regularly tested by staff and a record of the tests was kept.

Staff recruitment

The practice staffing consisted of a principal dentist, eight dentists, seven dental nurses, three hygienists, a practice manager, three receptionists, and one trainee dental nurse. The majority of staff had worked at the practice for a number of years and we saw that appropriate checks were carried out when they had started employment at the practice. The practice had recruited one, new member of staff in 2014 and we found effective recruitment and selection procedures had been used. We saw that the staff file for this person included relevant checks to ensure that the person being recruited was suitable and competent for the role. This included the use of an application form, interview notes, review of employment history, evidence of relevant qualifications, the checking of references, a check of registration with the General Dental Council and checks with the Disclosure and Barring Service (DBS).

We noted that the practice had carried out DBS checks for all members of staff within the past four years, regardless of the date when they had initially been recruited.

Monitoring health & safety and responding to risks

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

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors that were associated with hazardous substances had been identified and actions were described to minimise these risks. We saw that COSHH products were securely stored. Staff training files indicated that staff had received relevant training in managing COSHH products.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts arrived via email to the practice manager who then disseminated these alerts to the other staff. The practice manager also kept a historical file of alerts received which noted any actions they had taken in response to an alert. For example, advice regarding different medical devices or equipment were regularly received, with the last having arrived in April 2015. The practice manager had checked the equipment held at the practice to determine if the alert was relevant and made a note that this check had been carried out, but that no further action was required.

There was a business continuity plan which had been reviewed on an annual basis. The practice was one of three sites owned by the principal dentist. There was an arrangement in place with one of the owner's other practices to provide continuity of care in the event that the practice's premises could not be used. Key contacts, for example, for the servicing of electrics or plumbing, were kept up to date in the plan.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the dental nurses was the infection control lead. Staff files we reviewed showed that staff regularly attended external training courses in infection control.

The practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room with a clear flow from 'dirty' to 'clean.' One of the dental nurses demonstrated how they used the room and demonstrated a good understanding of the correct processes. Dental nurses wore appropriate protective equipment, such as heavy duty gloves and eye protection. We noted that all staff were currently manually cleaning instruments in each of the treatment rooms. However, the dedicated

decontamination room did allow for such cleaning to take place in it with dedicated sinks for cleaning, rinsing and hand washing. An illuminated magnifier was used to check for any debris during the cleaning stages. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp indicated how long they could be stored for before the sterilisation became ineffective.

An automatic data logger recorded any faults in the sterilisation process when items were put through the autoclave. The cycle did not continue if a fault was detected in the machine and a light indicated to staff that a problem had occurred. However, the practice did not use a system of daily logs recorded by a member of staff to monitor the effectiveness of the sterilisation process. For example, they did not keep a record of the warm-up cycle having taken place at the beginning of the day. There were no other systems for monitoring the effectiveness of the autoclave at periodic intervals.

We discussed this with staff on the day of the inspection. They showed us that nurses were referring to a checklist, which included daily, weekly and monthly duties related to infection control, but that a record of the process was not being kept. They determined that they would instigate such a process on the day of the inspection.

There was a second autoclave in a smaller side room. This was used by the hygienists. We found that this room did not comply with HTM 01-5 standards as the room was too small to ensure adequate separation between the clean and dirty areas. There was a side shelf for dirty instruments with clean instruments placed on top of the autoclave. However, this was a restricted space without ventilation and therefore the practice could not be confident that adequate separation of clean and dirty equipment was being maintained. We discussed this with the practice manager who agreed that this area was not suitable.

All of the staff were required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Newer members of staff also had a wider check of their immunisation history including rubella, tetanus, polio and tuberculosis. We discussed the possibility of carrying out these checks for longer-standing members of staff with the practice manager.

