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Blossomfield Complete Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Blossomfield Complete Dental Care is a dental practice providing general dental services on a predominantly private basis. NHS services are available to patients under 18 years of age. Additional services were also offered, such as dental implants, cosmetic dentistry and orthodontics. The service is provided by two dentists. They are supported by two dental hygienists, six dental nurses, two receptionists and a practice manager. A further two staff members are responsible for sterilising duties.

The practice is located near local amenities and bus routes. There is wheelchair access to the practice and car parking facilities. The premises consist of a waiting room, a reception area, kitchen, staff room, four treatment rooms, a decontamination room and a dedicated room for taking X-rays. Toilet facilities are also available and these offer full access for patients with disabilities. The practice opened at 8:15am on Monday to Thursday and at 8:30am on Fridays. Closing times varied between 3:30pm and 8pm.

Summary of findings

The provider is one of two dentists who co-own the premises from which the practice runs. Both providers are individually registered with the Care Quality Commission (CQC) This report refers only to Dr Skalka's roles and responsibilities within the practice. 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.

We looked at comment cards patients had completed prior to the inspection. We received feedback from 20 patients and this was very complimentary, however, one patient expressed their dissatisfaction about waiting times. Patients were positive about their experience and they commented that staff were caring, courteous and professional.

Our key findings were:

- The practice was organised and appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patient feedback was positive and centred around good quality care and courteous staff.
- An infection prevention and control policy was in place. The decontamination procedures followed recommended guidance. We found that the practice did not hold a blood spillage kit but this was ordered promptly.
- The practice had systems to assess and manage risks to patients, including health and safety, safeguarding, safe staff recruitment and the management of medical emergencies. The practice responded promptly to complete any necessary improvements.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties. All equipment was well maintained apart from one item used in the decontamination process. This had not been recently serviced but the practice responded promptly once this was brought to their attention.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Practice meetings were used for shared learning but these took place on an irregular basis.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as Public Health England (PHE). They must also ensure that staff are educated accordingly.
- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff. They should also review the frequency of staff meetings as regular staff meetings provide the opportunity to share learning and incidents with the whole team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and mostly in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff. The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements in some areas and these were actioned promptly.

Staff told us they felt confident about reporting accidents and incidents. Staff were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice was not registered to receive national safety and medicines alerts from the MHRA that affected the dental practice.

Are services effective?

No action

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

No action

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice and they described staff as caring and courteous. Patients felt involved in their treatment and it was fully explained to them.

Summary of findings

Are services responsive to people's needs?

No action

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

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Patients were able to contact staff when the practice was closed and arrangements were subsequently made for these patients requiring emergency dental care.

The practice had an effective complaints process.

The practice offered access for patients in wheelchairs. Ample car parking facilities were available and this included dedicated bays for patients with disabilities.

Are services well-led?

No action

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

There was a clearly defined management structure in place and staff we spoke with felt supported in their own particular roles.

There were systems in place to monitor the quality of the service including various audits. The practice used methods to successfully gain feedback from patients. Staff meetings did not take place on a regular basis.

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. All audits had documented learning points with action plans, where required.

Blossomfield Complete Dental Care

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 inspected Blossomfield Complete Dental Care on 8 November 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the provider, the practice manager, one other dentist, one hygienist, two dental nurses and the practice administrator/senior dental nurse. We also reviewed CQC comment cards which patients had completed. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place for staff to report accidents and incidents. We saw records of incidents and accidents and these were completed with sufficient details about what happened and any actions subsequently taken. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reportable incidents had taken place at the practice in the last 12 months.

It is important for staff to respond to national patient safety and medicines alerts that affect the dental profession. Staff we spoke with were aware of some recent alerts and were not registered with the Medicines and Healthcare products Regulatory Agency (MHRA). One of the receptionists (who was also the practice administrator) was responsible for obtaining information from the MHRA website and forwarded this information to the rest of the team during practice meetings. We were told that this took place on a monthly basis. Within 48 hours, we were sent evidence that the practice had registered with MHRA which is a more effective way for the practice to receive and action any urgent alerts. There was a policy present with details about the arrangements for staff to report any adverse drug reactions.

Staff we spoke with were aware of the Duty of Candour regulation. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and protection of vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local safeguarding teams and had previously contacted other agencies when making relevant referrals. Staff members we spoke with were all knowledgeable about safeguarding and were confident about when to refer concerns. The practice manager was the safeguarding lead in the practice but had not updated their training since November 2012. They planned to complete training soon and we were told that the provider would be temporarily appointed the safeguarding lead in the interim as they had completed training to a satisfactory level in 2015.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We saw rubber dam kits at the practice and were told that all dentists used them when carrying out root canal treatment whenever practically possible. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided.

All staff members we spoke with were aware of the whistleblowing process within the practice and there was a policy present. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

The practice had processes in place for the safe use of needles and other sharp instruments.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies in the practice were generally in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an automated external defibrillator (AED) present. 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.

