Whitecross Dental Care Limited

Mydentist - Wells Road - Bristol

Inspection Report

Wells Road Dental Centre
325a-327 Wells Road
Knowle
Bristol
BS4 2QB
Tel: 0117 971 3107
Website: www.idhgroup.co.uk

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Overall summary

The provider has not had a CQC inspection since registration. This provider is one of the four registered legal entities located at this dental centre and run by Integrated Dental Holdings (IDH) which has acquired all four legal entities. The other legal entities are Whitecross Dental Care Ltd, Gairloch House Dental House Partnership, and Broadwalk Dental Centre Partnership for which there are separate reports.

All four practices amalgamated and moved to the new purpose built premises in the middle of 2014 having been acquired by IDH. The practice is located in the main shopping area of Knowle, Bristol and has both a ground floor and first floor with entrances on both levels. Being a new build it is compliant with the Disability Discrimination Act (DDA) 1995.There is disabled access to both floors with the addition of disabled parking level with the first floor. The whole practice consists of fourteen modern purpose built surgeries and a reception desk located on each floor. There is a dedicated Local Decontamination Unit (LDU) which serves the entire building. The practice provides both NHS and private dental treatment to adults and children.

The one practice manager is legally responsible for making sure all four of the practices meets CQC requirements along with the registered directors for each of the four companies registered at this location.

We found the practice staff were friendly, welcoming and informative. The provider has created an atmosphere where excellence is promoted. We saw evidence of good communication and team work.

We spoke with five patients who reported they were very happy with the treatment they received at the practice. They told us they found the staff to be extremely person-centred and felt they were treated with respect. The comments on the CQC comment cards were also very complimentary about the staff and the service provided.

During the inspection we toured the premises and spoke with a majority of staff on duty across both inspection days. This included the principle dentist for the practice although he is employed by only one of the legal entities registered at this practice. To assess the quality of care provided by the practice, we looked at practice policies and protocols and other records. Our key findings were as follows:

Summary of findings

- The practice provided safe, effective and caring treatment which met patients' needs.
- There were systems in place for staff to report incidents. There were sufficient staff on duty to deliver the service. There was enough equipment available for staff to undertake their duties and we saw the premises were in a satisfactory state of repair. It was and clean and tidy.
- Patient's needs were assessed and care was planned and delivered in line with current best practice guidance. This included the promotion of good oral health. We saw evidence staff had received training appropriate to their roles and further training needs were identified and planned through an effective appraisal system.
- The patients we spoke with and all comment cards we reviewed indicated patients were consistently treated with kindness and respect by staff. It was reported that communication with patients and their families, and access to the service and to the dentists was good. Patients reported good access to the practice with emergency appointments available the same day.
- The practice had procedures in place to take into account any comments, concerns or complaints that were made to improve the practice.
- The practice had an accessible principle dentist and staff on duty told us they felt supported by the principle across all legal entities as the practice is run as one large practice. Staff reported patients were at the heart of the practice. This included the promotion of good oral health.

What people who use the service say.

We spoke with eight patients visiting the practice. The patients were a mixture of newly registered patients; patients who had been at Wells Road Dental Practice for a number of years and those who had been registered at other practices before they moved to large purpose built premises. Those who were not newly registered had used the dental services between two and ten years.

The majority of comments made by patients were positive and praised the practice staff. For example they spoke about: receiving excellent care and treatment; the efficiency of the service (one person told us another had been able to get an emergency appointment on the same day) and about the caring attitude of dentists.

We heard and observed how some patients found access to the practice and appointments easy and how telephones were answered after a short period of waiting. One patient told us staff had been unable to find their records on the IT system when they arrived however the reception staff had ensured they booked this patient in to an empty slot so they could be seen quickly.

Patients told us their privacy and dignity was always respected during consultations and they found the reception area was generally private enough for most discussions which were needed.

Patients spoken with told us the practice was always kept clean and tidy and since the lower floor had been refurbished to provide additional space and the upstairs refurbished the practice felt fresh, modern and spacious. Patients told us they liked the waiting areas now as they did not feel cramped. They also said the free parking was helpful. One patient told us the move had enhanced the practices efficiency, friendliness and caring approach.

Two patients reported the cost of treatments were not routinely discussed prior to treatment but other patients told us they had been advised in advance of the costs of treatment and advised they would be required to make an advanced payment for treatment.

Four patients told us they had received notification of the change of address and contact details of the dental practices which had moved in to this building. None of the patients, when asked, told us they had needed to complain.

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 the practice was safe because it had effective systems in place in the areas of infection control, clinical waste management; management of medical emergencies in the dental chair and dental radiographs. Staff demonstrated awareness of their responsibilities to raise concerns and report incidents and accidents. There were regular practice meetings that had items on the agenda regarding safety which demonstrated the practice was committed to providing a safe service for its patient population.

