

Endocare UK Limited

4-6 George Street

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 30 June 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

4-6 George Street is a dental practice located in the London Borough of Richmond-upon-Thames. The premises are situated in a high-street location. There are two treatment rooms, a decontamination room, reception room with waiting area, patient and staff toilets, staff kitchen and administrative offices. All of the rooms are located on the first floor of the building.

The practice provides private dental care services to adults and children. The practice only offers specialist endodontic services on referral or by self-referral.

The staff structure of the practice consists of a principal endodontist, two associate endodontists, two dental nurses, a practice manager and a receptionist.

The practice opening hours are Monday to Friday from 9.00am to 5.30pm.

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'. 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 inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

Summary of findings

Nineteen people provided feedback about the service. Patients 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 current guidance such as from the British, European and American Endodontic Societies.
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had 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.
- There were effective arrangements in place for managing medical emergencies.
- Equipment, such as the air compressor, fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had clear procedures for managing comments, concerns or complaints.
- The provider had a clear vision for the practice and staff told us they were well supported by the staff team.
- There were arrangements for identifying, recording and managing risks through the use of risk assessments and audit processes. However, we identified some areas where these processes should be improved.

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

- Review the practice's system for recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review recruitment procedures to ensure accurate, complete and detailed records are maintained for all staff.
- Review audit protocols to ensure audits of various aspects of the service are undertaken at regular intervals and, where applicable, learning points are documented and shared with all relevant staff.
- Review the practice's system for environmental cleaning taking into account current national guidelines. .
- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

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 in place to minimise the risks associated with providing dental services. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography. There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. We found the equipment used in the practice was well maintained and checked for effectiveness.

There were some areas where improvements should be made, for example, in relation to the management of environmental cleaning and recording keeping in relation to staff recruitment.

No
action


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 treatment options to ensure that patients could make informed decisions about any treatment. 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 all of the training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

No
action


Are services caring?

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

The practice provided clear, written information for patients which supported them to make decisions about their care and treatment.

We received positive feedback from patients. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

No
action


Are services responsive to people's needs?

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

Patients generally had good access to appointments, including emergency appointments, which were available on the same day. The culture of the practice promoted equality of access for all.

The needs of people in the local area had been considered and staff spoke a range of languages. However, the practice was not wheelchair accessible and the practice had not carried out a formal disability discrimination audit to identify what further reasonable adjustments could be made to the premises to accommodate the needs of patients.

There was a complaints policy in place.

No
action


Summary of findings

Are services well-led?

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

The practice had clinical governance and risk management structures in place. However, the systems currently in place could be improved. For example, a formal incident reporting policy was not in place. A system of audits was used to monitor and improve performance. However, the audit process had not always been used successfully to monitor and improve the quality of the service. For example, the X-ray audit was not comprehensive as it was not specific to each operator. There had not been an audit of dental care record keeping with a view to monitoring and improving quality.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with each other. They were confident in the abilities of the principal dentists to address any issues as they arose.

No
action


4-6 George Street

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 30 June 2016. The inspection took place over one day and was carried out by a CQC inspector and a dental specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with three members of staff. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. One of the dental nurses demonstrated how they carried out decontamination procedures of dental instruments.

Nineteen people provided feedback about the service. Patients 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

Staff understood the process for accident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There was an accident reporting book; there had been one accident recorded within the past year. Staff could describe the actions taken at the time, but there was no further system in place for discussing or sharing advice regarding the prevention of future accidents.

There was also no policy or other system in place for reporting and learning from incidents or significant events. We discussed this with the practice manager, one of the associate endodontists and a dental nurse. The staff were able to describe the actions they took at the time to review any accidents or incidents to prevent problems from recurring.

The practice staff were aware of the Duty of Candour requirements. [Duty of Candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity]. Staff told us that they were committed to operating in an open and transparent manner. Patients would be told if they were affected by something that went wrong; they would offer an apology to patients, and inform them of any actions that were taken as a result.

