

Smileabout Limited

College Street Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 September 2015 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 not 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

We carried out an announced comprehensive inspection on 2 September 2015 as part of our national programme of comprehensive inspections.

College Street Dental Centre provides private treatment to patients of all ages. The practice provides general dental services and specialist treatment such as implants and orthodontics.

The practice is in a converted residential property close to the centre of Petersfield. The practice has one surgery downstairs, three further surgeries on the first floor, a decontamination area that is also used to take radiographs and a separate waiting area. The practice had a computed tomography (X-ray CT) machine, which is a specialist X-ray machine that makes use of computer-processed combinations of many X-ray images taken from different angles to produce cross-sectional images.

The practice team consists of three dentists, a visiting consultant orthodontist, dental therapist, dental hygienist, practice manager, business development manager and three dental nurses.

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

Summary of findings

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.

During our inspection we spoke with two patients and reviewed five comments cards, which patients had completed in the two weeks prior to our visit. Seven people provided feedback about the service and all commented positively about the high quality care that they received at the practice.

Our key findings were:

- The practice had risk assessments in place to manage and monitor risks to patients and staff.
- The practice had effective systems in place to ensure that instruments used on patients were appropriately decontaminated.
- Patients care and treatment was assessed, planned and delivered according to their individual needs.

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

- Review the procedures for the decontamination of equipment to meet the essential requirements of HTM 01-05 and update action plans to outline how the surgery will move towards meeting current best practice requirements. Floors in the decontamination room must be sealed and bins used for the disposals of hazardous waste must have lids that can be closed

and operated in a way that does not compromise infection control. A schedule of cleaning and daily cleaning records must be maintained. Policies and procedures must all reflect the name of the current decontamination lead.

- Ensure that patient records stored in the decontamination area are removed and that other cupboards can be closed.
- Review the procedures for electrical safety in the decontamination room.
- Ensure that equipment and materials that have passed it's expiry date for use are removed.

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

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

- Review the policy for safeguarding vulnerable adults and children in line with the recommended date.
- Review the distribution of NICE guidance to staff and record any action taken as a result of guidance received.
- A single system for the management of referrals should be consistently operated and procedures put into place to process mail when a clinician is absent.
- Share the findings of the last private care plan provider audit with management and staff.

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 not providing safe care in accordance with the relevant regulations.

The practice had systems in place to assess, manage and monitor the risks to patients and staff. Appropriate equipment was available for the management of medical emergencies and the practice had a trained member of staff for the provision of first aid. There were systems in place to ensure that equipment was serviced and maintained.

Whilst instruments used for the provision of patient care were appropriately decontaminated, some aspects of the decontamination room did not meet the essential requirements of HTM 01-05 and some areas where improvements were required were not recorded in the provider plans to meet the current practice requirements of HTM 01-05. Specifically the provider had insufficient sinks for the washing and rinsing instruments and there were no separate hand washing sinks in the decontamination room.

We have told the provider to take action (see full details of this action in the requirement notices section at the end of this report).

Are services effective?

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

Patients care and treatment was assessed, planned and delivered according to their individual needs and appropriate records were maintained. Patients were given sufficient information about their proposed treatment to enable them to give informed consent.

Dental care records showed a structured approach to assessing and planning patient care and treatment and information about patients' medical conditions that could affect the planning of their treatment was updated at each appointment.

Are services caring?

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

The practice was sensitive to the needs of their patients and treated them with dignity and respect. Patients commented positively about the service they received and the patient satisfaction survey indicated that the patients were happy with their care and treatment. Patients were able to make suggestions to improve the practice and we were shown examples of how patients' suggestions had been implemented in order to make improvements to the practice facilities.

Are services responsive to people's needs?

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

The practice offered same day appointments for patients who had a dental emergency and provided an emergency out of hour's service for those patients who were in pain. The practice was accessible to patients who used wheelchairs and patients could see the clinician of their choice in a downstairs surgery by prior arrangement. However some specialist X-ray facilities were based on the first floor which made them inaccessible to patients who found stairs a barrier.