All information about safety was recorded, monitored, appropriately reviewed and addressed. Staff had received safeguarding training and the practice assessed risks to patients and managed these well. The evidence demonstrated a safe service with patients being protected from abuse and avoidable harm.

Are services effective?

The practice carried out effective consultations in line with current National Institute for Health and Care Excellence (NICE) guidance. Patients were provided with advice to help them maintain healthy teeth and prevent tooth decay. The dental care provided was effective, evidence based and focussed on the needs of the patients. We saw examples of very good collaborative team working.

The staff were up-to-date and received professional development appropriate to their role and learning needs. Staff who were registered with the General Dental Council (GDC) had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration. The evidence demonstrated care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible.

Are services caring?

The practice was a caring service. Patients were treated with dignity and respect and their privacy was maintained. Explanations about care and treatment were clear and followed up with a written treatment plan. Staff were aware of the need to maintain patient confidentiality. Patients felt involved in decisions about their care and treatment.

The latest patient survey reflected that patients were satisfied with the staff and the services provided at the practice. We found the service to be caring from interviewing staff and patients and from observing the patient journey from reception through to completion of treatment. This evidence demonstrated clinicians listened to patients, and provided the appropriate treatment in a caring and patient centred manner.

Are services responsive to people's needs?

The service was responsive to the needs of the local population by providing friendly family orientated dental care. NHS and private dental treatment was available at the practice and it met patients' needs. The appointments system was effective and patients were satisfied with it.

Patients could obtain emergency appointments on the same day as the service offered dedicated emergency slots at the end of each morning and afternoon session enabling effective and efficient treatment of patients with dental pain. The practice was accessible for patients with a disability or mobility limitations. Comments and complaints were dealt with effectively and where ideas for improvement had been identified these were actioned. The practice responded to patient views from the practice survey.

Summary of findings

Are services well-led?

The dental practice was well-led with robust clinical governance and risk management structures in place. The practice has a very experienced practice manager and principle dentist who worked across all four legal entities to ensure best practice service provision. The practice provided clear leadership and services offered were monitored to identify areas for improvement.

Staff were aware of their roles and responsibilities and how they impacted on the overall vision of the practice. Staff were aware of the way forward and vision for the practice. They felt well supported and could raise any concerns with the practice manager. All staff told us that it was a good place to work.

Training and development was available and performance monitored. Regular clinical and non-clinical audits took place. Patients were encouraged to provide feedback through a patient survey and by completing a comments book available at reception. The evidence gathered showed the leadership, management and governance of the organisation assures the delivery of person-centred care, supports learning and innovation and promotes an open and fair culture.

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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 and to pilot a new inspection process being introduced by the CQC for dental practice inspections in the primary dental care sector.

- This inspection was carried out on Monday and Tuesday 19 & 20 January 2015 by a lead inspector from the Care Quality Commission (CQC) and a specialist dental advisor working with CQC.
- Prior to the inspection we reviewed information we held about the provider and received from other organisations. We also viewed information we asked the provider to send us in advance of the inspection. This included their statement of purpose, a record of their complaints and how they dealt with them.
- During the inspection we had interviews with most members of staff, interviews with patients, a thorough inspection of all areas of the premises, an examination of all policies and processes and contracts to ensure the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also observed staff interaction with patients.
- We viewed the comments made by patients on comment cards we had left for them to complete prior to the inspection and read a compliments book that was available for patients in the reception area.

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?

Are services safe?

Our findings

Learning and improvement from incidents

The practice had effective systems in place to learn from and improve when significant events, accidents and near misses took place. This included how the incidents were to be recorded, analysed and investigated. This was through robust policies and procedures which were regularly reviewed by the practice manager. Although no incidents had occurred since registration, practice meetings took place each month, minutes were recorded and one of the fixed agenda items related to learning and improvement.

The practice made use of emails to cascade important information to staff. They also used a team approach to ensure relevant information was communicated to staff when required. Staff spoken with confirmed to us there was an effective communication system between them all so learning and changes in guidelines could be made available to them. Learning opportunities had been cascaded to them either informally or at team meetings.

Reliable safety systems and processes including safeguarding

The practice had a lead professional for safeguarding. They had received appropriate training to manage safeguarding issues at the practice with all dentists being trained to level 3 safeguarding children and vulnerable adults. Reception staff received level 1 training through an e-learning package and other members of staff received level 2 training. None of the staff had received specific training around domestic abuse. We advised the practice staff about the UK Department of Health guidance for healthcare professionals including dental professionals about dealing with domestic violence and abuse.

