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Perry Park Dental

Inspection Report

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Date of inspection visit: 10 January 2017
Date of publication: 03/03/2017

Overall summary

We carried out an announced comprehensive inspection on 10 January 2017 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

Perry Park Dental is a dental practice providing general dental services on a NHS and private basis. The service is provided by three dentists (one of whom is the provider). They are supported by three dental nurses (one of whom is a trainee) and a receptionist. Some of the dental nurses also carry out reception duties.

The practice is located on a main road near local amenities and bus routes. The whole practice is situated on the ground floor and is wheelchair-accessible. Car parking is available directly outside on the main road. The premises consist of a waiting room, a reception area, two offices, staff room, a storage room, decontamination room and two treatment rooms. Toilet facilities were also present for staff and for patients and these were wheelchair-accessible. The practice opened at 9am on Monday to Friday and closing times varied between 5:30pm and 6:30pm. The practice also opened on alternate Saturdays between 9am and 1pm.

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.

Fifty-two patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients. The information from patients was complimentary. Patients were extremely positive about their experience and they commented that staff were kind, caring and informative.

Summary of findings

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 kind and caring. Patients were able to make routine and emergency appointments when needed.
- The practice shared examples of how they demonstrated a strong commitment to their patients' dental care.
- 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. Some of these areas required improvements which were promptly resolved.
- 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.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Regular practice meetings were used for shared learning.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review the storage of dental care products and medicines requiring refrigeration to ensure they are stored in line with the manufacturer's guidance and the fridge temperature is monitored and recorded.
- Review the availability of medicines to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK).
- Review their processes for ensuring that recommended servicing and maintenance checks are carried out for essential equipment in a timely manner.

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. We identified some necessary improvements and these were promptly resolved by the provider.

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 mostly 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. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

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 entirely positive about the care they received from the practice. Patients described staff as kind, caring and welcoming. 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.

Summary of findings

Are services responsive to people's needs?

No action

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.

Are services well-led?

No action

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.

Perry Park Dental

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 Perry Park Dental on 10 January 2017. 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 and spoke with all staff present on the day – this included the provider, two dental nurses and the receptionist. We also reviewed CQC comment cards which patients had completed and spoke with three 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). No RIDDOR reportable incidents had taken place at the practice in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We saw that 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. The provider was aware of the practice's arrangements for staff to report adverse drug reactions.

Staff we spoke with were aware of the Duty of Candour regulation. 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.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and protection of vulnerable adult policies and 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. 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. Training records showed the safeguarding lead had completed training to an appropriate level in June 2016 (safeguarding children) and December 2015 (safeguarding vulnerable adults).

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We saw rubber dam kits at the practice and were told that all dentists used them when carrying out root canal treatment whenever practically possible. A rubber dam is a thin sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams 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 the patient's dental care records giving details as to how the patient's safety was assured.

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.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were aware of 'never events' although the practice did not have written processes to follow to prevent these happening. For example, there was no written process to make sure they did not extract the wrong tooth. However, staff described to us the methods they used to prevent such incidents from occurring.

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 mostly 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 and delivers an electrical shock to attempt to restore a normal heart rhythm.

Are services safe?

Staff received annual training in the management of medical emergencies. 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 emergency oxygen and weekly checks of the emergency medicines and the AED. The emergency medicines were all in date and stored securely.

A glucagon injection kit is used to treat episodes of severe hypoglycemia which is defined as having low blood glucose levels. This was available at the practice but the glucagon was not stored in the refrigerator. The manufacturer states that it can be stored outside the refrigerator but this does shorten the shelf life. The provider was unable to demonstrate that the expiry date had been amended. Within 48 hours, the provider informed us they had ordered a new glucagon kit as the previous one had expired once the date had been amended to account for its storage at room temperature. They had introduced a new policy to store all new glucagon kits in the fridge.

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

We noted that the practice did not have any buccal midazolam; this is an emergency medicine used to treat a number of conditions including seizures. The practice did have some midazolam in the correct dose but it was not available in the buccal form (it was for other routes such as intravenous, intramuscular and rectal). This was discussed with the provider and they emailed us within 48 hours to state they had placed an order for the appropriate midazolam.

Mercury and bodily fluid spillage kits were available to deal with any incidents. The provider ordered some eyewash solution within 48 hours of our visit.