The practice occasionally carried out dental visits to patients in nursing homes. These arrangements for the management of medical emergencies did not extend to these visits. Staff undertaking the external visits did not take emergency equipment or medicines with them. We discussed this with staff and they made a decision to cease further external visits with immediate effect. The practice would make arrangements with an alternative provider so that patients will still be able to benefit from this service.

Are services safe?

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in this area. All equipment and medicines were stored in a secure but accessible area.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and AED and monthly checks of the emergency medicines. The emergency medicines were all in date and stored securely. Glucagon was stored in the fridge and the temperature was monitored and documented on a daily basis to ensure it remained within the recommended parameters. A glucagon injection kit is used to treat episodes of severe hypoglycemia which is defined as having low blood glucose levels.

We noted that the practice did not have any midazolam in the buccal form as recommended by the BNF. This is an emergency medicine used to treat a number of conditions including seizures. The practice did have midazolam in the correct dose but it was not available in the buccal form. This is acceptable but does not follow the BNF guidance. This was discussed with staff and we saw evidence to confirm they had placed an order for the appropriate midazolam.

All staff we spoke with were aware of the location of this equipment and equipment and medicines were stored in purposely designed storage containers.

Staff recruitment

We looked at the recruitment records for two members of the practice team. The records we saw contained evidence of employment contracts, staff identity verification, written references, dental indemnity and General Dental Council (GDC) registration certificates. The practice did not hold evidence of one staff member's dental indemnity although we were told that they were indemnified. The provider was responsible for the payment of staff's indemnity and confirmed to us that payment had been made for that individual. They were on holiday on the day of our visit and we were told that all staff held plastic cards on their person which were issued by their indemnity organisation.

There were also Disclosure and Barring Service (DBS) checks present for staff members. We saw evidence that an application had been made to obtain this for a newly recruited staff member. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults.

The practice had a system in place to monitor the professional registration and dental indemnity of its clinical staff members.

The practice had a recruitment policy for the safe recruitment of staff, however, this did not have specific information about DBS checks or the number of references required for each potential post. Within two working days, the practice manager sent us an amended policy and this was more specific and contained all relevant details.

Monitoring health & safety and responding to risks

We saw evidence of a business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. The fire extinguishers had been serviced in August 2016. We saw evidence that fire drills took place in 2015 and 2016 to ensure staff were rehearsed in evacuation procedures. There were two fire exits on the ground floor and these had clear signage to show where the evacuation points were. Fire alarms were present and an external contractor serviced these annually. Staff told us they made a decision to not test these themselves on a weekly basis due to complaints received about the noise. Weekly testing is recommended and the practice manager contacted us after the inspection to inform us that the weekly tests would commence. A fire risk assessment had been carried out in 2009 and it stated that the next review was due in 2010. This had not taken place although we were told that no significant changes in the premises had taken place which affected the fire precautions. Within 48 hours, the practice manager and practice administrator completed a new fire risk assessment. Fire safety training had also been arranged for staff.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We

Are services safe?

looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice followed the guidance about 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)'. However, we identified some necessary improvements and the practice responded to these promptly. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be visually clean. Many patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition. Dental chairs were covered in non-porous material which aided effective cleaning.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance, an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

We observed waste was separated into safe and lockable containers for fortnightly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. Staff we spoke with were aware of disposable items that were intended for single use only.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place. The ultrasonic cleaning bath had not recently been serviced or externally validated. Within 48 hours, we received evidence of a new service contract which included these maintenance checks.

Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

Staff told us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All clinical and non-clinical areas were cleaned by an external cleaner. The practice had a dedicated area for the storage of their cleaning equipment. The practice did not have a kit for the management of a spillage of bodily fluids but this was ordered immediately after our visit.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We reviewed the audit from October 2016 and the findings were satisfactory and demonstrated that further action was not required.

Are services safe?

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A Legionella risk assessment was carried out by an external contractor. This was completed the day before our visit and the report was not yet available. We saw evidence that the practice checked the water temperature on a monthly basis to ensure that the temperature remained within the recommended range; however, the values were not recorded. Within 48 hours, we saw evidence of amended test sheets that required the logging of the temperature. Annual tests were carried out to check the water quality.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves.

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in January 2015 and this was repeated every two years.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only.

There was a separate fridge for the storage of medicines and dental materials. The temperature was monitored and recorded daily.

Stock rotation of all dental materials was carried out on a regular basis by the dental nurse and all materials we viewed were within their expiry date. A system was also in place for ensuring that all processed packaged instruments were within their expiry date.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used digital X-rays.

Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

We saw evidence that the practice carried out an X-ray audit in November 2016. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that the results were analysed and reported on. However, this audit did not include OPG X-rays. The provider informed us this would be actioned as soon as possible.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date, detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

We spoke with two dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were documented in the records we viewed.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE for all adults and children aged 7 and above (as per guidelines). We saw evidence that patients diagnosed with gum disease were appropriately treated.

The practice kept up to date with other current guidelines and research in order to 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 recalling patients for examination and review. Following clinical assessment, the dentists told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs were discussed with the patient and feedback from patients confirmed this.