One dentist in the practice told us about a recent incident regarding safeguarding/domestic abuse. The Practice Manager told us the dentists had a peer support group and they would discuss the case in this group to allow dissemination of lessons learnt.

A safeguarding policy was in place for staff to follow. Staff we spoke with had been trained in safeguarding procedures, knew the signs of abuse and how to report any suspected incident. The staff room displayed a flowchart to inform staff how to obtain support from external organisations and this included telephone numbers of the local authority safeguarding team for both children and adults.

National Patient Safety Alerts and notifications from the Medicine and Healthcare Regulatory Agency were acted upon appropriately and cascaded to relevant staff. On receipt of information systems and processes were reviewed to ensure patients received the most up to date and effective treatment and medicines to keep them safe.

Patients attending the practice were asked about their medical history and this was recorded and updated at subsequent visits. This ensured the dentist was aware of all medical conditions, medicines and allergies prior to providing care and treatment to each patient. The practice carried out regular patient record audits to check medical histories were being recorded effectively and reviewed at each visit.

The clinical records we reviewed were well-structured and contained sufficient detail. This enabled another dentist, if required, to see the plan of treatment, what had been done so far, what were the next steps and details of any possible alternative treatment discussed. This demonstrated the dentists and other staff were always aware of any risks to patients and would ensure they were safe during a consultation.

The practice was aware of the requirement to report certain accidents to the Health and Safety Executive. A system and recording procedure was in place for this purpose.

Staff working at the practice were aware of whistleblowing procedures and who to contact externally if there was an issue. Staff spoken with felt confident to raise any issue with the management of the practice They felt their concern would be dealt with professionally without them being discriminated against.

The practice had a business continuity plan that identified the steps to take if there was an emergency which affected the provision of services.

Infection control

There were effective systems in place to reduce the risk and spread of infection. We observed the practice was clean

Are services safe?

and well maintained, and this was confirmed by the five patients we interviewed. We saw evidence in a patient satisfaction survey that patients considered the practice to be a clean and safe environment.

We observed the practice followed national guidance in respect of the cleaning of dental premises-reference National Patient Safety Association publication (NPSA) –' The national specifications for cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises' 2010.

The practice manager showed us the cleaners room where all cleaning materials where appropriately colour coded and correctly stored. We were shown the cleaning protocol in the clinical governance file. We saw the mercury spillage kit, the body fluids spillage kit and the protocols accompanying such kits. We were shown documentary evidence staff had been appropriately trained in their use. Therefore the environment is safe for patients and staff and in the event of a spillage staff are trained and able to respond quickly and effectively.

A written infection control policy was in place for staff to follow, including an infection control risk assessment. All staff at the practice had received infection control training. The policy covered such areas as the cleaning and sterilisation of dental instruments, needle stick injury procedures, the general cleaning of the practice and the disposal of clinical waste. Staff were required to read the policy and record when this had occurred. Documentary evidence was seen which showed all staff at the practice had read the policy.

The practice had a dedicated decontamination room that was set out according to the Department of Health's guidance, Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices. The provider had appointed a decontamination lead as required in the guidance HTM01-05 and we saw documentary evidence of appropriate training in decontamination.

The decontamination process and protocols which are in place minimise the risk of infection both to staff and patients.

We found instruments were being cleaned and sterilised in line with published guidance (HTM 01-05). On the day of our inspection, a dental nurse demonstrated the decontamination process to us and used the correct procedures. We observed dirty instruments were sealed in containers (surgery specific) then transported via a suction air system to the local decontamination room (LDU) thus ensuring maximum safety for staff and patients. During the inspection the system ceased to work. It was evident the practice had a continuity process in place to manage system failures. Staff were made aware of the problem and nurses attended the LDU to collect empty boxes and start a hand delivery process.

We were shown the LDU which meets best practice standard as defined by HTM01-05. Personal protective equipment (PPE) was available and worn appropriately for staff working in the LDU. All decontamination equipment had been validated and all daily tests required carried out and logged appropriately. We saw evidence of essential maintenance of all decontamination equipment. After decontamination instruments are correctly pouched date stamped and returned to the relevant surgery by the air shaft. We observed in the dental surgery the correct storage of hand instruments and correct layout in the dental drawers as advised in HTM01-05.

We saw contracts were in place for the safe disposal of clinical waste and examined the waste transfer notes. We observed the different categories of dental waste was appropriately segregated and stored in a dedicated locked room. We observed non clinical waste was stored and disposed of correctly.

Personal Protective Equipment (PPE) was available to all staff and worn appropriately. Staff on arriving at work were provided with lockers and a changing room where they could change and wear appropriate PPE. This meant the risk of cross infection was minimalised.

Staff had undertaken hand washing training which had been logged, and appropriate protocols were seen to be in place. Above each sink we observed posters reminding staff re the hand washing policy. All these observed processes ensured staff and patients were in an environment where all recommended cross infection measures had been implemented.

A Legionella risk assessment had been carried out at the practice. Legionella is a bacteria found in the environment which can contaminate water systems in buildings One of the dental nurses demonstrated the measures taken to

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eliminate Legionella in the dental unit water lines (DUWL). The dental unit waterlines were routinely cleaned in accordance with HTM 01-05 to protect staff and patients from contracting aerosol infections.

Equipment and medicines

We inspected the clinical treatment areas and non-clinical areas and found all equipment fit for purpose. Records we viewed reflected all equipment in use at the practice was regularly maintained and serviced in line with manufacturers guidelines. Portable appliance testing (PAT) took place on all electrical equipment. Fire extinguishers were checked and serviced regularly and the fire alarm had been recently inspected and tested. The practice therefore provided a safe environment for patients and staff.

We saw evidence all dental materials and medicines were safely and securely stored.

The audit of the patients' dental records, discussions with the specialist dental advisor and the clinicians evidenced national guidance and best practice was being followed when prescribing medicines to patients.

X-ray machines were the subject of regular visible checks and records had been kept. A specialist company attended at regular intervals to calibrate all X-ray equipment to ensure they were operating safely. Where faults or repairs were required these were actioned in a timely fashion.

Medicines in use at the practice were stored and disposed of in line with published guidance. Medicines in use were checked and found to be in date. There were sufficient stocks available for use and these were rotated regularly. The ordering system was effective.

Monitoring health & safety and responding to risks

A health and safety policy and risk assessment was in place at the practice. This covered the risk to patients and staff who attended the practice. The risks had been identified and control measures put in place to reduce them. Regular health and safety audits took place at the practice to ensure the environment was safe for both patients and staff. Where issues had been identified remedial action had been taken in a timely manner.

There were also other policies and procedures in place to manage risks at the practice. These included infection prevention and control, a Legionella risk assessment, fire evacuation procedures and risks associated with hepatitis B. Processes were in place to monitor and reduce these risks so staff and patients were safe.

The practice had an induction process for all new staff members and this included familiarisation with health and safety issues.

Medical emergencies

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

The medical emergency drug kit was checked, and all drugs were in date and the contents of the kit, in accordance with Resuscitation Council UK guidelines. A protocol was seen, which ensured the various drugs in the kit were regularly checked and kept up to date. The medical emergency oxygen cylinder was examined and protocols and policies evidenced to ensure correct maintenance of the equipment was in place. Recent General Dental Council (GDC) /Resuscitation Council guidance requires all dental premises to have an Automatic External Defibrillator (AED) on site and suitably trained staff. We saw documentary evidence of such training and contracts to maintain this equipment.

Medical emergency training and cardiopulmonary resuscitation (CPR) for all staff was up to date as outlined by the Resuscitation Council UK. We noted that due to the large size of this dental practice training had been provided as part of a team which we observed was best practice. Therefore in the event of a medical emergency the staff present function as a team to ensure the best outcome for the patient.

Records seen and staff interviews confirmed all staff regularly participated in medical emergency training and fire drills ensuring they knew how to respond to an emergency. The patient record card audit carried out by the specialist dental advisor evidenced medical histories were updated for each course of treatment. A protocol was in place to flag up medical alerts to protect both staff and patients. Thus in the event of a medical emergency staff had access to all relevant medical information about each patient.

Staff recruitment

There was a practice recruitment policy in place. This policy set out the standards it followed when recruiting

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staff. Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body. We saw all staff were currently undertaking a criminal records check through the Disclosure and Barring Service (DBS).

A recently employed member of staff was currently undergoing an induction process and records had been kept. We spoke with this member of staff who told us they were following an induction process and they had been supported by colleagues with whom they worked.

Dentists and dental nurses working at the practice were all registered correctly with their professional body and had the necessary qualifications, skills and experience to work there. Training certificates were in place in their personal files to evidence qualifications and experience.

Radiography

In the extensive Radiation Protection File we noted that as a new build all radiographic equipment had been registered with the local Health and Safety Executive as required by the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).

X-ray equipment was situated in suitable areas and X-rays were carried out safely and in line with local rules which were relevant to the practice and equipment. These were clearly displayed. All staff had signed a document to indicate they had read the X-ray procedure and local rules to ensure the safe use of the equipment. Patients were required to complete medical history forms to assess whether it was safe for them to receive X-rays.

In the X-ray file we observed a Radiation Protection Adviser (RPA) had been appointed as required by IR(ME)R 2000. We observed all clinicians had received appropriate training in radiology as required by the General Dental Council (GDC). Each clinician showed the specialist dental advisor radiographs which were part of the patient electronic health record as all radiographs taken were digital. We observed the justification, quality assurance and a report on each radiograph was recorded in the patient's records in line with national guidance provided by the Faculty of General Dental Practitioners (FGDP UK). Therefore patients can be assured radiographs are only taken when clinically necessary by suitably qualified clinicians and the findings in each radiograph are acted upon.