Staff recruitment

We reviewed the recruitment records for three members of the practice team. The records we saw contained evidence of staff identity verification and written references. Some of the records contained contracts and induction plans. 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 in the records we reviewed. 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 had completed written risk assessments for staff that did not hold recent DBS certificates.

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

The practice had a recruitment policy for the safe recruitment of staff; however, this did not have specific information about the acceptance of historical DBS checks. Within two working days, the provider informed us that they had amended the policy to include this information.

Monitoring health & safety and responding to risks

We saw evidence of a 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. There was a general risk assessment for the practice to help identify potential hazards We reviewed several risk management policies. The provider showed us systems that were present to ensure fire safety at the practice. We saw evidence that the fire extinguishers had been serviced in August 2016.Fire drills took place every six months to ensure staff were rehearsed in evacuation procedures. Staff carried out and recorded weekly fire alarm tests and an external contractor serviced these a few days before our visit. There were two fire exits and both had clear signage to show where the evacuation point was. The provider had arranged for a fire officer to visit the practice the week after our visit to carry out an external fire risk assessment.

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. We saw evidence that this was regularly updated.

Are services safe?

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The policy was reviewed annually but needed to be amended to make it more specific to the practice, for example, it made reference to non-essential equipment in the practice that was not currently being used. The practice generally 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.

We observed the treatment rooms and the decontamination room to be visually clean. Many patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition. Dental chairs were covered in non-porous material which aided effective cleaning. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Decontamination procedures were carried out in a dedicated decontamination room. 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 room. The decontamination room did not contain a disposal bag for clinical waste. This was discussed with the provider and they informed us this had been added within 48 hours of our visit.

Sharps bins were appropriately located and out of the reach of children. We observed waste was separated into safe and lockable containers for monthly 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. We noted that some disposable items were left uncovered during treatment although they were stored in closed drawers. Within 48 hours, the provider informed us they had ordered new dispensers that would allow these items to remain covered within the drawers.

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. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. 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 autoclave on a daily basis. They also carried out regular tests of the ultrasonic cleaning bath. 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 staff. 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 October 2016 and found this to be satisfactory.

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 reviewed the Legionella risk assessment and this was carried out by an external contractor in July 2015. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range. One of the recommended actions in the risk assessment advised the provider to send a sample of water to a specialist laboratory so that they could analyse the quality of water. The provider told us they had followed this and had a certificate to confirm this. However, they were unable to produce the certificate on the day of our visit. Subsequent tests of the water quality had been carried out on a quarterly basis in-house.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves. However, the ultrasonic cleaning bath had not been serviced since 2010. Within 48 hours, the provider had arranged a date in February for this to be serviced. They told us this was the earliest available date. They told us they would ensure that an annual service would be carried out.

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 January 2017. Visual checks of the electrical equipment were carried out monthly by staff.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked. All prescriptions were stamped only at the time of issue. The practice dispensed antibiotics and these were stored securely. The practice maintained a log of all medicines that had been dispensed and the provider carried out audits of antibiotics.

There was a separate fridge for the storage of medicines and dental materials. Some medicines were stored in the fridge during the warmer months but removed during winter. A thermometer was available but the temperature was not monitored and recorded daily. Within 48 hours, the provider informed us that the temperature was now logged daily and they had assigned this duty to two staff members.

Stock rotation of all dental materials was carried out on a regular basis 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.

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.

The X-ray equipment in the treatment room was fitted with a part called a rectangular collimator which is good practice as it reduces the radiation dose to the patient. The equipment in the second room did not have this fitted but this machine was not used.

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 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, 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 the provider about the oral health assessments, treatment and advice given to patients and they showed us a selection of patient dental care records to corroborate this. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Some of the dentists were not consistently recording the patients' risk to developing oral health problems, such as oral cancer and decay. An audit of dental care record keeping was carried out in December 2016 and this highlighted some necessary improvements. The provider was already aware that some aspects of the dental care record keeping required improvements and planned to discuss the results from the previous audit to relevant staff members the week after our visit. They also planned to re-audit in two months to ensure that records were in line with current guidance.

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.

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 provider 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 stopping smoking and oral hygiene.

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.

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 child protection and confidentiality.

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 nurse as only qualified staff can register).

The provider monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that all of the employed dental nurses were part-time and had the flexibility to work additional hours, if required. Occasionally, the practice utilised 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

Are services effective?