There had been regular, six-monthly infection control audits with the last one having been completed in April 2015. This had not identified any issues. However, we noted a number of issues which had not been picked up through this audit. For example, one of the dentist's chairs had some small rips and tears which may have posed an environmental risk as adequate disinfection between patients could not be completed; disposable covers were not being used to minimise any risks. Cupboard doors and drawers were also faulty or in poor repair in this room meaning that cleaning these effectively was more difficult. We were told by staff that these had been long-standing issues but they were not recorded in the audit, and had not been considered in terms of the infection control risk. This indicated that the audit process was not being used to effectively reduce the risk of infection. We discussed the problems we had identified with the practice manager and principal dentist. They were both aware of the need to refurbish the treatment room. The principal dentist assured us that funds were being made available to replace or repair items that represented an infection control risk.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. This included clinical waste and safe disposal of sharps. Staff demonstrated they understood how to dispose of single-use items appropriately.

Records showed that a Legionella risk assessment had been carried out by an external company in November 2010. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). This process identified some risks. However, the practice had not taken action to reduce these risks at that time. They were able to demonstrate that a plan with a timeline in place to minimise risks was now in the process of being implemented. For example, work on the water tanks was booked to take place in July 2015. We saw evidence that dental water lines were being flushed in accordance with current guidance in order to prevent the growth of Legionella.

The premises appeared clean and tidy. There was a good supply of cleaning equipment which was stored appropriately. The practice had a cleaning schedule that covered all areas of the premises and detailed what and where equipment should be used. This took into account

national guidance on colour coding equipment to prevent the risk of infection spread. However, we noted that the cleaner employed to carry out general cleaning tasks had not received any training in infection control.

There were good supplies of protective equipment for patients and staff members including gloves, masks, eye protection and aprons. There were hand washing facilities in the treatment rooms, the decontamination room and the toilets.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced. Portable appliance testing (PAT) was completed in accordance with good practice guidance. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely in the administrative office. However, no record was kept of prescription numbers meaning that the practice would not be able to identify if any pads were missing.

Batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes. These medicines were stored safely and could not be accessed inappropriately by patients. The practice held one controlled drug which was securely locked away. However, we noted that other emergency medicines were stored in an unlocked area which could potentially have been accessed by patients as they walked through the practice. We made the principal dentist and practice manager aware of this risk.

There was appropriate equipment for carrying out intravenous sedation including equipment to monitor blood pressure, heart rate, breathing rate and oxygen levels in the blood. The practice also had appropriate supplies of reversal agent drugs.

Radiography (X-rays)

The practice kept a radiation protection file in relation to the use and maintenance of X–ray equipment. There were suitable arrangements in place to ensure the safety of the equipment. The local rules relating to the equipment were held in the file and displayed in clinical areas where X-rays were used. The procedures and equipment had been assessed by an external radiation protection adviser (RPA) within the recommended timescales. One of the clinical dental team was the radiation protection supervisor (RPS). All clinical staff including the RPS had completed radiation training. X-rays were graded and audited as they were taken.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We reviewed dental care records kept by each dentist and discussed patient care with the dentists. We found that the dentists regularly assessed patient's gum health and soft tissues (including lips, tongue and palate) were regularly examined. Dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP). They also recorded the justification, findings and quality assurance of X-ray images taken.

The records showed that an assessment of periodontal tissues was periodically undertaken using the basic periodontal examination (BPE) screening tool. (The BPE is a simple and rapid screening

tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action.

Staff followed a system whereby they checked each dentist's patient list at the start of each day to determine who would need to be asked to update their medical history in order to keep clinicians reliably informed of any changes in people's physical health which might affect the type of care they received.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients. The dentists were aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients. We saw that they were following the advice in the toolkit, for example, in relation to when a fluoride varnish might need to be applied to a patient's teeth.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. Dentists identified patients' smoking status and recorded this in their notes. This prompted them to provide advice or consider how smoking status might be impacting on their oral health. Dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were a range of health promotion materials displayed in the waiting area. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We reviewed staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies and infection control. There was an induction programme for new to staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff had recently all been engaged in a self-appraisal process with a view to identifying their personal development needs, including training and career aspirations. We examined some of the forms completed for this process and saw that they also provided a forum for staff to raise more general concerns about the smooth running of the practice. All of the forms had been reviewed by the principal dentist who was now in the process of setting up one-to-one meetings so that staff could complete a formal appraisal process.