The practice's radiation protection file contained the necessary documentation demonstrating maintenance of the X-ray equipment at the recommended intervals. Records viewed demonstrated the X-ray equipment was regularly tested, serviced and repairs undertaken when necessary.

Are services effective?

(for example, treatment is effective)

Our findings

Consent to care and treatment

The practice had a consent policy for staff which described the different types of consent which could be obtained, including written and verbal. This policy had been read by staff at the practice and signed by them. It explained how to take consent from a patient if their mental capacity was such that they might be unable to fully understand the implications of their treatment. This followed the guidelines of the Mental Capacity Act 2005.

Staff we spoke with had a clear understanding of consent issues. All staff understood consent could be withdrawn by a patient at any time. We asked about consent in relation to children under the age of 16 who attended for treatment without a parent or guardian. This is known as Gillick competence. Staff were aware of this area of consent and how to deal with such a patient. Where written consent for treatment was required, it was recorded on a form designed for the purpose.

We saw evidence in patient records of the use of the NHS form FP17DC06 which is a legal requirement for NHS band 2 and 3 cases which demonstrated patients were presented with treatment options and consent forms were signed by the patient. This demonstrated patients have informed choices regarding their dental treatment. Patients we spoke with also advised us they gave both verbal and written consent to their treatment.

All staff demonstrated an understanding of their responsibilities around information sharing, record documentation, the Mental Capacity Act 2005 and consent to care and treatment. Staff were able to describe in detail where to go if decisions needed to be made about a patients lack of capacity and best interest decisions need to be taken.

Monitoring and improving outcomes for people using best practice

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual dental treatment plan. We looked at a sample of treatment records. The records contained details of the condition of the teeth, gums and soft tissues lining the mouth. These were carried out at each dental health assessment and indicated the patient was made aware of changes in the condition of their oral health.

We discussed with the lead clinician and the practice manager how best practice was maintained by all the clinicians. We were shown the minutes of regular clinical team meetings where staff discussed best practice and protocols were produced and updated as required.

We observed feedback regarding this dental practice was very positive. The provider explained feedback from these patients is analysed and changes to be made discussed at staff meetings and recorded in minutes. The clinicians demonstrated they had maintained their continuing professional development (CPD) which demonstrated they are clinically competent and provide dental care in line with current best practice.

We observed several patient journey's from arrival to departure from the practice. At all times, the patients were treated with dignity and respect and communication with the patient was good. The patients we interviewed advised us their treatment options, costs and possible outcomes of their treatment had been fully discussed with them. We noted the patients we interviewed would recommend the practice to a friend.

The dentists told us they determined the recall interval by using a risk based approach based on the current National Institute for Health and Care Excellence (NICE) guidance. The recall interval was set following discussion of these risks with the patient.

Working with other services

The practice worked proactively with other dental providers to co-ordinate care and meet patient's needs when required. The practice involved other professionals and dental therapists in the care of their patients where this was in the best interest of the patient. The specialist dental advisor discussed with all the clinicians referral of patients to other services and was shown referral letters and the response and follow up from other services. This demonstrated the clinicians are working within their area of clinical competency and are able to refer patients to other providers when necessary.

We were shown a regular audit of the referral process takes place to ensure quality referrals. We were shown the

Are services effective?

(for example, treatment is effective)

protocol which had been produced to support clinicians in referring to other services. This ensures patients will be referred when the clinician feels the treatment the patient requires is out of their sphere of clinical competency. We saw documentary evidence of appropriate referrals in a timely manner.

Health promotion & prevention

The practice used a variety of methods for providing patients' with information. These included a practice website and patient information leaflets. We also saw the website had information about the practice, fees, opening times and contacts. Information displayed included good oral hygiene, early detection of oral cancer and children's oral health.

The waiting room and reception area at the practice contained a range of literature that explained the services offered at the practice in addition to information about effective dental hygiene and how to reduce the risk of poor dental health. There was also information and contact details displayed about how patients could access urgent dental care if required. The practice had a range of products patients could purchase which were suitable for both adults and children.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary advice was also given to them. On the day of our visit we spoke with a patient and their children. They told us their experience at the practice was positive and that they had been given advice about maintaining healthy teeth. Patients at high risk of tooth decay were identified and advised to use toothpaste with high fluoride levels to keep their teeth in a healthy condition.

We saw evidence in the clinical records that oral health promotion was carried out in line with the latest Department of Health (DOH) publication 'Delivering better oral health'. Risk assessments were carried out for dental decay and fluoride supplements prescribed in line with the guidance 'Delivering better oral health'.