Are services well-led?

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

Summary of findings

The practice had comprehensive systems in place to monitor the quality of the service provided. Staff within the practice supported each other to make improvements to the practice. Staff had regular appraisals and were supported to complete training for their continuous professional development. The practice had a Business Continuity Plan in place which outlined actions to be taken in the event of a failure of systems that would prevent the practice from being fully operational.

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Detailed findings

Background to this inspection

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

The inspection was carried out on 2 September 2015 by an inspector from the Care Quality Commission who was accompanied by a specialist dental advisor.

Prior to the inspection we reviewed information that we held about the provider and we reviewed information that we asked the provider to send us in advance of the inspection. During the inspection we spoke with a dentist, the practice manager, dental hygienist and dental nurses. We observed staff interaction with patients and looked at the premise and the treatment rooms.

We obtained feedback from seven patients who told us their views about the staff and the services provided. We reviewed a range of policies and procedures and other documents associated with the provision of treatment. We informed the local Healthwatch that we were inspecting the practice and requested that they shared any information they held.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were systems in place for recording and reporting accidents and incidents. There had been no reportable accidents at the practice since 2013. We reviewed the records for three significant events that had occurred in the last 12 months and found that they had been investigated and action taken as a result of the events had been recorded. Learning from significant events was shared with staff at monthly practice meetings. We reviewed minutes of practice meetings where learning from incidents had been shared.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding children and adults' policy that was available to all staff. The policy had a date for review of 16 August 2013 and had not been updated. Contact information was available for local adult and children safeguarding organisations. There was a separate Child Protection checklist that had been updated on 14 July 2015. The practice had a separate whistleblowing policy. The practice had a safeguarding lead and all staff had completed training in child protection and safeguarding vulnerable adults as part of training provided by a private medical insurance company. Staff had a good understanding of safeguarding procedures, including whistleblowing and were able to describe to us what they would do if they suspected a patient was being abused.

Dentists ensured that practices reflected current guidance in relation to safety. For example, the dentists used a latex free rubber dam for root canal to ensure patient safety and increase effectiveness of treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal treatment.

Medical emergencies

There were arrangements in place to deal with foreseeable emergencies. Emergency medicines, an automated external defibrillator (AED) and oxygen were available, stored in a central location and were accessible to all staff. An AED is 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. Records seen confirmed that emergency medicines were checked on a monthly basis and were all within their expiry date. A spare syringe of Buccal midazolam was stored in the refrigerator, even though, refrigeration was not required.

There were policies and procedures in place to identify what action should be taken in the event of a medical emergency and staff had a clear understanding of the procedures to follow. All staff had completed training in medical emergencies in line with Resuscitation Council UK guidelines and in line with continuous professional development (CPD) requirements set by the General Dental Council (GDC).

A dentist was the named First Aider for the practice and staff could identify this person by name.

Staff recruitment

We reviewed staff files for eight members of staff and found they contained evidence of checks that had been carried out to ensure staff working at the practice were suitable for their role. All clinical staff had received a check by the Disclosure and Barring Service (DBS) in line with the practice policy (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). Other checks included checks on registration with the GDC, proof of identification, references and Hepatitis B immunisation status of staff.

Monitoring health & safety and responding to risks

The practice had a Health and Safety Policy that had been updated in January 2015 and risk assessments had been carried out to manage risks at the location, including a fire risk assessment, sharps risk assessment and risk assessment for the management of legionella (a bacterium which can contaminate the water systems in buildings and especially the dental unit water lines). Fire safety equipment was available and in date for testing and checks had been completed by an external company in October 2014. Fire evacuation drills were completed every three months.

The practice compressor had been serviced in August 2015 and there was a schedule of testing for other equipment that indicated that they were in date, for example, portable appliance testing was completed on 25 February 2015.

Are services safe?