Reliable safety systems and processes (including safeguarding)

The principal dentist was the named practice lead for child and adult safeguarding. The practice had a well-designed safeguarding policy which referred to national guidance. Information about the local authority contacts for safeguarding concerns was displayed in various areas around the practice.

Staff were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia. All staff, with the exception of the receptionist, had completed relevant safeguarding training

to an appropriate level. We discussed the relevance of Level 1 training in child protection for the receptionist. The practice manager confirmed that this would now be completed.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. For example, we asked staff about the prevention of sharps injuries. Local anaesthetic was administered using a small, computer-controlled handpiece for delivering local anaesthetic. The dentists used a new needle and tubing for each patient. After use, the dentists disposed of the equipment directly into a sharps bin. We were told that the system prevented the need for resheathing needles during the delivery of local anaesthetics and thus helped minimise the risks to staff associated with the procedure.

The staff we spoke with demonstrated a clear understanding of the practice protocol with respect to handling sharps and needle stick injuries. There had been one sharps injury recorded in the past year; staff had taken appropriate steps following the incident and discussed how to prevent it from occurring again.

The practice followed other national guidelines on patient safety. For example, the practice used rubber dam for root canal treatments in line with guidance from the British Endodontic Society. (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. Rubber dam should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in patients' dental care records giving details as to how the patient's safety was assured).

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm).

The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental

Are services safe?

practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

Staff recruitment

The staff structure of the practice consists of a principal endodontist, two associate endodontists, two dental nurses, a practice manager and a receptionist.

The majority of staff had worked at the practice for a number of years, with the most recent recruit being a dental nurse who had been employed in 2012.

There was a recruitment policy in place which stated that all relevant checks would be carried out to confirm that any person being recruited was suitable for the role. This included the use of an application form, interview, review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council.

We checked five staff recruitment records, including the dental nurse recruited in 2012. We saw that the majority of relevant documents had been obtained prior to employment. However, we found that information regarding references that had been obtained were not recorded in the staff files. We discussed this issue with the practice manager who assured us that records of references would now be kept and recorded in relation to any new members of staff.

It was practice policy to carry out a Disclosure and Barring Service (DBS) check for all members of clinical staff prior to employment and periodically thereafter. We saw evidence that all members of staff had a DBS check. (The 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).

The provider offered conscious sedation at another location using an external contractor under a service-level agreement. The provider was in the process of setting up a similar agreement for the George Street location at the time of our inspection. The practice manager confirmed that conscious sedation would not be offered until the agreement was in place. Conscious sedation - (these are techniques in which the use of a drug or drugs produces a

state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation).

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.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice by post. These were disseminated at staff meetings, where appropriate.

There was an arrangement in place to direct patients to the provider's second practice for emergency appointments in the event that the practice's own premises became unfit for use. Key contacts for services in the local area were kept up to date in a business continuity plan. This could be used for reference purposes in the event that a maintenance problem occurred at the premises.

There were 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 identified risks. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted that some COSHH products used in cleaning were stored in an unlocked cupboard. We raised this with the practice manager who assured us that this cupboard would now be secured.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. The dental nurse was the infection control lead. 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 practice had carried out practice-wide infection control audits every six months and found high standards throughout the practice. We noted that the last audit had been completed in June 2016.

Are services safe?

We observed that the premises appeared clean and tidy. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand-washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in the treatment room, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that 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)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there were written guidelines for staff to follow for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. The treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in 2015. The practice was following recommendations to reduce the risk of Legionella, for example, through the regular testing of the water temperatures. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. 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 room which

ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were cleaned in an ultrasonic bath and then placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All pouches we checked had a date of sterilisation and an expiry date.

We saw that there were systems in place to ensure that the autoclaves and ultrasonic bath were working effectively. These included, for example, the automatic control test and steam penetration test for the autoclave. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles, as well as weekly and monthly tests for the washer disinfectant, were complete and up to date.

We observed that the dental nurse kept a log for each cycle of the ultrasonic bath and autoclave. This identified which instruments had been used for each patient. This provided a comprehensive audit trail which could be used in the event of any infection control concerns.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection.

Staff records 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. (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.)

