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Lansdown Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 March 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

Lansdown Dental Practice has three dentists, who work full time, three qualified dental nurses who are registered with the General Dental Council (GDC) and one trainee dental nurse. The practice's opening hours are 9.15 am to 5pm Monday, Tuesday and Friday, 9.15am to 7pm on Wednesday and 9.15am to 6pm on Thursday.

Lansdown Dental Practice provides NHS and private treatment for adults and children. The practice is situated in a converted property. The practice has three dental treatment rooms; one on the ground floor and two on the first floor and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and two waiting areas, one of which is on the first floor.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received

Summary of findings

feedback from 48 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

Our key findings were:

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place and staff had access to personal protective equipment.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Staff had been trained to deal with medical emergencies.
- Patients' confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Some staff from within the practice visited local schools to provide oral health and hygiene advice to children.
- The practice was well-led and staff felt involved and worked as a team.
- All staff were clear of their roles and responsibilities.

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

- Review the practices current system for monitoring the expiry dates of medicines to be used in an emergency situation and implement any changes needed to demonstrate that these expiry dates are monitored.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical record keeping.
- Review the practice's audit protocols of various aspects of the service, such as infection prevention and control, radiography and dental care records at regular intervals to help improve the quality of service. The practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Systems were in place for recording significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Systems were in place to manage risks to patients, medical emergencies, recruitment and complaints. Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). However documentation was not available to demonstrate that checks were being made to ensure medicines were within their expiry date.

Infection control audits were being undertaken, although not on a six monthly basis. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Patients' medical histories were not always updated on a regular basis and before any treatment took place.

Are services effective?

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

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

The practice used oral screening tools to identify oral disease.

Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. However, not all of the patients' dental care records demonstrated this.

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. Feedback from patients was overwhelmingly positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful.

Staff knew patients well and were welcoming and friendly when patients attended the practice.

Are services responsive to people's needs?

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

Patients could access treatment and emergency care when required. The practice had a ground floor treatment room and toilet which had been adapted to meet the needs of patients with a disability. Ramped access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference. We saw that where complaints had been received at the practice they were responded to and patients were offered a meeting with the principal dentist to discuss their concerns.

Summary of findings

Are services well-led?

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

Staff were supported to maintain their professional development and skills. Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

Lansdown Dental Practice

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.

This inspection took place on 8 March 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with seven members of staff, including the principal dentist. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records and patient dental health education programme.

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

Incident and accident reporting systems were in place and staff spoken with had a good awareness of the Reporting of Injuries Diseases and Dangerous Occurrences regulations (RIDDOR). Information and reporting forms were available for staff regarding RIDDOR. There had been no incidents to report under RIDDOR regulations. Accident books were available and recorded details of accidents that had occurred. Sharps injuries were recorded including details of the incident, investigation, advice given and learning. Action had been taken to prevent these types of injuries occurring in the future. For example disposable matrix bands had been introduced at the practice. We were told that discussions were held at practice meetings regarding accidents and significant events. We saw that there had been four significant events during 2015, all of these related to patients or staff feeling unwell and paramedics being called. Significant event forms recorded sufficient details regarding the event, action taken and a review of the event including learning outcomes. The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. We were told that any alerts that related to the dental practice would be discussed with all staff at a practice meeting.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. Staff had signed to confirm that they had read and understood these policies. We saw from the minutes of a recent practice meeting that these policies had been discussed with staff. We were shown evidence to demonstrate that appropriate levels of safeguarding training had been booked for all staff for 13 April 2016. Staff spoken with were aware of when to raise a safeguarding concern and how to do this. Contact details for external agencies such as the local authority responsible for investigations were on display in the reception and readily available to all staff. Staff were aware of who held the lead role regarding safeguarding and confirmed that they were always available for support and advice if required.

We spoke with a dental nurse about the prevention of needle stick injuries. They explained that the practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a needle protection device and for disposing of used needles into the sharps bin. There had been two needle stick injuries at the practice within the last 12 months. We observed that this had been reported through the practice incident reporting system and managed in accordance with practice policy. We saw that sharps information was on display in the decontamination room and other locations were sharps bins were located. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

The practice used rubber dam when carrying out root canal treatment. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth. The British Endodontic Society recommends the use of rubber dam for root canal treatment.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. There was an automated external defibrillator (AED), a portable electronic device that analyses life-threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment with all staff receiving update training in July 2015. We saw that the pads available with the AED had expired. Following this inspection we were shown evidence that new pads had been ordered. The practice had access to oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. We saw that one emergency medicine was being stored in the fridge; however staff were not carrying out fridge temperature checks to ensure that this medication was stored at the appropriate temperature. This medicine could be stored outside the fridge but would have a

reduced shelf life and the expiry date would therefore need to be amended. We were told that the medicine would be stored outside of the fridge and the expiry date amended accordingly.

