Mr. Robert Tobin

The Dental Centre

Inspection Report

5 Hedingham Grove
Chelmsley Wood
Birmingham
B37 7TP
Tel: 01217701533
Website: www.thedentalcentre.co.uk

Date of inspection visit: 6 September 2016
Date of publication: 15/11/2016

Overall summary

We carried out an announced comprehensive inspection on 6 September 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

The Dental Centre is a dental practice providing general dental services on a NHS and private basis. The service is provided by seven dentists. They are supported by eight dental nurses (three of whom are trainees), a practice manager (who is a registered dentist) and two receptionists. All of the dental nurses also carry out reception duties.

The practice is located in a residential area near local amenities and bus routes. There is wheelchair access to the practice and car parking facilities. The premises consist of a waiting room, a reception area, two treatment rooms, store cupboards and toilet facilities for people with disabilities on the ground floor. The first floor comprises of two decontamination rooms, a storage room, six treatment rooms, an office, a waiting room, a reception area, a staff changing room, two storage rooms, a staff toilet and accessible toilet facilities. There is also a dedicated room for taking X-rays. A lift and staircase connect the ground and first floors. The practice opened from 9am to 5pm on Monday to Friday.

The provider is registered with the Care Quality Commission (CQC) as an individual. 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.

Thirty-eight patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three

Summary of findings

patients during our visit. Patient feedback was positive about the care they received from the practice. They described staff as caring, knowledgeable and respectful. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and others praised the staff for their child-friendly approach.

Our key findings were:

- The practice was organised and appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patients told us they found the staff polite and friendly. Patients were able to make routine and emergency appointments when needed.
- An infection prevention and control policy was in place. We saw the decontamination procedures followed recommended guidance.
- The practice had systems to assess and manage risks to patients, including health and safety, safeguarding, safe staff recruitment and the management of medical emergencies.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- The practice had a strong focus on promoting oral health to the community, particularly patients diagnosed with dementia.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Practice meetings were used for shared learning.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.
- Not all of the dentists were following recognised guidance with respect to their dental care record keeping.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society
- Review the practice's protocols for recording in the patients' dental care records the quality of the X-ray and the clinical X-ray findings.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'.

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

Are services effective?

No action

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Dental care record keeping was mostly in line with guidance issued by the Faculty of General Dental Practice (FGDP). Not all of the dentists consistently recorded clinical findings following X-rays as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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

Are services caring?

No action

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. Patients described staff as friendly and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding. Several patients commented that the practice was child-friendly.

Summary of findings

Are services responsive to people's needs?

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

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

The practice had an effective complaints process.

The practice offered full access for patients with limited mobility.

No action

Are services well-led?

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

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

There were systems in place to monitor the quality of the service including various audits. The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

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

No action

The Dental Centre

Detailed findings

Background to this inspection

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

We inspected The Dental Centre on 6 September 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

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

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We reviewed the documents for a recent RIDDOR reportable incident and found that it had been managed appropriately.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The provider was responsible for obtaining information from relevant emails and forwarding this information to the rest of the team. We were told this was also discussed in staff meetings. The provider was aware of the practice's arrangements for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local safeguarding teams. The provider was the safeguarding lead in the practice and had received refresher training in August 2016. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. The provider planned to hold internal safeguarding training for staff in the near future.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. We saw rubber dam kits at the practice but not all dentists used them when carrying out root canal treatment. Within 48 hours, the provider contacted us to inform us that they had informed all dentists that rubber dam kits should be used for all root canal treatment procedures.

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

Not all staff we spoke with were aware of the duty of candour regulation; however, staff were able to give us examples of situations when they acted in accordance with this regulation. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were aware of 'never events' and the practice had written processes to follow to prevent these happening.

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

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies in the practice were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an automated external defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

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

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the AED, weekly checks of the emergency oxygen and monthly checks of the emergency medicines. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency

medicine) was stored in the fridge but the temperature was not monitored to ensure it remained within the recommended parameters. Within 48 hours, the provider contacted us with a new policy and log sheets which stated that the daily temperature would be recorded on a daily basis. It also had details about maximum and minimum temperatures so that staff could alert the provider if the temperature did fall outside the recommended range.