Clinicians carried out a risk assessment regarding the health of the patient's gums (periodontal disease). All clinicians carried out a Basic Periodontal Examination (BPE) as described in the guidance from the British Society of Periodontology (BSP). As per guidance a BPE score of more triggered a full periodontal charting which was recorded in the patients digital records. Clinicians referred to the in house dental hygienist for on going periodontal treatment.

We interviewed the dental hygienist and examined their records which evidenced they were treating patients in line with current best practice. We observed some of the patients were using the new General dental Council (GDC) guidance on direct access. 'Direct Access' means giving patients the option to see a dental care professional (DCP) without having to see a dentist first and without a prescription from a dentist.

We observed the hygienist worked in the dental surgery unsupported i.e. not chaperoned. The GDC standards for the dental team makes it clear this is not best practice. The GDC standard 6.2.2 states 'you should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting.

Staffing

The ratio of dentists to dental nurses was one to one. Dental staff were appropriately trained and registered with their professional body. Staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. Staff files showed details of the number of hours they had undertaken and training certificates to evidence attendance. Non-clinical staff were appropriately trained to carry out their duties and training was the subject of regular monitoring at the practice. Records seen reflected staff training was up to date and met the needs of patients.

A policy was in place which identified how the practice managed staff personal and professional development, including appraisal. Staff spoken with felt valued and thought they were effectively trained. Staff new to the practice went through an induction process to ensure they were familiar with the way the practice ran and before being allowed to work unsupervised.

Staff numbers were the subject of monitoring and identified staff shortages were planned for in advance wherever possible. At the time of our inspection there had been no need to use locum staff but a system was in place to check they were appropriately qualified and experienced should the practice need to use them.

Are services effective?

(for example, treatment is effective)

Staff we spoke with felt supported at the practice. They told us the manager and dentists were always available for advice and guidance. They had access to the practice computer system which contained information which further supported them in the workplace. This included current dental and good practice guidance.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff at the practice treated patients with dignity and respect and maintained their privacy. We observed the receptionists at both reception areas handling patient telephone calls. At all times they were polite and professional with patients. The reception area was open plan and the waiting room was adjacent, separated by a short corridor. We were told that when a confidential issue arose patients could be taken to a private room to discuss any issue. We observed in the clinical areas both the dental nurse and dentist engaging well with their patients. We saw evidence in the records patients were given informed choice regarding their dental treatment.

We sat in the waiting room area and noted conversations at reception could not be overheard as music was being played in the waiting room and in reception. This afforded an additional layer of privacy for patients. Consultation room doors were closed at all times and conversations could not be heard from outside.

A data protection and confidentiality policy was in place of which staff were aware. This covered disclosure of patient information and their conditions and the secure handling of patient information. We observed the interaction between staff and patients and found staff were careful not to discuss patient details within the hearing of other patients at the practice. Records were held securely.

Patients we spoke with felt practice staff were kind and caring. They told us they treated them with dignity and respect and were helpful. Patients who were nervous about seeing the dentist were reassured to make their experience less stressful. The patient survey reflected patients were very satisfied with the way staff treated them at the practice.

Patients were able to give feedback regarding any issues via the patient satisfaction survey.

Patients we talked with advised us they were always treated with dignity and respect by all staff.

The patients interviewed were highly complementary about all the staff in the practice. The patients interviewed advised us their entire family came and they would recommend the practice friends. Patients told us the staff spoke with their children in a gentle manner taking care to explain things in a way they understood whilst at the same time putting them at ease.

Involvement in decisions about care and treatment

Patients spoken with felt involved with their care and treatment. They told us the clinical staff provided them with clear explanations about the consultation and the options for treatment. They said they felt listened to and did not feel rushed. Costs were made clear to them and they were given time to decide about the proposed treatment.

The practice provided NHS and private dental treatment. Each patient was provided with a written treatment plan that had been designed by the practice and which was bespoke to them. NHS patients also received the NHS treatment plan designed for that purpose. Where treatment involved more extensive dental work, patients were given time to consider the treatment suggested. The patient records examined indicated the clinicians involved their patients in choices regarding their treatment options. Patients were also given written options regarding their treatment. The patients we talked with indicated they were fully informed regarding their treatment options.

The results of the patient survey and the comments left for us by patients, reflected patients felt involved in the decisions about their care and treatment and it had been explained to them in a way they understood.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice leaflet and website explained the range of services offered to patients. This included both NHS and private treatments which were available. The costs of NHS and private treatments were clearly displayed in the reception and waiting room areas.

