Brigstock Dental Practice

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Inspection Report

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Date of inspection visit: 16 July 2015
Date of publication: 06/08/2015

Overall summary

We carried out an announced comprehensive inspection on 16 July 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 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.

Brigstock Dental Practice is located in the London Borough of Croydon. The premises are on two floors and consist of seven treatment rooms, two dedicated decontamination rooms, two waiting rooms with one reception area, an administrative office, a staff room and two toilets.

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

The practice is owned in a partnership consisting of one senior principal dentist, two other principal dentists and a practice manager. Additionally, there are three associate dentists and one trainee dentist, a hygienist, four fully-qualified dental nurses, two trainee nurses and two receptionists.

The practice is open Monday to Friday from 9.00am to 6.00pm and on Saturday from 9.00am to 1.00pm.

The practice changed its registration with the Care Quality Commission (CQC) in May 2014 following the setting up of the new partnership structure. It has not been inspected since that time. One of the principal dentists is the registered manager. A registered manager is a person who is registered with CQC to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We carried out an announced, comprehensive inspection on 16 July 2015. The inspection took place over one day and was carried out by a CQC inspector and a specialist advisor.

49 people provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

Our key findings were:

- Patients' needs were assessed and care was planned in line with best practice guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and patient practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentists had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review recruitment procedures to ensure that a full employment history, at least two references, and records of other relevant background checks are sought and kept for all members of staff.
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK).
- Monitor and record the temperature of the fridge where dental products and medicines are stored to ensure temperatures remain within the recommended range.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

The practice had systems and protocols which were used to minimise the risks associated with providing dental services. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting potential abuse. There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography.

We found the equipment used in the practice was well maintained and checked for effectiveness. Some additional items of equipment required for managing medical emergencies, such as portable suction, were not available at the time of our inspection visit.

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained the treatment options to patients to ensure they could make informed decisions. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the GDC.

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

We received positive feedback from patients about the quality of the care provided at the practice. They felt that the staff were patient and caring; they told us that they were treated with dignity and respect at all times. We found that patient records were stored securely and patient confidentiality was well maintained.

Are services responsive to people's needs?
We found that this practice was providing responsive care in accordance with the relevant regulations.

Patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment rooms on the ground floor. Patients were invited to provide feedback via a satisfaction survey and a feedback box situated in the waiting room.

There was a complaints policy which was displayed in the waiting room. Three complaints had been received by the practice in the past year and were the subject of current investigations. The practice manager was following the complaints policy in terms of carying out and recording the investigations they had made. The clinical staff could describe to us actions they had already taken to ensure that any problems did not recur.

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 clinical governance and risk management protocols in place. These were disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentists. Feedback from staff and patients was used to monitor and drive improvement in standards of care.

However, we noted that some records related to staff recruitment had not been kept in line with the practice recruitment policy. We discussed this with the practice manager who assured us that these documents would now be obtained and kept on file.

Brigstock Dental Practice

Detailed findings

Background to this inspection

We carried out an announced, comprehensive inspection on 16 July 2015. The inspection took place over one day. The inspection was led by a CQC inspector. They were accompanied by a specialist advisor.

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

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

49 people provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and learning from incidents. Six incidents had been recorded in the past year. There was a policy for staff to follow for the reporting of these events and we saw that this had been followed in these cases.

Incidents had been appropriately recorded and investigated. Actions taken at the time and any lessons that could be learned to prevent a recurrence were noted and discussed with individual members of staff. Staff meetings were also convened when wider learning points could be disseminated or if the investigation resulted in a change in protocols. For example, a meeting had been held in June 2015 following an incident involving a patient. The minutes of the meeting recorded that the incident had been discussed and we reviewed a new protocol that had been put in place to prevent a recurrence of the problem. We discussed this issue with members of the clinical team. They could all recall discussing the incident and understood the new protocol. This demonstrated that learning had been effectively disseminated with a view to improving the quality of care.