Emergency medicines and oxygen were all in date and stored in a central location known to all staff. The principal dentist told us that they monitored the expiry dates of medicines and equipment but there were no records to demonstrate this.

We saw that a first aid kit was available which contained some equipment for use in treating minor injuries. We were told that one of the dental nurses had completed first aid training; this staff member confirmed that her training was now out of date and update training was required. Following this inspection we were sent email demonstrating that a member of staff had been booked on an emergency first aid at work course in April 2016.

Staff recruitment

We discussed the recruitment of staff and looked at two recruitment files in order to check that recruitment procedures had been followed. We saw that both files contained pre-employment information such as proof of identity, details of qualifications and registration with professional bodies. One file contained a written reference obtained prior to employment. We were told that a verbal reference had been obtained regarding the other member of staff as their previous employer was well known to this dental practice. We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

There were enough staff to support dentists and the hygienist during patient treatment. We were told that a trainee dental nurse had recently been employed as reviews of staffing levels undertaken had identified a need. There was a low staff turnover at this practice and apart from the newly employed trainee dental nurse all other dental nurses and reception staff had worked at the practice between two and 32 years. The principal dentist was aware of the importance of retaining a team of motivated, well trained staff. We were told that staff worked well as a team and staff we spoke with said that they enjoyed working at the practice and were proud of the work that they undertook. The provider planned for staff absences to ensure the service was uninterrupted. We were told that there was enough dental nurses to provide cover during times of annual leave or unexpected sick leave. All dental nurses spent some time working on the reception area to provide support and to gain knowledge of reception and administrative tasks. One of the reception staff members was also a registered dental nurse and could provide dental nurse cover when required.

Monitoring health & safety and responding to risks

Systems were in place to monitor and manage risks to patients, staff and visitors to the practice and to deal with foreseeable emergencies. A health and safety poster was on display in the reception office area and health and safety policies were readily available to staff. The topics covered by the policy included manual handling, slips, trips and falls, dealing with a mercury spillage and fire safety. All staff we spoke with were aware of the location of policies and said that they could access this information at any time. We were told that advice and support was provided by the health and safety lead.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire log book contained the practice's fire safety policy, staff had signed to confirm that they had read and understood the fire policy. A fire risk assessment had been completed by an external company in February 2016. The practice had developed an action plan. There was no documentary evidence to demonstrate actions taken. The principal dentist confirmed that although the majority of action had been completed there were still some issues for action. However, the risk assessment had only been received at the practice within the previous two weeks and the action plan was still in the process of being addressed. We saw that new emergency lighting was in place in corridors as a result of the fire risk assessment. There were no records to demonstrate that checks had been made on emergency lighting as yet. Arrangements had been made for an external contractor to visit the practice and demonstrate the emergency lighting systems and show staff how to check to ensure that these lights were in good working order. We saw that other checks were made of fire safety equipment such as fire extinguishers, fire doors and smoke alarms. Staff spoken with were able to describe the procedure involved in an evacuation, and the muster point for staff and visitors. However we were

told that there had been no actual fire drills where staff had to evacuate the building. Discussions had been held regarding the actions to take. The principal dentist told us that they would plan an actual fire drill within the next month. On-line fire safety training had been booked for all staff.

The practice had measures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Records of all the substances at use in the practice which may pose a risk to health were kept in a COSHH file.

The practice carried out a number of risk assessments including radiation, fire safety and health and safety and a general practice risk assessment had also been carried out. A health and safety checklist dated February 2007 was available this was a tick list used to demonstrate that the practice complied with health and safety legislation. This had been reviewed on an annual basis from 2013 onwards.

Practice meeting minutes demonstrated that fire safety had been discussed and staff confirmed that these 'refresher' sessions were useful.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and toilet were visibly clean, tidy and uncluttered. The practice employed a cleaner to undertake environmental cleaning of non-clinical areas and dental nurses were responsible for cleaning and infection control in all clinical rooms. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises. Patient feedback reported that the practice was always clean and tidy.

There were hand washing facilities in each treatment room and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Adequate supplies of liquid soaps and paper hand towels were available throughout the premises. Posters describing hand washing techniques were displayed in the dental treatment rooms and the decontamination room. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms.