The practice provided continuity of care to their patients by ensuring they saw the same dentist each time they attended. When this was not possible they were able to see one of the other dentists. Patients new to the practice were required to complete a patient questionnaire so the practice could conduct an initial assessment and respond to their needs.

The practice undertook a patient survey annually and the results of it were analysed to identify improvement areas. We found the practice was responsive to the needs of patients and where relevant changes had been made to the services provided to improve patient care and experience. Patients were also signposted to the NHS Choices website and invited to post suggestions or comments if they wished.

The practice ensured there were time slots available for emergencies each day and we observed a patient requesting an appointment at short notice. The practice offered an appointment which suited the patient's requirements the same day.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

Being a new purpose built practice it is compliant with the Disability Discrimination Act (DDA) 1995. Staff we spoke with confirmed they were aware of the equality and diversity policy. When we reviewed the policy we saw all staff had signed to say they had read and understood the policy. There was also an equality and human rights policy in place.

The reception area, waiting room and consulting rooms were all spacious. Toilet facilities were available for patients to use. A hearing loop was in use at the reception desk for those who had hearing difficulties. Patients who were living in vulnerable circumstances were welcome at the practice and a new patient questionnaire invited them to identify their religious beliefs and cultures.

Access to the service

The patients we spoke with advised us they were able to get a routine appointment when they required one. The patient feedback form and CQC forms also confirmed this.

We were shown by the practice manager how access to dental services has been improved by extending opening times. Early morning, evening and weekend appointments are all available thus enabling patient's access to dental care when needed. We observed at both entrances to the premise information for patients was displayed about how to access care out of hours.

Concerns & complaints

The practice had a complaint procedure which was advertised on the practice website, in the reception area and in the practice leaflet. It explained to patients the procedure to follow, the timescales involved for investigation, the person responsible for handling the matter and details of other external organisations that a complainant could contact. It also covered any learning and how this would be cascaded to staff.

The practice manager showed us the practice complaint policy and demonstrated how it was implemented. They explained the practice had a policy of trying to resolve any patient issues in person to reduce the possibility of a formal complaint proceeding. We were shown documentary evidence how complaints are recorded. There had been five complaints received in the last 12 months and four of the five had been resolved to the patient's satisfaction We followed the complaint pathway from initial complaint to resolution which demonstrated a robust process for handling and resolving patient complaints.

Patients we spoke with on the day of our inspection had not had any cause to complain. They felt staff at the practice would treat any matter seriously and investigate it professionally.

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Our findings

Leadership, openness and transparency

The practice had a statement of purpose which described their vision, values and objectives. Staff spoken with were aware of this vision and how they contributed to it. Clinical lead professionals had been identified and staff were aware of who they were and their own responsibilities

Staff told us there was an atmosphere of openness and transparency and a 'no blame' culture. They told us they were encouraged to raise issues and concerns in order to make improvements. They felt included in the day to day management of the practice and thought the leadership was effective.

It was evident there was a clear leadership structure with regular monitoring and assessment of the services provided at this practice. The provider has appointed a practice manager and a lead clinician whom we observed had a good working relationship.

We evidenced regular staff meetings are held and saw these were well planned and minuted. Staff advised us they were able to take any issue to the lead clinician or practice manager as appropriate. Staff were aware of the whistle blowing policy which we reviewed and found to be appropriate.

Patients were encouraged to participate in feedback via CQC forms and the practice feedback questionnaires which were available. We saw evidence these were analysed discussed at staff meetings, minutes made and appropriate action taken.

We spoke to a dental nurse who had been employed for a number of years, a trainee and hygienist. The trainee had been in post for two weeks and had not had any dental experience previously however they had been a patient at the practice and it was the trainee's experience of this and their confidence in the service that led them to apply to the practice. The trainee was very enthusiastic and praised the support received from the practice manager and the nursing staff. They told us in detail about the three month induction programme and the online training process. They outline for us the training they had received in the first two weeks about a range of subjects including safeguarding, fire, health & safety, hand washing and infection control.

The dental nurse told us about the monthly team meetings and how these included necessary updates around practice and problems or concerns from staff or patients. The dental nurse told us the practice manager is approachable and accessible.

All staff told us they would recommend the practice to family and friends and the team was inclusive and the working atmosphere nice. Staff told us they felt confident to prompt dentists and raise issues. An example of this was if the dentist had forgotten to give any health promotion or education to a patient they were able to act as a prompt before the patient left the room.

Governance arrangements

We saw in the extensive clinical governance file protocols and process to ensure the practice was compliant with all current legislation affecting dental practices. We were provided with evidence from patients, members of staff, an inspection of the premises and from examining all the processes and policies in clinical governance file.

The practice had identified a number of lead roles in relation to governance. These included health and safety, infection prevention and control, safeguarding, human resources and complaint handling. Leadership was provided by the practice manager and dental lead professional who oversaw and monitored service provision at the practice.