We noted that it was the practice policy to offer an apology when things went wrong. We saw an example of a written apology that had been offered following a patient's complaint.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). None of the accidents or incidents had required notification under the RIDDOR guidance.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. This information was displayed in the staff room so that staff could access the information promptly. These details were also kept with the safeguarding policy.

The principal dentist was the safeguarding lead for the protection of vulnerable children and adults. Staff had completed safeguarding training and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead.

Staff were aware of the practice policy in relation to raising concerns about another member of staff's performance (a process sometimes referred to as 'whistleblowing'). Staff told us they knew they could raise such issues with one of the principal dentists or practice manager. They also knew that they could contact the Care Quality Commission (CQC) if any concerns remained unaddressed.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. A practice-wide risk assessment had been carried out which covered topics such as fire safety, the safe use of X-ray equipment, disposal of waste, and the safe use of sharps (needles and sharp instruments). We spoke with one of the dentists about the sharps protocol that had been put in place following this risk assessment to check that staff were aware of the outcomes of these assessments. The dentist explained the use of sharps in line with this protocol. For example, they knew that the discarding of the used needle was the dentist's responsibility.

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

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. Staff received annual training in using the emergency equipment. We noted that the training also included responding to different scenarios, such as a patient fainting, using role-playing drills. The most recent staff training sessions had taken place in June 2015.

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. These medicines were all in date and fit for use.

The practice had an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life

threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). Oxygen and other related items, such as manual breathing aids, were also available. However, we noted that some equipment recommended by the Resuscitation Council UK, such as a portable suction were not present.

The emergency medicines and equipment were stored in a cupboard in the staff room. Staff were aware of this arrangement. However, we noted that the equipment was not easily removed from the cupboard which could cause some delay in the event of needing to respond to an emergency. The principal dentists were aware of this issue and would address the problem during a planned refurbishment of the staff room.

Staff recruitment

The practice staffing consisted of one senior principal dentist, two other principal dentists and a practice manager. Additionally, there were three associate dentists, one trainee dentist, a hygienist, four fully-qualified dental nurses, two trainee nurses and two receptionists.

There was a recruitment policy in place and we reviewed the recruitment files for five staff members. We saw that relevant checks to ensure that the person being recruited was suitable and competent for the role had generally been carried out. This included the use of an application form, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

However, some of the staff files lacked some records. In two cases no employment history record was kept, for example, in the form of curriculum vitae (CV). In one case this related to a newly qualified dentist who had not worked at any other practice; in another case the dentist had trained at the practice and consequently their employment history was known to the practice. We also saw that although references were generally sought, this was usually only one reference whereas two references are generally recommended. In one file there were no references at all. We discussed this with the practice manager who told us they had received a verbal reference from a local practice for this member of staff, but they had not kept a record of this discussion.

We noted that it was the practice's policy to carry out Disclosure and Barring Service (DBS) checks for all members of staff. Details related to these checks were generally kept. However, in one file, for a nurse employed in March 2014, there was evidence that an application form had been commenced but had not yet been submitted. The manager assured us that they would complete this application as soon as possible. We observed that the recruitment of newer members of staff was undertaken properly in line with the policy and all relevant documents were held.

Monitoring health & safety and responding to risks

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

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise these risks. COSHH products were securely stored. One of the associate dentists was responsible for maintaining the file and disseminated information about how to minimise the risks associated with new products to staff before they were used.

The practice responded promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice manager and disseminated by them to the staff, where appropriate. The staff we spoke with could recall examples of recent guidance received and disseminated in this way. For example, one of the principal dentists referred to advice received in relation to the use of chlorhexidine.

There was a business continuity plan in place. This had been kept up to date with key contacts in the local area. There was also an arrangement in place to use another practice's premises for emergency appointments in the event that the practice's own premises became unfit for use.