Staff were aware of their responsibilities in relation to the Control of Substances Hazardous to Health (COSHH) and there was a comprehensive COSHH file. COSHH assessments were in date and reflected the current materials used. All staff had signed to indicate that they had read the COSHH file.

We were advised that alerts were received from the Medicines and Healthcare Products Regulatory Agency and these were placed in the staff room for staff to review. Any actions as a result of alerts received were discussed at practice meetings and minutes of practice meetings were available.

The practice had systems in place to minimise risks in relation to sharps by using the aim safe finger guards, which are a dental needle safety devices. We were told that there had been no sharps injuries within the last two years.

Infection control

In November 2009 the Department of Health published the Health Technical Memorandum 01-05 Decontamination in primary care dental practices (HTM 01-05) which was updated in March 2013. This document describes in detail the processes and practices essential to prevent the transmission of infections and promote clean safe care. It is used by dental practices to guide them to deliver an expected standard of decontamination.

The practice had systems in place to reduce the risk and spread of infection. The practice had a dedicated lead for infection prevention and control and staff could identify the named lead. However we noted that one document identified the named lead as another member of staff and had not been updated in line with other policy documents. Staff were aware of the safe practices to meet the essential standards of HTM 01-05. We observed the decontamination process in between patients and saw that staff used appropriate personal protective equipment. A member of staff described the infection control procedures used during an implant procedure in order to prevent the implant site from becoming infected.

The practice had a decontamination room but due to the constraints of the building, this room was also used to take X-rays. This meant that patients could enter the room during the decontamination process and the room was not only accessible to staff. Instruments were placed into rigid plastic boxes in the surgeries and taken to the decontamination room to be washed, rinsed and sterilised.

The room only had one sink and removable bowl was used to separate the washing and rinsing processes. This sink was also used for hand hygiene and does not meet the essential requirements of HTM01-05. The room layout did not enable staff to follow a dirty to clean workflow. The illuminated magnifier was plugged into an electrical extension that hung from a cabinet and the electrical wires were close to the sink.

Instruments were sterilised using non-vacuum sterilisers in the decontamination room and moved back to the surgery to be stored in sealed packages and date stamped with their expiry date. We found that the expiry date on some instruments held in the surgeries had passed and were told that these were no longer used. If instruments were being used for surgical procedures once packaged they were removed from the surgery to the staff room where they were sterilised again using a vacuum steriliser.

There were gaps between the skirting boards and the floor in the decontamination room that had not been sealed and surgeries did not have curved skirting that could be easily cleaned. We noted that there were two boxes of patient records which were open and stored on top of the cupboards in the decontamination area and we were told that these would be moved into storage. Cupboards in the decontamination area contained consumable stores and some of these cupboards did not close and therefore items were exposed during the decontamination process. These deficiencies were not reflected in the practice plan to attain current best practice in infection control.

Equipment used in the decontamination process was tested in accordance with the manufacturer's instructions and records of tests were maintained. Disposable equipment was used where possible and items that were for single use only were identifiable.

The practice had procedures in place for the management of hazardous waste. A mercury spillage kit and a body fluid spillage kit were available. There were separate bins for the disposal of hazardous waste and general waste but a bin used for the disposal of hazardous waste did not have a lid on and other bins could not be opened using a foot pedal. This meant that staff would have to remove the bin lid during the decontamination process and therefore the lid would become contaminated. Separate containers were in place for the disposal of amalgam (filling material). Healthcare waste was disposed of in orange bags by a specialist company, who collected the waste every two

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weeks. Prior to this the waste was stored in a locked yellow bin at the rear of the practice that was secured to the wall. Records of the transfer of clinical waste to the specialist company were available.

The practice had completed audits of infection control procedures every three months and the last audit was completed on 20 August 2015. Actions from audits were discussed at practice meetings and staff received training in infection control by a private care plan provider as part of annual training updates. The infection control audits had not identified all concerns, for example, that some bins that were used for healthcare waste did not have lids on them and that records were stored in the decontamination area.