One of the dentists was providing intravenous sedation at the practice. They renewed appropriate training in relation to sedation periodically and provided dental nurses with in-house sedation training. There was an adequate number of nursing staff available to ensure that an appropriate staff ratio was maintained during sedation. During the self-appraisal process some of the nurses had expressed an interest in completing formal sedation training with an external provider. The principal dentist and practice manager told us they were supportive of this interest and would be looking to provide this training.

Working with other services

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

Are services effective?

(for example, treatment is effective)

referral to other providers, for example, for oral surgery, orthodontics or advanced conservation. There had been some recent issues with referrals due to a new system being implemented locally for the management of referrals. Staff demonstrated that they were working with the other providers to resolve these external issues. Referrals were followed up and the outcomes were appropriately recorded in patient's notes. Dentists within the practice also referred work on to each other, depending on the particular skills and specialisms required for any given treatment.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. Formal written consent was also obtained using standard treatment plan forms. Patients were asked to read and sign these before starting a course of treatment. Written consent forms were also completed by patients prior to any treatment requiring intravenous sedation.

We saw evidence that the requirements of the Mental Capacity Act 2005 (MCA) had been discussed at staff meetings. Dentists and dental nurses were aware of the Mental Capacity Act (2005). They could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The comments cards we received and the patients we spoke with all commented positively on staff's caring and helpful attitude. Parents were pleased with the level of care their children received. Patients who reported some anxiety about visiting the dentist commented that the dental staff were good about providing them with reassurance. We observed staff were welcoming and helpful when patients arrived for their appointment.

The practice obtained regular feedback from patients via a satisfaction survey; data were analysed every three months. We noted that the overwhelming majority of feedback about staff was positive and corroborated our own findings regarding staff's caring attitude.

Doors were always closed when patients were in the treatment rooms. Patients indicated they were treated with dignity and respect at all times.

Patient records were stored electronically. They were password protected and regularly backed up. Staff understood the importance of data protection and confidentiality. They described systems in place to ensure that confidentiality was maintained. For example, reception staff told us that they were careful about the angle of their computer screen to ensure that visitors could not observe the content of patient records in the reception area. Staff also told us that people could request to have confidential discussions in an empty treatment room, if necessary.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of NHS and private dental charges or fees. However, one patient noted that this information was not prominently displayed and they had not noticed it. Patients did comment that dentists were open and transparent about discussing fees prior to treatment and that they were content with the explanations given.

Staff told us that they took time to explain the treatment options available. They spent time answering patients' questions and gave patients a copy of their treatment plan. There was a range of information leaflets in the waiting area which described the different types of dental treatments available. The patient feedback we received via discussions and comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. The practice manager gave a clear description about which types of treatment or reviews would require longer appointments.

Staff told us they had enough time to treat patients and that patients could generally book an appointment in good time to see the dentist of their choice. The feedback we received from patients confirmed that they could get an appointment within a reasonable time frame and that they had adequate time scheduled with the dentist to assess their needs and receive treatment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. Staff spoke five different languages and also had access to a telephone translation service. They provided written information for people who were hard of hearing and large print documents for patients with some visual impairment.

A disability discrimination audit was carried out yearly to monitor access to the service. This had identified two treatment rooms which were wheelchair accessible. The audit had identified some areas where improvements could be made in the coming year. This included the installation of a call bell and hand rail in one of the public toilets.

Access to the service

The practice was open from 8.00am to 5.30pm Monday to Friday, and from 9.00am to 1.00opm on Saturday. The practice displayed its opening hours on their premises and on the practice website. New patients were also given a practice information leaflet which included the practice contact details and opening hours.