Systems were in place to reduce the risk and spread of infection within the practice. An infection control policy was in place, this had been reviewed on an annual basis. All staff had signed documentation to confirm that they had read and would work in accordance with this policy. The policy was not on display; having this information on display in the treatment rooms and decontamination areas helps to remind staff of the actions to take to maintain infection prevention and control. The practice had a nominated infection control lead who was responsible for ensuring infection prevention and control measures were followed.

Infection prevention and control audits were completed on an annual basis. The last audit was undertaken in January 2015 and the practice achieved an assessment score of 99%. The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. The principal dentist told us that six monthly audits would be completed in the future. We were told that the results of infection control audits were discussed in practice meetings. The minutes of the practice meeting did not record in detail topics discussed or details of information given to staff.

We looked at the procedures in place for the decontamination of used dental instruments. A separate decontamination room was available for instrument processing. The decontamination room had dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). Systems were in place to ensure that instruments were safely transported between treatment rooms and the decontamination room. The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included heavy duty gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. All the

equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. Clinical waste storage was in an area where members of the public could not access it. Sharps bins were appropriately located and out of the reach of children. Waste consignment notices were available for inspection.

Staff recruitment files that we saw had information which recoded the Hepatitis B status of staff. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. We were told that this information was not available for the cleaner but the principal dentist would obtain this as soon as possible.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. A risk assessment regarding Legionella had been carried out by an external agency and a further risk assessment was due in May 2016. The principal dentist told us they were checking the water temperature on a monthly basis to try and ensure that the temperature remained within the recommended range; we saw records to confirm that this was taking place.

Equipment and medicines

Equipment checks were being completed where relevant and we saw copies of maintenance contracts for essential equipment such as X-ray sets and the autoclave. Portable appliance testing (PAT) was completed in June 2015 by a qualified engineer. (PAT confirms that electrical appliances are routinely checked for safety).

Prescription medicines were dispensed by the provider. Records of these were detailed in the patient's dental care record. We found that prescription pads were securely stored to prevent loss due to theft. Records were kept to demonstrate prescription pad usage. The batch numbers and expiry dates for local anaesthetics were recorded in patient dental care records. All of these medicines were stored securely for the protection of patients.

Radiography (X-rays)

The principal dentist told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed. We saw documentation to confirm this. However the current RPS was a member of staff who had not kept up to date with their radiation safety training and no longer took X-rays. Systems were not in place to ensure that the RPS was qualified to ensure that equipment was operated safely. We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety. Local rules were available in the treatment room for all staff to reference if needed.

We saw copies of the critical examination packs for each of the X-ray sets along with the maintenance logs. The maintenance logs were within the current recommended interval of three years. We saw that the X-ray equipment was not fitted with collimators, (collimators reduce the radiation dose to the patient). Following the inspection we were sent evidence to demonstrate that collimators had been fitted. We saw that signs were in place on doors conforming to legal requirements to inform patients that X-ray machines were located in the room.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. One of the dentists had carried out an X-ray audit. There were no audits available for any of the x-rays taken by other dentists at the practice. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. The principal dentist told us that audit would commence for all dentists who worked at the practice to ensure consistent good quality.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept both electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. We discussed oral health assessments; we were told that a routine examination included an assessment of soft tissue lining the mouth, gums and any sign of mouth cancer. Dental care records we saw showed that details of the condition of patient's gums using the basic periodontal examination (BPE) was recorded. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. The practice referred to National Institute for Health and Care Excellence guidelines to determine how frequently to recall patients and regarding removal of lower wisdom teeth. However patient dental care records that we saw did not demonstrate that all of the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping, although discussions with dentists demonstrated that they were aware of this guidance. Dentists and the hygienist were not all following the same system for record keeping and some dentists preferred to use paper record cards and others computerised records which were more detailed.

We were told that medical history records were updated by each patient every time they attended for a routine check-up and details were entered on their dental care record. However we saw the medical history for one patient, who had been attending the practice on a regular basis, had not been reviewed for six years. This was reviewed and updated on the day of inspection. We saw evidence that other medical history records had not been updated on a regular basis.

The principal dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice, high concentration fluoride toothpaste prescription and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products.

Health promotion & prevention

From discussions with the principal dentist and dental nurses it was apparent that there was a strong focus at the practice on preventative care and supporting patients to ensure better oral health. We discussed 'The Delivering Better Oral Health Toolkit' with the principal dentist. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). We saw that information regarding diet and oral health was on display in the reception area. Leaflets regarding dental treatments and high concentration fluoride toothpaste were available for patients, who were also able to purchase a range of dental hygiene products to maintain healthy teeth and gums. We were told that free samples of toothpaste were occasionally available but none were available on the day of inspection.