The practice had a risk assessment regarding the management of legionella dated 1 April 2014 and we were advised that the risk assessment was completed by an external company every two years. Dental unit water lines were flushed through daily and water samples were tested for the presence of bacteria on a monthly basis. Records of test results were retained in the practice.

The practice was cleaned using staff from an externally contracted company. Cleaners brought all of their cleaning equipment and materials with them each day. There was no schedule of cleaning for the staff to follow but monthly records were completed to audit the quality of cleaning. The practice manager completed a visual check of contracted cleaning on a daily basis but this was not recorded. Other cleaning checks on non-clinical areas, such as toilets were recorded on daily check sheets but these were laminated sheets that were wiped clean at the end of each day and therefore did not form part of a continuous assessment. We noted that some patients' information leaflets had been placed in the patient's toilets and advised staff that these should be removed.

Equipment and medicines

All equipment, including emergency equipment and equipment that was used as part of the decontamination process was regularly maintained and serviced. This included equipment such as autoclaves (used in the sterilisations on instruments). Records confirmed that service, maintenance and testing had taken place.

The practice appeared to have sufficient quantities of instruments and equipment for routine use, including

dental handpieces and this meant that staff were not pressured to sterilise instruments between patients or that patients appointments were delayed whilst staff waited for instruments to be sterilised.

The practice ensured that prescription pads were stored securely when not in use. Dentists issued some medicines to patients on completion of surgical procedures. The expiry date and batch number of medicines prescribed were recorded on the patients treatment records. Medication prescribed was clearly labelled and accompanied by an information sheet that contained all relevant information from the safety data sheet such as information about the quantities to be taken and any possible contraindications or side effects.

Where the practice used local anaesthetic the batch number and expiry date was recorded in the patient treatment records. Materials used were in date for use with the exception of the Panavia Oxyguard 11, which had expired in April 2014. We were told that this was no longer used.

Radiography (X-rays).

The practice had a radiation protection file that contained all of the information required to meet the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 and the Ionising Radiation Regulations 1999. This file contained details of the Radiation Protection Advisor and the Radiation Protection Supervisor, who was a named dentist. Evidence of maintenance and critical testing of the X-ray set was available and we saw records that indicated that equipment repairs had been undertaken when required. Dentists are required to make notification to the Health and Safety Executive prior to working with ionising radiation and following certain occurrences as required by the Ionising Radiations Regulations 1999 (IRR99) and a notification had been completed.

The local rules for the safe use of ionising radiation were displayed in each surgery to provide staff with guidance on the safe use of radiography within the practice. Staff had completed training in dental radiography and staff confirmed that only qualified members of the team took X-rays. Female patients were asked prior to radiographs being taken if there was any chance that they could be pregnant, in line with current requirements. The practice had a centrally located Orthopantomogram machine (specialist X-ray machine used to take X-rays of the whole

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mouth) and a computed tomography (X-ray CT) machine to take more detailed X-rays of patients. However this machine was located on the first floor and was therefore not accessible to patients with mobility difficulties.

The practice used digital X-rays and aiming devices (these are devices used to ensure the X-ray film and machines are correctly placed) which improved the quality of images and

meant that the number that had to be retaken was minimal. An audit of radiographs was undertaken every three months and the last audit was carried out on 27 July 2015. The findings of the audit and any actions required were discussed with staff at monthly staff meetings and these meetings were minuted.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Patients care and treatment was assessed, planned and delivered according to their individual needs. Dentists used a systematic and structured approach to assessing and planning treatment.

All patients had an up to date medical history completed using a paper record when they attended for examination and these were updated at subsequent visits. This information was recorded in the patients clinical care record and was checked by clinical staff prior to the start of the examination. We spoke with two patients who told us that the dentist always asked if there had been any changes to their medical conditions or any medicines they were taking.