There was a full range of policies and procedures in use at the practice. These included health and safety, infection prevention control, patient confidentiality and recruitment. These had been reviewed, signed and dated by all staff who had read them. For each policy a responsible person had been identified.

The practice also used a dental patient computerised record system. This was monitored regularly by the registered manager to ensure performance levels and standards were maintained. All staff had been trained in its use.

An audit timetable was in place to regularly audit the services provided. They also had an effective system in place to monitor the latest dental guidance and then implement it at the practice to ensure patients received the most up to date clinical advice and treatment. We carried out an audit of patient records with each of the clinicians on duty on each of the two days of the visit. The specialist

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dental adviser noted the high quality of patient records of each clinician. The clinicians were providing dental treatment which referred to current published best practice guidance. The radiographs in the patient records had been justified, quality assured and findings reported in the records according to current best practice.

The audit timetable identified the type of audit required and the frequency. These were clearly documented and carried out at the identified timescales. Record keeping was clear and where areas for improvement had been identified these had been actioned and completed. We were shown the results of various audits which are regularly undertaken in the practice. The audits we reviewed were:-a record card keeping audit, an antimicrobial prescribing audit, an audit of radiographs taken, an audit on decontamination processes and an audit on referrals. This demonstrated the practice has a robust system in place for monitoring service provision and implementing improvement when needed which benefits staff and patients.

In relation to patient records, each dentist was separately audited so patterns and trends could be identified. Patient records were examined to ensure minimum standards had been maintained, including recording a health history, whether prevention advice was given and the quality of the oral health assessment. This was then the subject of feedback to individual dentists in order to improve the quality of the dentistry.

People's personal records including medical records were accurate and fit for purpose. We carried out a record card audit for a number of cases treated by each dentist. We saw the patient records contained full and contemporaneous notes. The standard of record card keeping followed current best practice. Patient records contained detailed treatment plans and signed consent forms were present. We saw evidence medical histories were updated for each course of treatment. A protocol was in place to flag up medical alerts to protect both staff and patients.

Staff meetings were held monthly and we were told performance was discussed. Staff spoken with were aware of the standards expected of them and told us they were effectively supervised.

We saw the computer records were password protected to ensure confidentiality of personal data which complied with the Data Protection Act 1998.

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

The practice sought feedback from patients through a patient survey, a complaints process, a compliments and comments book and by inviting comments and feedback through their practice website. Patients are encouraged to give formal feedback via the practice feedback forms which are prominently displayed at both reception areas. We evidenced as a result of patient feedback a touch screen was available in the reception area to advise of their arrival at the practice.

We looked at the results of the methods in use for obtaining feedback and found patients were extremely satisfied with the services provided. They were complimentary about the clinical and non-clinical staff, the politeness of reception staff, the quality of the dentistry and the cleanliness of the practice.

Staff we spoke with told us their views were sought at appraisal, team meetings and informally. They told us their views were listened to and ideas adopted.

Staff were able to give feedback to the practice manager and clinical dental lead. We evidence regular minuted staff meetings where a variety of topics were discussed. We observed good communication between the management, clinical and non-clinical staff.

Management lead through learning and improvement

The management of the practice was focused on achieving high standards of care and treatment with an ethos of continuous learning and improvement. Staff at the practice were all working towards a common goal to deliver high quality care and treatment.

Communication between the staff members was effective and a variety of systems were used to ensure safe processes were in place and learning cascaded. These included staff meetings, informal discussions, and the computerised software system in use at the practice.

Complaints were treated professionally and with learning in mind changes in procedures made if required.

The registered manager/lead dentist attended a local dental committee along with other dentists from the area to share good practice. This was then cascaded to staff at

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team meetings. Staff meetings were used to discuss performance issues and a regular cycle of audits took place across clinical and non-clinical areas. Staff received appropriate professional development.

We were shown certificates in the staff files which demonstrated staff had attended appropriate training for their role. The provider showed us the system for recording training which showed the provider ensured all relevant training was attended so that staff were working within their sphere of competency.

There were practice meeting records showing regular 'in house' training covering a wide variety of topics. The specialist dental advisor interviewed the dentists present regarding their learning needs. We were told the provider supported the staff in their individual Continuing professional development (CPD) and had given them all protected learning time to ensure they maintained their verifiable CPD as required by the General dental Council (GDC).

We spoke with members of staff who confirmed they had their learning needs identified and that there was enough training provided for them. Staff told us they were quite confident in raising concerns and the practice manager showed us the relevant policies. All staff received professional development appropriate to their role and learning needs. We saw evidence of previous regular staff meetings which were minuted and which showed the organisation was committed to a continuing personal improvement of staff at all levels.