One dental nurse had completed a training course in oral health education and had visited a local primary school to provide oral hygiene instruction and advice on healthy eating. We were told that this was a fun event and involved quizzes, prizes and a dental pack for all children who attended.

During appointments the dentist and dental nurse explained tooth brushing and interdental cleaning techniques to patients in a way they understood and dietary, smoking and alcohol advice was given to them. However not all of the dental care records seen corroborated this.

Staffing

New staff had a period of induction to familiarise themselves with the way the practice ran. Staff signed induction documentation to confirm that they had received copies of information such as employment policies and procedures and the practice's mission statement. Induction records detailed a list of training undertaken, there was no information regarding how the training took place or how the staff member was deemed competent. However, we spoke with one member of staff who confirmed that the induction process gave them the information they needed to be able to fulfil their job role and they felt fully supported throughout the process.

Dental staff were appropriately registered with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. Staff told us that they had good access to training to maintain their continuous professional development (CPD) and were encouraged to undertake courses to further their skills. CPD is a compulsory

Are services effective?

(for example, treatment is effective)

requirement of registration as a general dental professional and its activity contributes to their professional development. Not all of the files that we looked at recorded the number of CPD hour's staff had undertaken. The principal dentist told us that staff often kept this information at home and it was their responsibility to ensure they kept up to date with CPD requirements. However, we were told that the principal dentist reviewed CPD records and discussed this with staff during appraisal meetings and we saw documentary evidence to demonstrate this.

Recruitment files contained copies of training certificates. We saw that the practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation and infection control, as well as other specific dental topics.

The practice had procedures for appraising staff performance. Formal appraisal meetings were held on an annual basis, personal development and training was discussed during appraisal meetings. Staff told us that they were able to speak out during these meetings, training could be requested and any issues or concerns discussed. Support could be provided to staff that were falling behind CPD requirements. Staff told us that the provider was supportive and approachable and always available for advice and guidance.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. Copies of referrals letters were kept on patient records but patients were not routinely offered a copy of any referral letter. There was no formal system for ensuring patients had received their referral appointment. Patients were asked to contact the practice if they did not receive an appointment. When the patient had received their treatment, they would be discharged back to the practice for further follow-up and monitoring. We were told that there were no patients' complaints relating to referrals to specialised services.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. We saw that consent and the MCA had been a topic for discussion at a recent practice meeting. However the meeting minutes did not record in any detail what had been discussed or who had attended the meeting. We spoke with the dentists and found that they had a good understanding of the MCA and its relevance in obtaining consent. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

Staff confirmed individual treatment options were discussed with each patient. We were told that patients were given verbal and written information to support them to make decisions about treatment. This included the dentist explaining treatment, giving patients a treatment plan and confirmation of the treatment plan with the patient by reception staff. We saw that leaflets were available in the waiting area explaining some treatments. However, not all of the dental care records seen clearly demonstrated that individual treatment options, risks, referral options, benefits and costs were discussed with each patient.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable cabinets. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure.

47 patients provided overwhelmingly positive feedback about the practice on comment cards which were completed prior to our inspection. Patients commented that staff were professional, friendly, helpful and caring. On the day of our visit we witnessed patients being treated with dignity by reception staff. Staff said that many of the patients were longstanding and they knew them well. During the inspection we observed staff speaking with patients over the phone and in the reception, staff were friendly, respectful and helpful and engaged in general conversation, which patients said made them feel at ease.

Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. We were told that patients would be able to have a confidential discussion with staff in one of the unused treatment rooms or in the office behind reception if required.

Involvement in decisions about care and treatment

Information regarding NHS and private costs was clearly displayed in the waiting area. Information leaflets regarding some of the treatments undertaken at the practice were available in the waiting area. Staff told us that they always provided verbal information to patients to enable them to make informed choices. We were told that treatment plans were provided to patients which detailed treatments and costs. We saw that these were available in some of the dental care records. Other records seen lacked detail regarding risks, referral options, treatment options and costs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS and private treatment. NHS and private treatment costs were clearly displayed in the waiting area. Other information available to patients included the complaints procedure and practice patient information leaflet. The practice's website described the range of services offered to patients which included general dentistry, tooth whitening and dental veneers.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. There were vacant appointment slots to accommodate urgent appointments. Feedback confirmed that patients were rarely kept waiting beyond their appointment time.

Tackling inequity and promoting equality

The practice was located on the ground and first floor of a converted building on a busy street. There was a car park at the front of the building and some nearby unrestricted on street parking. As part of our inspection we conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Entrance to the dental practice was suitable for patients with mobility difficulties or wheelchair users. There was one treatment room and a toilet for patients use on the ground floor and two treatment rooms on the first floor. The toilet had been adapted to meet the needs of disabled patients.