(for example, treatment is effective)

us that senior staff were readily available to speak with at all times for support and advice. The provider was contactable via telephone on the days they were not present at the practice.

A dental nurse always worked with each dentist and an additional nurse was sometimes available each day to help with decontamination procedures. The General Dental Council (GDC) recommends that dental staff are supported by an appropriately trained member of the dental team at all times when treating patients. The practice opened in 2009 and the provider did occasionally treat emergency patients without a dental nurse in 2010. However, they recognised this was an issue and subsequently recruited additional staff. There have not been any issues with staff shortages since 2010.

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 orthodontic treatment. We viewed two referral letters and noted that they were comprehensive to ensure the specialist services had all the relevant information required.

Staff understood the procedure for urgent referrals, for example, patients with suspected oral cancer. A referral tracker was used to allow staff to track the progress of referrals.

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 written treatment plans were given to all patients. Consent forms were available for specific procedures such as tooth extractions and root canal treatment.

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 were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Fifty-two 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 entirely positive about the care they received from the practice. They described staff as kind, knowledgeable and helpful. Patients commented they felt involved in their treatment and it was fully explained to them in a respectful manner. Feedback confirmed that staff were professional and informative and provided advice about dental health. Nervous patients said they felt at ease here and others praised the staff for their child-friendly approach. Several patients had recommended the practice to their family and friends.

Some patients had been visiting this practice for many years and they stated they would not go anywhere else.

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 or female dentists at the practice. Patients could also request a referral for dental treatment under sedation.

We saw that patients were very complimentary and grateful to the practice for the dental care they received. We saw many cards addressed to the practice which thanked staff for their kindness and support. We also reviewed a book which contained patient testimonials.

The practice had a small, limited NHS contract and the practice owner provided pro bono NHS treatment for their NHS patients to ensure continuity of their care. This demonstrated a strong commitment to their patients' dental care.

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.

Examination and treatment fees were displayed in the waiting room.

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 fully accessible to patients in wheelchairs. Car parking was available near the main entrance to the practice. There were toilet facilities and these were wheelchair-accessible. The reception desk had a dedicated area at a lower level so that staff could converse at eye level with patients in wheelchairs.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were usually seen on time and 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. We reviewed the appointment system and saw that emergency slots were available on a daily basis to accommodate patients requiring urgent treatment. If these slots became unavailable, the practice was able to accommodate patients by utilising a 'sit and wait' policy. They had also extended their opening hours to accommodate patients when the need had arisen.

Patient feedback confirmed that the practice was providing an excellent service that met their needs. The practice sent appointment reminders via text to all patients that had consented.

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 did not have an audio loop system for patients who might have hearing impairments. However, the practice used various methods so that patients with hearing impairments could still access the services – these included provided written information and speaking slowly to enable patients to lip-read. The practice provided written information in large font for patients who were partially sighted.

Staff spoke a variety of languages and we were told they also used an online translation service to communicate with patients who did not speak the same language as the staff.

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 able to speak to the provider at all times for telephone advice.

The practice opened at 9am on Monday to Friday and closing times varied between 5:30pm and 6:30pm. The practice also opened on alternate Saturdays between 9am and 1pm.

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 any learning identified was cascaded personally to team members and records confirmed that this was 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. 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 ionising radiation, display screen equipment and pregnant staff.

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.

The provider had systems in place to support communication about the quality and safety of services. Staff told us they were aware of the need to be open, honest and apologetic to patients if mistakes in their care were made. This was in line with the Duty of Candour regulation.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. 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. Audits were also present for the prescribing of antimicrobials and failed appointments.

Staff meetings took place monthly. 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, confidentiality and infection control had been discussed in the last six months.

All staff received annual appraisals. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed. We reviewed three appraisals and found these to be comprehensive and transparent.

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. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. Patients were invited to complete satisfaction surveys and this was an ongoing process. We saw evidence that the results were collated and analysed every two months. There was a dedicated book in the waiting area for patients' testimonials.

Patients had made comments on the NHS Choices website. The practice had not yet responded to the entries on the website. The provider told us they regularly reviewed these comments but had not been able to respond due to technical issues with the website. They told us they had contacted the administrator and were awaiting contact.

Staff we spoke with told us their views were sought and listened to although there were no dedicated staff satisfaction questionnaires.