During the examination the dentist recorded examinations of the soft tissues, teeth and other relevant observations. The patients last X-rays were also reviewed. We were told that many patients saw the dental hygienist every six months and this was appointment was followed by a routine dental examination. The dentist hygienist assessed the patient's gums and recorded this information in the patient's record. This information was reviewed by the dentist as part of the examination and we were told that if the patient required further treatment by the dental hygienist they were asked to make another appointment. This request was followed up with a prescription that contained sufficient information and direction for the dental hygienist to carry out treatment. Patients were given options for treatment and we saw that treatment options were documented and provided to patients to consider along with the associated costs. A patient told us they were given time to consider the treatment options available to them.

Patients received an aftercare pack following surgery and this included contact numbers should they require to contact a dentist out of routine surgery hours. Dentists at the practice provided their own out of hours service to patients.

We saw that dentists were aware of and used guidance from the National Institute for Care and Health Excellence (NICE) to assess patients. NICE provided dentists with guidance in management of wisdom teeth, patient dental recall and antibiotic prophylaxis prescribing. However staff

could not easily locate guidance within the practice and we found a folder containing only one item of NICE guidance. There was no evidence that updated NICE guidance had been distributed to staff through the practice systems.

Health promotion & prevention

Two dental hygienists worked part-time at the practice. The dental hygienists provided treatment for gum disease and provided advice on the prevention of decay and oral health education, including tooth brushing techniques and oral hygiene products. They also provided advice and support to patients who had dental implants. We were told that the majority of patients receiving dental hygiene treatment were adults and the level of dental decay in children registered at the practice was low, with many children maintaining a good standard of oral hygiene and attending for regular dental examinations. Oral health advice and fluoride treatments were available to children and fluoride treatments were available.

The dentist completed checks of soft tissues in the mouth for signs of oral cancer on all patients as part of the examination process and we saw that changes to the soft tissues were discussed with patients. When changes to the soft tissue had been identified we saw that patients had been appropriately referred to hospital specialists for further investigations.

Staffing

The practice had systems in place to support staff to be suitably skilled to meet patients' needs. Records showed that staff completed continuous professional development (CPD) in line with General Dental Council (GDC) requirements. All staff, with the exception of one had completed a CPD training day covering recommended subjects such as medical emergencies, infection controls and complaints management on 18 July 2015 and the other member of staff completed training on 1 May 2015. The practice held learning sessions during lunch times where companies visited the practice and provided training in how to use their products. The practice had a copy of the GDC publication Standards for Dental Care professionals in the surgery to provide guidance to staff about the standards they were required to maintain as part of their professional registration. All staff attended practice meetings that were held on a monthly basis and were minuted.

Are services effective?

(for example, treatment is effective)

Staffing levels were monitored and staff absences were planned to ensure that the service was uninterrupted. There was a staff rota available to ensure that each dentist was supported by a trained dental nurse but the dental hygienist was not supported by a dental nurse. Dental nurses did not undertake any extended duties. All staff had a current job description and received annual appraisals in line with the practice policy.

Working with other services

The practice referred patients to secondary (hospital) care when necessary and referred patients to other dentists for specialist advice. For example, patients were referred to an endodontic specialist or to maxillofacial surgeons. Patients were referred to the practice by other dentists for specialist treatments such as implants or orthodontics. Referrals that were sent and received were tracked to ensure completion of treatment but there was no single system that was continuously used and updated and we were told that some information that had been stored in the referral folder had been stored there in error. Information regarding patients who had been referred for urgent treatment using the two week wait system had been tracked using the practice computer. Dentists opened their own mail and if they were away then mail was stored in their tray until their return and this could result in a delay in letters being actioned.

Consent to care and treatment

The practice ensured that patients were given sufficient information about their proposed treatment to enable them to give informed consent. The dentists explained

treatment options to the patients and recorded discussions in the dental care records. The first appointment with the dental hygienist involved a full discussion and explanation about the treatment plan that was being proposed and the completion of detailed patient records.