Infection control

There were systems in place to reduce the risk and spread of infection. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation

and disposal of clinical waste. The senior principal dentist was the infection control lead. Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

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

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

We examined the facilities for cleaning and decontaminating dental instruments. There were two decontamination rooms; one on each floor of the premises. On the first floor there was a single room with a clear flow from 'dirty' to 'clean'. On the ground floor there were two separate rooms; one for 'dirty' and one for 'clean' instruments. One of the dental nurses demonstrated how they used the room on the first floor and showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. Items were manually cleaned and then inspected using an illuminated magnifier to check for any debris. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp was used to indicate when the sterilisation became ineffective.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating that the equipment was working well.

The practice had carried out regular infection control audits every six months. The practice had also had an external agency carry out an infection control audit in April 2015. This audit had found a very high level (99%) of compliance with infection control guidance.

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

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines.

A Legionella risk assessment had also been carried out by an appropriate contractor in April 2015. A number of recommendations had been made. This included adjusting the boiler temperature and keeping a monthly log of hot and cold water temperatures. We saw that the practice manager had responded to this advice and the temperature log demonstrated that water was within the required temperature to prevent the growth of Legionella.

The practice had a cleaning schedule that covered all areas of the premises. The practice employed domestic staff to carry out more general cleaning of the premises. There was a cleaning schedule to follow. The practice manager reviewed the domestic staff's work to ensure schedules were being effectively followed. We noted that the premises appeared clean and tidy on the day of the inspection.

Equipment and medicines

We found that the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing that the air compressor, fire equipment and X-ray equipment had all been inspected and serviced in 2015. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in July 2014. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

Are services safe?

Some items, such as tooth whitening products, were being stored in a fridge in line with the manufacturer's guidance. However, we noted that the practice was not routinely checking the temperature of the fridge to ensure that storage of these items remained within the recommended range.

Radiography (X-rays)

Radiography equipment was available in all of the seven treatment rooms. There was also a dedicated room for carrying out larger, panoramic X-rays.

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). There was a well-maintained radiation protection file, in line with these regulations. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive.

We saw evidence that staff had either completed radiation training, or were booked on to an appropriate course to renew their training in October 2015. We reviewed a sample of dental care records where X-rays had been taken. These records showed that dental X-rays were justified, reported on and quality assured every time. The practice had also carried out an audit of their X-ray performance in 2014 which demonstrated that X-rays were being taken to a high standard. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. One of the principal dentists and one of the associate dentists described how they carried out patient assessments and we reviewed a sample of thedental care records. We found that the dentists regularly assessed patient's gum health and soft tissues (including lips, tongue and palate). The dentists took X-rays at appropriate intervals, as informed by guidance issued by the Faculty of General Dental Practice (FGDP).

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

tool used by dentists to indicate the level of treatment need in relation to a patient's gums.) Different BPE scores triggered further clinical action. Details of the treatments carried out were also documented; local anaesthetic details including type, site of administration, batch number and expiry date were recorded.

The reception staff gave all new patients a medical history form to complete prior to seeing the dentist for the first time. The dentists' notes showed that this history was reviewed at each subsequent appointment. This kept the dentist reliably informed of any changes in people's physical health which might affect the type of care they received.

The practice kept up to date with current guidelines and research in order to continually develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to deciding appropriate intervals for recalling patients, antibiotic prescribing and wisdom teeth extraction. The dentists were also aware of the Delivering Better Oral Health Toolkit when considering care and advice for patients. 'Delivering better oral health' is an evidence-based toolkit to support dental teams in improving their patients' oral and general health.

Health promotion & prevention

The reception area contained leaflets that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The practice had a range of products that patients could purchase that were suitable for both adults and children.

Our discussions with the dentists and nurse, together with our review of the dental care records showed that, where relevant, preventative dental information was given in order to improve outcomes for patients. This included advice around smoking cessation, alcohol consumption and diet. Additionally, all the dentists carried checks to look for the signs of oral cancer.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to patients in a way they understood. One of the principal dentists also told us about a health promotion day which they had held in the past year where children were encouraged to attend. Oral hygiene and dietary advice had been discussed with the use of appropriate demonstrations.