Staff told us that they had very few patients who were not able to converse confidently in English. The practice had access to a translation service which had been used once in the past but which could be accessed in the future as needed.

Access to the service

The practice was open from 9.15 am to 5pm Monday, Tuesday and Friday, 9.15am to 7pm on Wednesday and 9.15am to 6pm on Thursday (closed between 1pm to 2pm).

The practice displayed its opening hours on the premises and on the practice website. Staff we spoke with told us that patients could access appointments when they wanted them. We were shown that emergency slots were kept each day for those patients that were in pain and we were told that these patients would be seen within 24 hours if necessary. Appointments were booked by telephoning the practice or in person by attending the practice. Patients' feedback confirmed that they were happy with the availability of routine and emergency appointments. We found that patients could access care and treatment in a timely way and the appointment system met their needs.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. The policy also recorded contact details such as NHS England, the General Dental Council and the Dental Complaints Service. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. A copy of the complaints policy was on display in the reception area.

Staff spoken with were knowledgeable about how to handle a complaint. We were told that wherever possible, verbal complaints would be dealt with by reception staff at the time they were received. The complaints process involved an initial apology, discussion with patient, investigation and feedback to the patient. Staff said that patients were always given an apology and offered a meeting with the principal dentist. We saw the records for the two complaints received at the practice. The practice had followed their procedure responding to complainants in a timely manner and always offering an apology. Learning outcomes were discussed with staff as appropriate.

Staff told us about systems in place to try and reduce the risk of complaint, for example putting notes on patient's records about specific requirements they may have such as times for appointments or preferences regarding which dentist they see.

Are services well-led?

Our findings

Governance arrangements

The practice had some arrangements in place for monitoring and improving the quality of services provided for patients. Governance arrangements in place helped to ensure risks were identified, understood and managed appropriately. For example, risk management processes regarding fire safety and infection control were in place to ensure the safety of patients and staff members. We saw a number of policies and procedures in place to govern the practice and we saw these covered a wide range of topics. For example, infection control and health and safety. Staff were aware of where policies and procedures were held and we saw these were easily accessible. Signing sheets were in place for some policies which staff had completed to say that they had read and understood the policies and procedures. Staff we spoke with were aware of their roles and responsibilities within the practice

Leadership, openness and transparency

The culture of the practice was open and supportive. Staff told us that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately. Staff said that the principal dentist was approachable and supportive. Complaints systems encouraged candour, openness and honesty. The principal dentist said that staff were motivated and hardworking and staff told us that they enjoyed working at the practice and were proud of the service they provided.

Formal practice meetings were held as needed. We saw that two meetings had been held so far during 2016. We saw that occasionally these meetings were used to provide update training to staff, to discuss changes at the practice or any issues or concerns. Minutes of these meetings were kept, although these did not record detailed information, particularly relating to any training conducted during the meeting.

Learning and improvement

Staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. CPD and training needs were discussed during annual appraisal meetings and support was offered if required. Staff confirmed that they were encouraged to undertake training.

Practice meetings were held and were minuted. We saw that discussions were held in relation to practice policies and learning was disseminated for example regarding fire safety, adult safeguarding and child protection and mental capacity. However, minutes of meetings did not record detailed information about issues discussed. These meeting minutes would therefore not be useful for staff members who were absent on the day of the meeting to update themselves and could did not provide enough detail to remind staff of discussions held.

The practice did not have a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography and these audits did not fulfil all requirements. For example the infection control audit was undertaken on an annual basis and the radiography audit was not available for all staff at the practice. We saw evidence of a record card audit. The principal dentist confirmed that changes would be made to this and other audits to develop a structured audit plan to ensure completed audit cycles would be established.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. We saw that the NHS Friends and Family Test was available for patients to complete. The friends and family test is a national programme to allow patients to provide feedback on the services provided. We looked at the results from December 2015 and January 2016 and saw that these recorded positive comments and patients were extremely likely to recommend the dental practice.

The practice undertook its own patient survey. Staff told us that patients could give feedback at any time they visited. Satisfaction surveys were handed out to patients on a continuous basis and the results collated and reviewed every month. We looked at some surveys which we were told had recently been completed. There was no date of issue or completion on the surveys seen. Satisfaction surveys that we saw recorded positive comments. A member of staff was responsible for collating results and had completed charts for ease of analysis of results. We were told that surveys were occasionally discussed at practice meetings. However, the results of surveys was not fed back to patients including details of any action taken when suggestions or comments had been made.