All patients were provided with a written treatment plan which included the costs associated with treatment options and given time to consider these options between consultation and treatment. Patients signed a copy of their treatment plan, which included associated costs prior to the commencement of treatment and this information was stored in the patient record. The patients that we spoke with confirmed that they had been fully informed about their treatment options and were aware of the costs involved. Information about treatment costs for private treatment and treatment provided under private medical insurance was available to all patients in the practice waiting area and leaflets regarding private care plan payments and treatment options were also available for patients to take away.

The service was unable to provide evidence of staff training in the Mental Capacity Act 2005, a member of staff told us that they had undertaken this training and staff were clear about how they would deal with a situation if they had reason to believe that a person lacked the capacity to consent to care or treatment. The Gillick competency test was discussed and staff indicated that they understood how this test was applied (The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During our visit we spoke with patients about their care and treatment and we reviewed Care Quality Commission comments cards. Patients commented positively about the care and treatment they received and the professional and caring attitude shown by staff. We observed patients were treated with dignity and respect and staff addressed patients using their preferred name or title. Staff offered to assist patients with their shopping bags and encouraged them not to rush when they were using the stairs.

Patient consultations were completed with the doors to the surgeries closed and the practice had policies and procedures on patient confidentiality. Patients were given their medical history forms to complete in hard copy on a clipboard and they were discussed in the surgery so that confidential information was not over heard by other patients in the waiting room. The practice used portable telephones so that they could take calls that included the discussion of confidential information in a surgery that was

not in use or in a staff only area. Computers were password protected and patient files were stored in locked cabinets behind the reception in order to protect patient confidentiality.

Involvement in decisions about care and treatment

Patients who used the service were given appropriate information about their care and treatment. Information and a patient told us that their treatment options, including the cost of treatments, were discussed with them, they understood the treatment options that had been given to them and they had been given time to consider the treatment options available. The practice provided leaflets to patients about types of treatment and these leaflets explained why the treatment was necessary, the treatment procedure and any care that was required after the treatment had been completed. Patients signed an agreed treatment plan that included the cost of treatment prior to the treatment being carried out.

The practice completed an annual patient satisfaction survey and patients indicated that they were happy with the care that they had received. Results of the survey were discussed at the practice meeting and discussions were minuted.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided some general dentistry to patients, predominantly as part of a private insurance plan but also provided some specialist treatment to patients such as implants and orthodontics. The practice referred patients to other dentists with the appropriate qualifications and experience for some other specialist treatment, such as endodontics and other dentists in the area referred patients to the practice for implants. Appointment times were varied in length to meet the patients' needs and patients were given consultation appointments prior to treatment to discuss the treatment options available to them. The dentist was supported by two part-time dental hygienists and could refer patients to the dental hygienist if they needed treatment and support to maintain good oral health.

The practice did not provide treatment to patients under sedation but patients who were anxious could be referred to another practice for treatment under conscious sedation. The practice provided specialist radiography services including orthopantomograms and computed tomography scans for patients which meant that they did not have to be referred to other practices or to hospital for these X-rays to be done. The practice provided treatment privately and under a private insurance plan, which gave patients the option to spread the cost of their dental treatment.

Tackling inequity and promoting equality

The practice had a ground floor surgery that was accessible to patients with mobility difficulties but the toilet on the ground floor was not wheelchair accessible. The practice had installed a ramp and a handrail to improve access for patients and we were told that patients who could not use the stairs were still able to see the dentist of their choice and this was arranged in the ground floor surgery. The reception counter was purpose built at a low level making it easier to communicate with patients that were in wheelchairs. However, specialist X-ray facilities were only available on the first floor and could not be accessed by patients in wheelchairs or those patients who could not use the stairs.