Staffing

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

Staff told us they had yearly appraisals which identified their training and development needs. We saw that notes were kept from these meetings. This led to changes which reflected their career development goals. For example, one of the reception staff told us that the partners were supportive of her enrolling in training which would advance her skills so that she could ultimately take on more responsibilities.

Working with other services

The practice was working towards providing a range of specialist services to reduce the need to refer patients

Are services effective?

(for example, treatment is effective)

elsewhere. For example, there was a specialist in endodontics working at the practice in a treatment room which had been set up for this purpose with the inclusion of a dental microscope.

One of the principal dentists explained how they currently worked with other services. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. The practice held copies of relevant referral criteria for secondary and tertiary care providers in order to guide their referring practices.

A referral letter was prepared and sent to the hospital with full details of the dentists findings and a copy was stored in the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was monitored after referral back to the practice to ensure patients received a satisfactory outcome and appropriate post-procedure care.

Consent to care and treatment

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

We saw evidence that the requirements of the Mental Capacity Act 2005 (MCA) had been considered by the practice. 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.

The clinical staff could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. They described a recent example where they had needed to escalate a concern regarding the ability of an elderly and frail patient's ability to make a decision about their care. We saw that the practice had consulted with relevant parties for advice and information in this case. For example, they had discussed the issue with the local social services department, the patient's care home and the patient's relatives in order to reach a conclusion on how to act in that person's best interests.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We collected feedback from 49 patients. They described a positive view of the service provided. Patients commented that staff were always helpful and considerate. Some patients particularly noted that staff were sympathetic and reassuring when they were nervous and this helped to put them at ease. During the inspection we also observed staff in the reception area. They were polite and courteous towards patients and the general atmosphere was welcoming and friendly.

The practice obtained regular feedback from patients via a satisfaction survey. The practice manager was responsible for analysing the results of the survey on an annual basis. We noted from their report in 2014 that the majority of feedback about staff was positive and corroborated our own findings regarding staff's caring attitude. The results of the survey were discussed at a staff meeting and the practice manager also shared any negative feedback directly with the relevant dentists if and when this occurred so that staff could improve their communication skills in response.

There were systems in place to ensure that patients' confidential information was protected. Dental care records were stored electronically. Paper correspondence was scanned and added to the electronic record and stored separately for reference purposes. Electronic records were password protected and regularly backed up; paper records were stored securely in locked files. Staff understood the importance of data protection and confidentiality and had received training in information governance. Reception staff told us that people could request to have confidential discussions in the administrative office, if necessary.

Involvement in decisions about care and treatment

The practice displayed information in the waiting area which gave details of the NHS and private dental charges and fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available. Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We reviewed a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

We spoke with three dentists and one nurse on the day of our visit. They understood the importance of providing clear explanations of treatments and costs in order to promote a shared decision-making process with their patients. They also showed us how they used written information, models and computer screens to provide visual and written prompts. For example, each treatment room had a large television screen linked to the computer system. Dentists could share photographs or microscope images with their patients to discuss the findings of their examinations.

The patient feedback we received via discussions and comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. The dentists we spoke with told us they scheduled additional time for patients depending on their knowledge of the patient's needs and the treatments required. They could request longer appointments where they knew they had particularly difficult cases that might require extra clinical time.

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions.

Some of the clinical staff spoke additional languages which reflected the needs of the local population. Reception staff told us they had access to a translation service and had arranged for interpreters to accompany patients, where needed. There was written information for people who were hard of hearing and as well as large print documents for patients with some visual impairment.

The practice had also considered the needs of patients with mobility issues. The entrance and treatment rooms on the ground floor were all wheelchair accessible. There was a lowered desk in the reception area for wheelchair users and a disabled toilet. One of the patients who provided us with feedback in a comment card told us they had switched to using this practice because of its good access arrangements.

Access to the service

The practice was open Monday to Friday from 9.00am to 6.00pm and on Saturday from 9.00am to 1.00pm. The practice displayed its opening hours on their premises and on the practice website. There were copies of a practice information leaflet, which patients could take away with them, displayed in the reception. These leaflets included the practice contact details and opening hours.