Environmental cleaning was carried out by an external contractor. We observed that the contractor had not effectively used the national colour coding scheme. There were correctly coloured mops, but not buckets. The storage of cleaning equipment meant that damp items were housed in an overly warm environment next to the boiler or water cylinder. Mops had been stored head down. The

Are services safe?

cleaning cupboards were cluttered. The practice manager assured us they would review the cleaning protocols and storage arrangements in conjunction with the contractor to address our concerns.

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. Portable appliance testing (PAT) had been completed in accordance with good practice guidance in April 2015. PAT is the name of a process during which electrical appliances are routinely checked for safety.

The practice stored and dispensed some medicines including antibiotics and paracetamol. Medicines were correctly labelled and a log had been kept of which medicines had been given to which patient. There was a prescribing policy which the staff were following.

The use by dates of medicines, oxygen cylinder and equipment were monitored using weekly and monthly check sheets to enable staff to replace out-of-date drugs and equipment promptly.

Radiography (X-rays)

The practice held relevant documents in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This records contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file was a comprehensive initial risk assessment for the X-ray set along with the three-yearly maintenance logs and a copy of the local rules. There was evidence in the staff records that they had completed radiography and radiation protection training.

Audits on X-ray quality were undertaken at regular intervals. However, we noted that the audit structure did not allow for an assessment of each, individual X-ray operator's effectiveness.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The endodontist working at the practice on the day of the inspection described to us how they carried out their assessments. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at any subsequent visits. This was followed by a review of the patient's complaint and need for endodontic treatment.

The patient's dental care record was then updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included details of the costs involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements. The endodontists also routinely offered a follow-up appointment six months after the completion of all treatment to check that their patients were happy with the result and that they had addressed all of their patients' concerns.

The endodontist we spoke with confirmed that the practice placed an emphasis on keeping up to date with relevant guidance, for example, from the European Society of Endodontology, with a view to offering patients a high quality of care.

Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. The endodontist told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. They were aware of the need to discuss a general preventive agenda with their patients. They told us they held discussion with their patients, where appropriate, around smoking cessation, sensible alcohol use and dietary advice. The dentists also carried out examinations to check for the early signs of oral cancer.

We observed that there were health promotion materials displayed in the waiting areas. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

Staffing

Staff told us they received appropriate professional development and training. We checked the training records of all staff and saw they had engaged in continuing professional development (CPD) with a view to meeting the requirements of the General Dental Council. This included responding to emergencies, infection control, safeguarding training and radiography and radiation protection training.

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 records demonstrated that they had been engaged in an appraisal process within the past year. The staff we spoke with told us they felt well supervised and had good access to the practice manager and principal dentist to discuss career aspirations and any concerns related to their work.

Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients.

The endodontist working on the day of the inspection explained how they worked with other services, when required. They 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. For example, the practice referred patients to another provider for CBCT scans (cone beam computed tomography). There was also a system in place for referring patients to hospital consultants using a fast track process for suspected cases of oral cancer.

We reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practice's records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to

Are services effective?

(for example, treatment is effective)

the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

Consent to care and treatment

The practice ensured valid consent was obtained for all care and treatment. We spoke staff about their understanding of consent. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign formal written consent forms for specific treatments.

All of the staff we spoke with were aware of the Mental Capacity Act 2005. (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 dentists we spoke with could describe scenarios for how they would manage a patient who lacked the capacity to consent to dental treatment. They noted that they would involve the patient's family, along with social workers and other professionals involved in the care of the patient, to ensure that the best interests of the patient were met.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

All of the feedback we received from patients was positive and referred to the staff's caring and helpful attitude. Patients indicated that they felt comfortable and relaxed with their dentist and that they were made to feel at ease during consultations and treatments. We observed staff were welcoming and helpful when patients arrived for their appointment or made enquiries over the phone.

Staff were aware of the importance of protecting patients' privacy and dignity. The treatment rooms were situated away from the main waiting area and the staff told us that the doors were closed at all times when patients were having treatment. We observed this to be the case throughout the day of the inspection.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored in an electronic format. Records stored on the computer were password protected and regularly backed up.