Access to the service

The practice leaflet advertised surgery opening hours and opening hours were advertised on the practice website and on a TV screen in reception. The practice was open between 8.30am and 5.30pm Monday to Thursday and between 8.30am and 4pm on a Friday. The practice did not offer any extended opening hours to meet the needs of patients who were at work during the day. Appointments were available during the working day for patients to be seen in an emergency and we were told that dentists would see patients that required urgent treatment in addition to appointments that were scheduled. The procedure for obtaining emergency treatment out of routine opening hours was available on the telephone answer machine which was switched on when the practice was closed. Dentists at the practice provided an on call service to patients in an emergency and patients who had surgical procedures were given the out of hours contact number as part of their post-operative instructions.

The practice provided a text message service to remind patients about their appointments and had a cancellation policy that was available on the practice information leaflet that required patients to provide a minimum of three days' notice prior to cancellation.

Concerns & complaints

The practice had a complaints procedure that was displayed to patients and a copy of the practice complaints procedure was available to patients on request. However there was no information about how to complain available to patients via the practice website or in the practice information leaflet.

The practice had procedures in place, for acknowledging, recording and investigating complaints and suggestions should they be made by patients. The summary of complaints showed that the practice had received eight complaints within the last ten months. The practice had responded to patients in order to resolve their complaints. Learning from incidents and complaints was discussed at monthly staff meetings. For example, we reviewed a complaint where a patient had complained about receiving marketing information from the practice and the patient had received an apology and had been removed from the mailing list.

Are services well-led?

Our findings

Governance arrangements

The practice manager was also the registered manager and was responsible for the day to day management at the service. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. The practice manager had put systems in place to manage the service.

Some policies and procedure had been reviewed and updated but others were duplicated with more than one policy in place and some duplicated policies had not been updated. Where there was more than one policy this meant that policies could not be used consistently. For example, the Child Protection Policy was scheduled for update in August 2013 and the date of review had not been changed but there was a separate Child Protection checklist that had been updated on 14 July 2015.

The procedure for managing referrals was inconsistent and the same procedure was not being followed for each patient referral.

There were systems in place to manage risk and risk assessments such as those for managing health and safety were updated. The practice had dedicated leads for infection control and safeguarding. Audits were completed to monitor the quality of the service provision and included audits on record keeping, infection control, X-rays, hand hygiene and clinical waste. However we were told that the last audit by a private dental insurance company had been completed and the report had gone to the Business Development Manager. The practice manager was not aware of the contents of the report or whether any actions were required.

The practice had a Business Continuity Plan that had been completed in August 2013 and included action to be taken to manage the service in the event of an unavoidable failure of systems such as computers.

Leadership, openness and transparency

The practice manager was in day to day charge at the location and was well supported by staff within the practice. The practice manager had delegated responsibility for some key roles such as Infection Control and safeguarding and the practice had a Business Development Manager. Staff within the practice supported each other to carry out their roles and staff had a short team meeting every morning at 9am to discuss any key information that was relevant to the running of the practice on that day. The practice held monthly team meetings that were minuted.

Learning and improvement

Staff told us they had access to training and training records were available as part of staff files. Staff were supported to undertake continuous professional development as required by the General Dental Council. Staff received appraisals annually and staff told us that they felt supported within the practice. The practice had lunchtime learning sessions and company representative visited the practice to provide information on their products.

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

Patients who used the service were able to provide feedback about the service and feedback forms were available to patients. We were given examples of how staff had used patient feedback to make improvements to the service, such as providing hand rails to help patients who were less mobile. The practice completed a satisfaction survey on an annual basis and the results of the survey indicated that patients were happy with the care they received. Staff told that they were comfortable to raise issues with the practice manager and were confident that they would be supported in doing so.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12: Safe care and treatment</p> <p>1.Care and treatment must be provided in a safe way for service users.</p> <p>2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include</p> <p>h.assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;</p> <p>How the regulation was not being met:</p> <p>The provider had not reviewed the procedures for the decontamination of equipment to meet the essential requirements of HTM 01-05 and was not meeting the regulation.</p>