We asked the practice manager about access to the service in an emergency or outside of normal opening hours. They told us the answer phone message gave details on how to access out of hours emergency treatment.

The practice manager told us that the dentists had some gaps in their schedule on any given day which meant that patients who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. Patients told us that they could get an appointment in good time and some people noted that they had been seen promptly on the day they presented with an urgent issue.

Concerns & complaints

Information about how to make a complaint was displayed in the reception area. There was a complaints policy describing how the practice handled formal and informal complaints from patients. There had been one complaint recorded in the past year. This had been received by a receptionist over the phone and had been dealt with by the practice manager, with input from the principal dentist, in line with the practice policy.

The practice also had a suggestions box and comments book available for patients to provide feedback. This was displayed in the waiting area. We reviewed the comments book and saw that two further concerns had been reported by patients within the past year. We discussed these with the practice manager and they gave a clear account of how the practice had responded to the issues identified.

We saw that that dealing with complaints was a standing item on the practice meeting agenda. However, we noted from our review of the meeting minutes that the complaints received had not been discussed at a staff meeting. Therefore the practice could not demonstrate how they had identified or shared any wider learning points related to the complaints process which could lead to improvements in their practice.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of these policies and procedures and acted in line with them. Staff were being supported to meet their professional standards and complete continuing professional development standards set by the General Dental Council. Records, including those related to patient care and treatment, as well as staff employment, were kept accurately.

There were arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. However, these assessments were not always being used effectively to drive improvements in a timely manner. For example the Legionella risk assessment had been carried out in 2010, but issues identified during this assessment were only being addressed in 2015.

We also found that practice meetings were scheduled to take place every month with a set agenda to discuss a range of governance issues, including complaints and incidents. However, the minutes from these meetings indicated that only three meetings had taken place in 2014 and only two meetings had taken place so far in 2015. Incidents and complaints had not been discussed at any of these meetings in order to share learning or to decide on a strategy to prevent events from occurring again. For example, there had been one sharps injury in 2014 and another in 2015. Neither of these had been discussed at a staff meeting to share learning about what could have been done differently to prevent these injuries or to remind staff about the contents of the sharps injury protocol.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with either the principal dentist or the practice manager. They felt they were listened to and responded to when they did so. Staff told us they enjoyed their work and were well supported by the management team.

We spoke with the principal dentist who outlined the practice's ethos for providing good care for patients. They had a clear vision about the future of the practice which included making improvements to the premises. Staff were aware of these plans and shared the overall ethos.

A system of staff appraisals was in the process of being implemented to identify staff's training and career goals. The principal dentist and the practice manager were aware which members of staff were interested in taking additional training courses and supported this as a way of improving the mix of skills available at the practice. For example, one of the dental nurses had completed 'prevention in practice' training and others had expressed an interest in taking further training in relation to sedation.

Management lead through learning and improvement

All clinical staff were up to date with their continuing professional development (CPD). All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

Appropriate audits were carried out, but we found that these were not always being used as effective tools for supporting continuous improvement. For example, the infection control audits had not successfully identified a number of issues around infection control which were noted by the inspection team during our site visit. We also found that the quality of each dentist's clinical records was being audited every year by the practice manager. However, the dentists had not reviewed the results of these audits or used the information to improve their performance.

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

The practice gathered feedback from patients through the use of a patient satisfaction survey, a comments book and suggestions box. They had also started to collect information through the 'Friends and Family Test', although they had only received one response to this test so far.

The feedback received through the patient survey was reviewed every three months. The majority of feedback had been positive. The practice manager was also aware of other ad hoc feedback which indicated that the height of

Are services well-led?

the chairs in the waiting area were not high enough for all elderly patients. This had led them to review the seating arrangements. They could also demonstrate that they had implemented a price reduction for the hygienist following patient feedback on fees. This information was displayed in the waiting area.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **The provider had not ensured that their audit and governance systems were effective.** **Regulation 17 (1) (2) (f)**