We asked the practice manager about access to the service in an emergency or outside of normal opening hours. They told us that they reserved two sessions with each dentist every day for emergency appointments. We reviewed the appointments system and saw that this was the case. This meant that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. They also directed patients to local NHS out of hours services when the practice was closed. The information about these services was displayed in the practice information leaflet, on the practice answerphone, and on the website.

Concerns & complaints

There was a complaints policy which described how the practice handled formal and informal complaints from patients. Information about how to make a complaint was displayed in the reception area and on the practice website. The practice also had a suggestions box displayed in the waiting area.

There had been three complaints recorded in the past year and these were all subject to an ongoing investigation in line with the practice policy. The practice manager and one of the principal dentists had carried out investigations and discussed learning points with relevant members of staff. We reviewed one of the recent cases in details and discussed this with members of the clinical team. They could clearly describe the discussions that had taken place at a practice meeting and the changes in protocols that had been established as a result. This showed that the practice learnt from investigating complaints in order to improve the quality of care.

We noted from the file of historical complaints that patients routinely received a written response, including an apology, when anything had not been managed appropriately.

Are services well-led?

Our findings

Governance arrangements

The practice had good governance arrangements with an effective management structure. The practice had changed its ownership from a single provider to a partnership in May 2014 with a view to securing the long-term future of the practice. All of the staff were aware of these new arrangements.

The principal dentists and practice manager had implemented suitable arrangements for identifying, recording and managing risks through the use of scheduled risk assessments and audits. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them.

We noted one instance where practice policies had not been strictly followed. This was in relation to the recruitment policy and the keeping of up-to-date staff files. There were some documents missing from the staff files we reviewed including employment histories, references and a Disclosure and Barring Service (DBS) check. We discussed this with the practice manager at the time of the inspection. We were satisfied with the explanations given regarding the employment histories and references. There was also evidence that a DBS application had been started for the member of staff where we found this missing. The manager told us they would complete this application as soon as possible. We observed that the recruitment of newer members of staff was undertaken properly in line with the policy and all relevant documents were held.

There were weekly informal practice meetings, as well as more formal staff meetings every three months, to discuss key governance issues. For example, we saw minutes from meetings where issues such as complaints, incidents, infection control and patient care had been discussed. This facilitated an environment where improvement and continuous learning were supported.

Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with one of the principal dentists or the practice manager. They felt they were listened to and responded to when they did so.

We spoke with two of the partners, who were both dentists, about their vision for the practice. They told us they placed a high priority on maintaining standards of care through the provision of a skilled clinical team, robust administrative support and the maintenance and renewal of the practice premises to reflect best practice guidance. They were committed to developing and expanding the business and were keen to enable further specialist care to be carried out on site. The wider staff team were aware of these plans and were supportive of the management's goals.

Staff told us they enjoyed their work and were well supported by the principal dentists. They received regular appraisals which commented on their own performance and elicited their goals for the future.

Management lead through learning and improvement

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC). The senior principal dentist demonstrated a long history of training and mentoring new dentists and nurses in order to contribute to the development of a new generation of skilled professionals.

The practice had a programme of clinical audit and risk assessments in place. These included audits for infection control, clinical record keeping and X-ray quality which showed a generally high standard of work. Risk assessments were being successfully used to minimise the identified risks. For example, we saw evidence of actions taken following a recent Legionella risk assessment.

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

The practice gathered feedback from patients through the use of a yearly patient satisfaction survey and a suggestions box in the ground floor waiting area. The

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survey covered topics such as the quality of staff explanations, cleanliness of the premises, and general satisfaction with care. The majority of responses indicated a high level of satisfaction.

We noted that the practice acted on feedback from patients where they could. For example, chairs in the waiting area on the first floor had been replaced following feedback that some of the chairs had been tired and worn.

Staff commented that the principal dentists were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums to give their feedback.