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

Staff recruitment

The practice had a recruitment policy for the safe recruitment of staff. We looked at the recruitment records for four members of the practice team. The records we saw contained evidence of employment contracts, curricula vitae and staff identity verification. The recruitment policy stated they would seek two references for all new staff members; however, not all of the records contained two references. We were told that verbal references were provided for some staff but these were not documented. We discussed this and were assured that all future verbal references would be recorded. Subsequently, the provider contacted us within 48 hours with an amended recruitment policy which was comprehensive and clearly stated the practice's position regarding references and processes they would follow in the event that written references were not available.

Where relevant, the files contained copies of staff's dental indemnity and General dental Council (GDC) registration certificates. There were also Disclosure and Barring Service (DBS) checks present for the staff members. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults. The provider had applied for DBS checks for all staff and was awaiting details for a newly recruited staff member.

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

Monitoring health & safety and responding to risks

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

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that the fire extinguishers had been serviced in March 2016 and they were visually checked and documented every month by staff at the practice. Fire drills took place every six months to ensure staff were rehearsed in evacuation procedures. Staff carried out and recorded weekly checks of the fire alarms and fire escape routes. There were two fire exits on the ground floor and these had clear signage to show where the evacuation point was. An external fire risk assessment had been carried out in January 2016 and all recommended actions had been completed.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff. At the time of our visit, the provider had requested further information from one staff member's occupational health physician to ensure that they had adequately responded to the immunisation. The provider contacted us a few weeks after our visit to confirm that this staff member was immune.

We observed the treatment rooms and the decontamination rooms to be visually clean, tidy and free from clutter. Many patients commented that the practice

was clean and tidy. Work surfaces and drawers were free from clutter. The clinical areas had sealed flooring which was in good condition. Dental chairs were covered in non-porous material which aided effective cleaning.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. The practice used computers and the keyboards in the treatment rooms had water-proof covers.

Decontamination procedures were carried out in two dedicated decontamination rooms. HTM 01-05 recommends the provision of two separate rooms as this provides for a higher degree of separation between dirty instruments awaiting decontamination and cleaned/ sterilized instruments that are to be placed in trays, packs or containers for use. In accordance with HTM 01-05 guidance, an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination rooms.

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

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

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument – this included all the necessary information and was easily accessible. Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

Staff told us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All clinical and non-clinical areas were cleaned daily by an external contractor. The practice had a dedicated area for the storage of their cleaning equipment.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out in line with current guidance. We reviewed the audit from June 2016 and an action plan was documented subsequent to the analysis of the results. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in December 2015. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves. The practice purchased a new ultrasonic cleaning bath annually as they were unable to find an adequately trained contractor to service this equipment.

Are services safe?

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in August 2016.

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

There was a separate fridge for the storage of medicines and dental materials. The temperature was not monitored or recorded. Within 48 hours, the provider contacted us with a new policy and log sheets which stated that the daily temperature would be recorded on a daily basis. It also had details about maximum and minimum temperatures so that staff could alert the provider if the temperature did fall outside the recommended range.

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

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used digital X-rays. Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these. The OPG equipment was new and had only been installed two weeks before our visit. The provider told us that they were still waiting for an external contractor to certify that this new machine was operating within the recommended parameters.

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

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

Rectangular collimators were available at the practice and these are attached to the X-ray machines. This is good practice as it reduces the radiation dose to the patient. These were removable but only two were available. The provider told us that they had ordered six more as they were currently being shared between the treatment rooms.

We saw evidence that the dentists were up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

We saw evidence that the practice carried out an X-ray audit in March 2016. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that the results were analysed and reported on.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

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

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

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

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentists told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records. However, one dentist was not consistently reporting on the X-ray findings and this was discussed with the provider. Within 48 hours, the provider informed us they would be conducting an audit on dental care record keeping and that it would encompass all dentists' records at the practice. They told us this audit would take place in October 2016.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The dentists we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were oral health promotion leaflets available in the practice to support patients in looking after their health. Examples included information on oral cancer and supporting patients with dementia.

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

The practice promoted oral health in the local community using various methods. Staff had visited local schools to increase awareness of the importance of oral health. Tooth brushing techniques were demonstrated and balloons and goody bags were given to children. One of the dental nurses had received training in smoking cessation advice. They worked together with the pharmacy (next door to the practice) to assist and encourage patients.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This included areas such as fire safety, confidentiality and safeguarding.

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

The practice manager monitored staffing levels and planned for staff absences to ensure the service was

Are services effective?

(for example, treatment is effective)

uninterrupted. We were told that dental nurses were often transferred from the provider's other local practices and staff were happy to travel between the two locations if required. As a result, the practice did not require the services of a locum dental nurse agency.

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

We were told that the dental nurses were encouraged to carry out further training. Some of the dental nurses had completed additional training which enabled them to take dental X-rays and apply fluoride varnish to teeth.

Working with other services

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

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

Consent to care and treatment

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

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

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

Staff members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Staff and patients told us that written treatment plans were provided. Patients told us they were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Thirty-eight patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was positive about the care they received from the practice. They described staff as caring, knowledgeable and respectful. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and others praised the staff for their child-friendly approach.

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

We were told that the practice appropriately supported children and anxious patients using various methods. Longer appointments were arranged to allow additional time for discussions. They also had the choice of seeing male of female dentists at the practice. Patients could also request a referral for dental treatment under sedation.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment (where applicable) was discussed with them and this information was also provided to them in the form of a customised written treatment plan. Some patients stated that the costs were discussed verbally but that they did not recall receiving a written plan. However, we were told that all patients received written treatment plans.

Examination and treatment fees were available in the practice leaflet.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. The practice was purpose built and fully accessible to patients in wheelchairs. There was a lift present and toilet facilities with disabled access the reception area had a dedicated area at a lower level so that staff could converse at eye level with patients in wheelchairs. There was car parking available for patients with physical disabilities near the main entrance to the practice.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were not always seen on time but they felt that the wait was not too long. They told us that it was easy to make an appointment. Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. The practice utilised a 'sit and wait' policy for their patients requiring urgent treatment. We saw that many patients failed to attend their appointments. Consequently, the dentists could accommodate additional patients requiring urgent treatment

Patient feedback confirmed that the practice was providing a good service that met their needs. The practice sent appointment reminders to all patients that had consented. The method used depended on the patient's preference, for example, via text message, email, letter or telephone reminders. The patient's preference was recorded on their file.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services. The practice had an audio loop system for patients who might have hearing impairments. The practice welcomed patients who were blind or visually impaired and were considering signs in Braille in future to improve access. The practice already had a sign in Braille at the refuge point for patients with disabilities. Also, the practice had access to sign language interpreters, if required.

The practice had access to an interpreting service for patients that were unable to speak fluent English. Some of the staff spoke different languages relevant to patients such as Punjabi, Hindi and Urdu.

The practice was heavily involved in promoting oral health in patients diagnosed with dementia. Three of the staff members had received additional training in the management of patients with dementia. They had contacted local GPs to encourage them to refer patients with early dementia so that their oral health needs could be met. They provided information to patients and their carers.

Access to the service

Feedback from patients confirmed they could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment via the telephone answering service and information was also displayed at the main entrance and in the practice leaflet.

The practice opening hours were from 9am to 5pm on Monday to Friday.

Concerns & complaints

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

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. There was a designated complaints lead and all verbal complaints were documented too. We found that complainants had been responded to in a professional manner. We were told that

Are services responsive to people's needs?

(for example, to feedback?)

any learning identified was cascaded personally to team members and also discussed in staff meetings. We saw examples of changes and improvements that were made as a result of concerns raised by patients.

Are services well-led?

Our findings

Governance arrangements

The provider was in charge of the day to day running of the service. In their absence, there was an appointed deputy lead and also a head nurse. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments. The practice also had risk assessments for areas such as fire safety, pregnant workers and handling cash.

The practice was a member of the BDA (British Dental Association) Good Practice scheme. This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities.

Leadership, openness and transparency

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

Learning and improvement

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

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

Staff meetings took place every one or two months. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as complaints, fire safety and consent had been discussed in the last six months.

We reviewed a selection of staff files and saw that employed staff received appraisals annually. At the time of our visit, the dentists were not appraised; however, the provider told us they had planned to introduce these for dentists too. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. An example included placing a television in the waiting room. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. There was a suggestions box in the waiting room for patients. Patients were invited to complete satisfaction surveys online on the practice website. The practice undertook the NHS Family and Friends Test (FFT) and the results from July 2016 were displayed in the reception area. The FFT captures feedback from patients undergoing NHS dental care. There were also comment cards in the reception area and patients were encouraged to leave feedback by advertising this information in the practice leaflet.

Staff we spoke with told us their views were sought and listened to and there were dedicated staff satisfaction questionnaires.