Involvement in decisions about care and treatment

The practice displayed information on its website which gave details of the private dental charges or fees. This information was also displayed in the waiting area.

The staff we spoke with told us they worked towards providing clear explanations about treatment and prevention strategies. The endodontist used a range of methods to ensure that patients understood the options available to them. For example, they showed patients copies of their X-rays and discussed the issues raised. They also directed patients to review information on their website which further explained the treatments available.

We saw evidence in the dental care records that the dentists recorded the information they had provided to patients about their treatment and the options open to them. The patient feedback we received 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' dental needs. There were set appointment times for routine check-ups and more minor treatments. The dentists could also decide on the length of time needed for their patient's consultation and treatment. The feedback we received from patients indicated that they felt they had enough time with the dentist and were not rushed.

Staff told us that patients could book an appointment in good time to see the dentist. The feedback we received from patients confirmed that they could get an appointment when they needed one, and that this included good access to emergency appointments on the day that they needed to be seen.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours and guides to different types of dental treatments. There was also a practice leaflet which included advice about the types of services that were on offer. The practice had a website which reinforced this information.

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. There was an equality and diversity policy, which staff were following.

Staff spoke a range of different languages, which supported some patients to access the service. They were also able to provide large print, written information for people who were hard of hearing or visually impaired.

The practice was not wheelchair accessible with treatment rooms situated on the first floor. The practice manager told

us they referred people to another practice if they needed wheelchair access. However, we noted that the practice had not carried out a formal disability discrimination audit to identify and consider what reasonable adjustments could be made to the premises to accommodate the needs of disabled patients.

Access to the service

The practice opening hours are Monday to Friday from 9.00am to 5.30pm. The practice displayed its opening hours on their premises and on the practice website.

We asked the practice manager about access to the service in an emergency or outside of normal opening hours. They told us that calls were directed to a mobile phone which they reviewed at regular intervals. They spoke with patients and then contacted the dentists so that they could carry out an assessment of their patients' needs, as necessary.

The reception staff told us that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, were seen on the same day that they alerted the practice to their concerns. The feedback we received via comments cards confirmed that patients had good access to the dentist in the event of needing emergency treatment.

Concerns & complaints

Information about how to make a complaint was available, upon request, from reception staff. There was a formal complaints policy describing how the practice handled formal and informal complaints from patients. There had not been any complaints recorded in the past year.

Patients were also invited to give feedback through a comments book in the waiting area. The dentists also collated and reviewed ad hoc, written feedback that they received from their patients in letters written to the practice. The information received demonstrated that patients were highly satisfied with the care they received.

Are services well-led?

Our findings

Governance arrangements

The practice had governance arrangements and a clear management structure. There were relevant policies and procedures in place. Staff were aware of these and acted in line with them.

Records related to patient care and treatments were kept accurately. Staff records were generally well maintained, although improvements could be made particularly in relation to the recording of references during any recruitment process.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. We identified some areas where improvements were required. For example, in relation the recording and review of incidents. We also identified a few areas where actions to mitigate risk could be improved, for example, in relation to environmental cleaning. The staff we spoke with about these issues were responsive to our feedback and confirmed that they would act to remedy these issues.

Staff told us there were regular staff meetings to discuss ongoing concerns and key governance issues such as infection control. These meetings were not minuted, but it was evident through our discussions with staff that they were a team who communicated well with each other.

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 the principal dentist and the practice manager. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring and committed to their work and overall there was a strong sense that staff worked together as a team.

Staff were being engaged in an appraisal process, at the time of the inspection, to identifying their training needs and overall career goals.

Learning and improvement

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control and X-ray quality. However, we found that the audit process had not always been used successfully to monitor and improve the quality of the service. For example, the X-ray audit was not comprehensive as it did not cover each clinician taking X-rays at the practice. The practice had also not systematically audited the quality of dental care record keeping.

We found that 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).

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

Patients were invited to give feedback through a comments book in the waiting area. The dentists also collated and reviewed ad hoc, written feedback that they received from their patients in letters written to the practice. The information received demonstrated that patients were satisfied with the care they received.

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