Health promotion & prevention

The dentists we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

The practice was aware of the provision of preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive oral hygiene advice. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. All new staff were given written information about areas such as health and safety, infection control and confidentiality.

Staff told us they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC.

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that some of the employed dental nurses were part-time and had the flexibility to work additional hours, if required. Occasionally, the practice utilised a locum dental nurse agency.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us that senior staff were readily available to speak with at all times for support and advice.

We were told that the dental nurses were encouraged to carry out further training. Some of the dental nurses had completed additional training which enabled them to take dental impressions and assist with dental implant placement.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist dental services for complex oral surgery. We viewed two referral letters and noted that both were comprehensive to ensure the specialist services had all the relevant information required. Patients were given the option of receiving a copy of their referral letter.

Are services effective?

(for example, treatment is effective)

Staff understood the procedure for urgent referrals, for example, patients with suspected oral cancer.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began and this was recorded in the dental care records.

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The 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.

Staff members we spoke with were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff members and clinical records confirmed individual treatment options, risks, benefits and costs were discussed with each patient. We saw that written treatment plans were provided. We were told that comprehensive letters were given to patients that required more complex dental treatment. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Twenty patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection. Patient feedback was positive about the care they received from the practice. They described staff as courteous, caring and professional. Patients commented they felt involved in their treatment and it was fully explained to them. Several patients commented that they had attended this practice for many years and would not go anywhere else.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy – this was discussed during their induction and was also mentioned in their employment contracts. The reception area was not left unattended and confidential patient information was stored in a secure area. Staff told us they had individual passwords for the computers where confidential patient information was stored. There was always a room available for patients to have private discussions with staff. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

We were told that the practice appropriately supported children and anxious patients using various methods. Longer appointments were arranged to allow additional time for discussions. Existing and new patients were given the practice manager's telephone number and they were able to discuss any aspects of their care or treatment with them. They also had the choice of seeing three different dentists at the practice. Patients could also request a referral for dental treatment under sedation.

The practice offered services such as free refreshments and free Wi-Fi to their patients. A handbook for patients was available in the waiting room with information about the practice and staff.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Several patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as it was all situated on the ground floor. There was a car parking bay for patients with physical disabilities near the main entrance to the practice as well as a large car park. There were toilet facilities available and these were wheelchair-accessible.

Patient feedback confirmed that the practice was providing an excellent service that met their needs.

The practice had an appointment system in place to respond to patients' needs. Staff told us that patients were usually seen on time and that they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred. Some feedback from patients stated that they were often kept waiting beyond their appointment time.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. The dentists used dedicated emergency slots on a daily basis to accommodate patients requiring urgent treatment. If these slots became unavailable, the practice was able to accommodate patients by extending their opening hours.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services. The practice had an audio loop system for patients who might have hearing impairments. Also, the practice had access to sign language interpreters, if required.

The practice had access to an interpreting service for patients that were unable to speak fluent English but the practice had not needed to use this service as they had not encountered any problems communicating with patients.

The practice accommodated patients with visual impairments. All written information (including practice leaflets) was available in large font. The practice also had access to a service that provided information in Braille.

Access to the service

The practice had a system in place for patients requiring urgent dental care when the practice was closed. This information was readily available to patients.

The practice opened at 8:15am on Monday to Thursday and at 8:30am on Fridays. Closing times varied between 3:30pm and 8pm.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and accessible to patients. This included details of external organisations in the event that patients were dissatisfied with the practice's response.

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. All complaints we reviewed were resolved to the complainants' satisfaction. There was a designated complaints lead. We saw examples of changes that were made as a result of concerns raised by patients. One example was the introduction of additional treatment sessions by the dentist to reduce waiting times for patients.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments. The practice also had risk assessments for areas such as the autoclaves, radiation and amalgam. Staff told us that the governance and leadership was good and the practice manager was available at all times.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead, complaints lead and infection control lead.

The provider had systems in place to support communication about the quality and safety of services. Staff told us they were aware of the need to be open, honest and apologetic to patients if mistakes in their care were made. This was in line with the Duty of Candour regulation.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. Some essential training was free for staff members and included emergency resuscitation and basic life support. The GDC requires all registrants to undertake CPD to maintain their professional registration.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control.

Staff meetings took place on an irregular basis – we saw that three formal meetings had taken place in the past 18 months. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as consent, complaints and significant events had been discussed in the last three meetings. We were told that staff meetings would be held more regularly with immediate effect.

Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed. We were not able to review any appraisals on the day of our visit but staff told us they thought they were previously carried out in 2014. The practice manager was aware that these were overdue and had already scheduled these for January 2017. We were told that these were usually held annually but some mitigating circumstances had resulted in a delay.

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

Feedback from patients and staff confirmed that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. There was a suggestions box in the waiting room for patients. Patients were also invited to complete satisfaction surveys every two years. Patients had not made any comments on the NHS Choices website although the option was available for the practice's NHS patients.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires.