

Dr. Ranjna Sharma

Purity Dudley

Inspection Report

74 Dixons Green Road
Dudley
West Midlands
DY2 7DJ
Tel: 01384 252387
Website: Puritydental.co.uk

Date of inspection visit: 8 February 2017
Date of publication: 10/04/2017

Overall summary

We carried out an unannounced comprehensive inspection on 8 February 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

Purity Dental Practice has nine dentists (including the principal, a dentist with a special interest in orthodontics, a foundation dentist an oral surgery consultant and a dentist with a special interest in oral surgery), a practice manager, seven qualified dental nurses who are registered with the General Dental Council (GDC), three trainee dental nurses, three dental therapists and four receptionists. The practice's opening hours are 9am to 8pm on Monday and Tuesday, 9am to 5.30pm Wednesday to Friday and Saturday 8am to 12pm. The practice closes for lunch between the hours of 1pm to 2pm on a Wednesday when staff training or meetings take place.

Purity Dental Practice provides mainly NHS dental treatments to patients of all ages but also offers private treatment options. The practice has two dental treatment rooms on the ground floor and four on the first floor. Sterilisation and packing of dental instruments takes place in a separate decontamination room. There is a reception with adjoining waiting area on the ground floor.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures in place with infection prevention and control audits being undertaken

Summary of findings

recently, although audits had not been completed on a six monthly basis prior to this. Staff had access to personal protective equipment such as gloves and aprons. However there was no evidence that all staff were up to date with their hepatitis B vaccination.

- The dentist used nationally recognised guidance in the care and treatment of patients.
- There was appropriate equipment for staff to undertake their duties. Although one piece of equipment was overdue for service.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- Staff had been trained to deal with medical emergencies and the provider had emergency equipment in line with the Resuscitation Council (UK) guidelines with the exception of two sizes of oropharyngeal airways which were ordered following this inspection.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The governance systems were effective.

- The practice was well-led and there were clearly defined leadership roles within the practice. Staff told us they felt supported, involved and they all worked as a team.

There were areas where the provider could make improvements and should

- Review the storage of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are stored securely.
- Review systems in place for the undertaking of regular servicing and maintenance of equipment used during surgical procedures and provide evidence to demonstrate that where issues are identified these are acted upon.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Systems were in place for recording events and accidents and guidance was available regarding the Reporting of Injuries, Diseases and Dangerous Occurrences.

The medical emergency kit was missing two sizes of oropharyngeal airways which are recorded in national guidelines. These were purchased on the day following our inspection.

The practice had undertaken relevant recruitment checks to ensure patient safety.

Decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use. Infection control audits were being undertaken on a six monthly basis.

A surgical drill which had been purchased by the practice in 2015 had not been serviced or maintained. This was overdue for service.

No action



Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. Referrals were made to secondary care services if the treatment required was not provided by the practice.

The practice used oral screening tools to identify oral disease. Patients' dental care records confirmed that staff were following recognised professional guidelines.

Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC).

No action



Are services caring?

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

We observed the staff to be welcoming and caring towards the patients. Staff treated patients with kindness and respect and they were aware of the importance of confidentiality. Patient's privacy and confidentiality was maintained on the day of the inspection.

Confidential patient information was securely kept.

No action



Are services responsive to people's needs?

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

Patients had good access to treatment and urgent care when required. The practice had ground floor treatment rooms. Level access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

No action



Summary of findings

The practice had an efficient appointment system in place to respond to patients' needs. There were clear instructions for patients requiring urgent care when the practice was closed.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference. Staff were familiar with the complaints procedure.

Are services well-led?

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

There were good governance arrangements and a clearly defined management structure in place. Systems were in place to share information with staff by means of informal weekly meetings and formal practice meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us that the culture within the practice was open and transparent.

No action



Purity Dudley

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.

This unannounced inspection took place on 8 February 2017 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with four

members of staff. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records.

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

Systems were in place to enable staff to report incidents and accidents. Accident reporting books and significant event reporting forms were available. We saw that there had been three accidents reported during 2016 with the date of the last accident being 6 July 2016. We were told that accidents were discussed at practice meetings as and when they occurred.

We were told that accidents and incidents were discussed at staff meetings. We looked at the minutes of recent staff meetings to confirm this. We saw that a recent incident was discussed at a meeting although we were unable to find the incident record regarding this. The practice manager and principal dentist confirmed that a follow up telephone conversation had recently been held with the person involved and this may be the reason for the missing information. Details of this accident were forwarded to us following this inspection. However we were told that a new log sheet would be developed to ensure staff kept an up to date log of all accidents and incidents and these would be reviewed on a regular basis.

The practice had reported 13 significant events within the last 12 months. Forms were also completed to record any follow up action taken. The practice manager was the significant events lead and staff spoken with were aware of who held this role. The practice manager confirmed that they were encouraging staff to report incidents to enable improvements and learning to take place. The practice had developed a 'blame free culture policy' as well as an incident management policy, significant event reporting forms and a significant event/critical event toolkit. The practice manager was able to discuss changes in working practices which had been implemented following significant events. For example security gates had been put up at the rear of the practice.

Information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) was available for staff. Staff spoken with were aware of what issues required reporting under RIDDOR regulations. We were told that there had been no events at the practice that required reporting under RIDDOR.

We discussed national patient safety and medicines alerts with the practice manager and with the lead nurse. These were received into the practice via email by the lead nurse. We were told that any alerts that were relevant to the practice would be discussed at a practice meeting.

The practice had not developed a Duty of Candour policy although documentation we were shown regarding complaints, incidents and the practice's being open policy demonstrated that staff were following the principles of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding file which contained information for staff regarding identifying and reporting child protection and adult safeguarding issues. For example we saw that policies were in place regarding child protection and safeguarding vulnerable adults, as well as contact details for Dudley safeguarding, Childline, emergency duty social workers and children's referral services. Other useful information for staff included a child protection and the dental team flowchart for action and information regarding keeping adults safe from abuse. Staff had signed documentation to confirm that they had been consulted over how the safeguarding policy had been implemented.

Leaflets and posters regarding child protection and adult safeguarding were on display in the waiting area.

All staff spoken with said that they would speak with the practice manager or the principal dentist for advice or to report suspicions of abuse. We were told that there had been no safeguarding issues to report. Records seen demonstrated that staff had also completed the appropriate level of safeguarding training. On-line training was available to all staff.

We discussed sharps injuries with the principal dentist and we looked at the practice's sharps policies. We were told that there had been sharps injuries at the practice



Are services safe?

previously which had resulted in the practice changing to the use of safer sharps. Dental nurses we spoke with confirmed that dentists took responsibility for disposal of sharps.

A sharps risk assessment had been completed and sharps information was on display in treatment rooms and other locations where sharps bins were located. Sharps bins were stored in appropriate locations which were out of the reach of children. We found that the practice was complying with the Health and Safety (Sharp instruments in healthcare) Regulations 2013.

We asked about the instruments which were used during root canal treatment. We were told that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). A risk assessment was produced for every occasion when it was not possible to use a rubber dam with documentation completed as appropriate. Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support on 17 November 2016.

Emergency equipment including oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available. We saw records to demonstrate that daily checks were made on this equipment to ensure that it was in good working order. Daily checks did not include checks of the AED pads to ensure that they were available and within their expiry dates. The practice manager confirmed that these would be added to the check sheet.

We noted that some equipment as recommended by the Resuscitation Council UK guidelines were not available. For example two sizes of oropharyngeal airways were missing.

The practice manager told us that they had been advised to dispose of these as they were not required. We were sent evidence to demonstrate that new airways had been ordered the day following this inspection.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored and we were told that these were checked on a monthly basis to ensure they were within date for safe use. Guidelines provided by the Resuscitation Council (UK) suggest that checks should be undertaken on at least a weekly basis.

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. The clinical lead was the designated first aider and had undertaken relevant training which was due for update in November 2017.

Staff recruitment

We discussed the recruitment of staff and were shown staff recruitment files. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary and a Disclosure and Barring Service (DBS) check (or a risk assessment if a DBS was not needed). We looked at three staff recruitment files and saw that the information required was available. A standard layout was used in each file for ease of access to information.

We saw that evidence that disclosure and barring service checks (DBS) were in place for the majority of staff. DBS checks were available from previous places of employment for newly employed staff and the practice had sent their own DBS check request for these staff. It was the practice's policy to renew DBS checks for all staff every three years. We were told that staff without up to date DBS checks were not able to be left alone with patients until the return of their check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks



Are services safe?

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that the practice had developed a health and safety policy which had been reviewed on an annual basis. The principal dentist was the named lead regarding health and safety with support provided by the practice manager and lead nurse. All staff spoken with said that they could speak with any of these staff for health and safety advice if required. A monthly health and safety 'walk through' was completed. This included checking emergency exits/routes, fire detection, first aid, radiation protection, infection control, clinical waste and medical emergencies.

Numerous risk assessments had been completed. For example, we saw risk assessments for fire, radiation, sharps injury, trainee dental nurse, students on work placements, pregnant and nursing mothers, staff, display screen equipment and a general practice risk assessment. Risk assessments were reviewed on an annual basis.

We discussed fire safety with staff and looked at the practice's fire risk assessment. We saw that the risk assessment had been reviewed and updated on an annual basis by the lead nurse. Detailed information was recorded including information regarding any actions required to reduce risk. A fire safety log book was available and contained information regarding routine checks and servicing. Records seen confirmed that the practice's fire safety systems such as fire alarms, emergency lighting and fire extinguishers were subject to routine maintenance in November 2016 by external professionals. Records were also available to demonstrate that a visual check was completed of fire extinguishers on a weekly basis.

The practice's fire safety policy records the practice manager as the fire officer with fire marshals being the practice manager and lead nurse.

We looked at the practice's COSHH file; we saw that a COSHH policy was available and blank COSHH audit forms. Details of all substances used at the practice which may pose a risk to health were recorded in this file. We noted that not all COSHH items were securely stored, for example we saw that domestic bleach was stored on the floor in one of the treatment rooms.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and toilet were visibly clean, tidy and

uncluttered. An external cleaning company were employed to undertake environmental cleaning. We saw that cleaning logs to demonstrate which cleaning tasks were undertaken and by whom were available. Cleaning staff completed a log book and a supervisor employed by the cleaning company visited the practice on a monthly basis to complete a review.

Infection prevention and control policies and procedures had been developed to keep patients safe. These had been reviewed on an annual basis.

We were shown a copy of the last infection prevention and control audit which was dated November 2016. This audit had been completed by the foundation dentist. We asked to see any previous audits; records shown to us did not demonstrate that the practice had been completing regular six monthly infection control audits as identified in the guidance HTM 01-05, the practice manager confirmed that these audits had been completed on an annual basis prior to her employment at the practice. Paperwork had been developed for the next audit which was scheduled to take place in May 2017.

Records were not available to demonstrate that all staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. The practice manager confirmed that they would ensure that where records did not prove up to date immunisation status, staff would be referred to the occupational health department. Following this inspection the practice manager provided evidence that three staff including the principal dentist and lead nurse have completed a screening form and would be attending occupational health.

Records demonstrated that all staff had undertaken training regarding the principles of infection control.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.



Are services safe?

We looked at the procedures in place for the decontamination of used dental instruments. Decontamination of used dental instruments took place in a separate decontamination room which had clearly identified zones in operation to reduce the risk of cross contamination. A dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. There was a clear flow of instruments through the dirty zone to the clean area. Staff wore PPE during the process to protect themselves from injury which included gloves, aprons and protective eye wear. We found that instruments were manually cleaned, rinsed, inspected under an illuminated magnifier and then sterilised in an autoclave. Instruments such as rubber dam, forceps and any surgical instruments were also placed in a washer disinfectant. Clean instruments were packaged; date stamped and appropriately stored in cupboards.

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

A risk assessment regarding Legionella had been carried out by an external agency on 20 June 2016. The risk assessment identified a low risk but some issues for action were identified. Staff were completing monthly water temperature checks and records were kept to demonstrate temperatures. However there was no evidence available to demonstrate that action had been taken to address other issues. For example a thermostatic mixing valve was required in the ground floor adapted toilet, outlets were required to be cleaned and descaled on a quarterly basis, pipes were to be insulated and the Legionella management policy was to be communicated to staff. Following this inspection we received information from the practice manager stating that verbal confirmation of a fix date for the thermostatic mixing valve was 10 February 2017. We were told that the practice were obtaining quotes for the insulation of pipework and this should be completed by 20 February 2017.

The practice had a waste contractor in place to dispose of hazardous waste. We looked at waste transfer notices and the storage areas for clinical and municipal waste. Clinical

waste was securely stored in an area that was not accessible to patients. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

The practice had maintenance contracts for essential equipment and records seen demonstrated the dates on which the equipment had recently been serviced. For example fire safety equipment had been serviced in November 2016 and the autoclaves serviced in December 2016. All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in February 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test. A further annual test had been booked to take place on 16 February 2017.

The practice had Glucagon; an emergency medicine used to treat people with diabetes who had low blood sugar. This medicine can be either stored in a refrigerator or at room temperature. If stored at room temperature the use by date must be reduced. We saw that the practice were not storing glucagon in the fridge and had not reduced the expiry date by a sufficient amount of time. Records were checked and the expiry date reduced as appropriate during this inspection.

The practice provided sedation for patients who were anxious about dental treatment. The practice provided the necessary equipment for use during sedation of patients. For example we saw pulse oximeter, blood pressure machines and other dedicated surgical equipment. We were not shown any evidence to demonstrate that one piece of equipment had been serviced. The practice manager contacted the manufacturer and identified that the drill which was purchased in 2015 and had not been serviced since was overdue for service. We were told that this would be arranged immediately.

Prescription pads were securely stored. We saw that a log of the prescription number was recorded on patient dental care records but there was no system in place to monitor



Are services safe?

which prescriptions had been used. We discussed this with the practice manager and principal dentist. Following this inspection we received confirmation that a prescription log had been implemented.

Radiography (X-rays)

The practice had developed a radiation protection file. This contained information regarding X-ray sets at the practice and the name of the Radiation Protection Advisor (RPA) and the Radiation Protection Supervisor (RPS). These had been appointed to ensure equipment was operated safely and by qualified staff only. The lead nurse was the RPS and an external company had been contracted to provide the RPA services.

We saw that the practice had notified the Health and Safety Executive on 11 April 2016 that they were planning to carry out work with ionising radiation. Local rules were available in each of the treatment rooms where X-ray machines were located for all staff to reference if needed.

We saw evidence that dentists were up to date with the required continuing professional development on radiation safety.

The practice had six intra-oral X-ray sets, only one of which had a rectangular collimators fitted. Intra-oral X-rays take an image of a few teeth at a time and rectangular collimators reduce the amount of radiation to the patient by decreasing the amount of radiation scatter. Current guidance for dental practitioners recommends rectangular collimation to be retro-fitted to existing equipment at the earliest opportunity (where this is not already available).

Copies of the maintenance logs for each of the X-ray sets were available for review. The maintenance logs were within the current recommended interval of three years. Critical examination packs for each of the X-ray sets were also available dated 19 April 2016. The annual mechanical and electrical service was last completed on 10 January 2017.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines.

We saw a recent X-ray audit completed in January to June 2016.



Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with two dentists and we saw dental care records to illustrate our discussions. The practice kept up to date detailed electronic dental care records.

Medical history forms were given to patients to fill in when they initially registered at the practice. A dental nurse told us that these were verbally checked with patients at every appointment and if no changes the form was signed by the patient and computer records confirmed by the dentist. Where there had been any change in medical history patients were requested to complete a new form. This ensured that the dentist was kept informed of any changes to the patient's general health which may have an impact on treatment. In addition, the dentists told us they discussed patients' lifestyle and behaviour, this was recorded in the patients' dental care records.

We were told patients were recalled on an individual risk based assessment in line with current guidance. This takes into account the likelihood of the patient experiencing dental disease. Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE).

The Dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. Oral hygiene assessments were recorded.

Patient dental care records that we were shown demonstrated that the dentist was following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

Health promotion & prevention

The practice focused on preventative care and supporting patients. For example, high concentration fluoride was prescribed for adults at high risk of dental disease and fluoride varnish was applied to the teeth of all children as required in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staff told us the dentists would always provide oral hygiene advice to patients where appropriate. Interdental cleaning

and flossing was also explained to patients and we were told that information leaflets were given to patients as necessary. Details of discussions regarding improving oral health were recorded in patient dental care records. Oral health promotion leaflets and information about dental treatments were on display in the waiting room.

The medical history form patients completed included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice.

The practice manager confirmed that various activities took place to promote oral health and hygiene. For example the practice had written to all local schools to offer staff from the practice to give a talk. One school had responded and staff had put together a school pack which included colouring in books, dental passports and free samples. The foundation dentist and a dental nurse plan to visit this school in the near future.

Staff told us that during half term week the practice were trying to encourage children to attend. Staff were going to dress up as fairies, advertisements were being placed in local newspapers and appointment slots were being set aside for special children's' clinics. Staff discussed the importance of encouraging children to attend the dentist for regular review of their oral health and hygiene.

Staffing

Practice staff included nine dentists (including the principal, a dentist with a special interest in orthodontics, a foundation dentist an oral surgery consultant and a dentist with a special interest in oral surgery), seven qualified dental nurses who were registered with the General Dental Council (GDC), three trainee dental nurses, three dental therapists, a practice manager and four receptionists.

There were enough staff to support dentists during patient treatment. We were told that all dentists and dental therapists worked with a dental nurse. The practice planned for staff absences to ensure the service was uninterrupted. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave with part time dental nurses being requested to cover staff leave wherever possible.

We discussed staff training with the practice manager and with a dental nurse. Training was provided to staff via



Are services effective?

(for example, treatment is effective)

attendance at courses, in-house and on-line training. We saw training certificates to demonstrate that staff had completed training such as infection control, basic life support and safeguarding. Some dental nurses had completed training in other specific dental topics such as radiography, fluoride varnish application, impression taking and sedation. Staff spoken with said that they received all necessary training to enable them to perform their job confidently and were able to ask for help and advice as required. Staff said that the practice encouraged staff to complete training and the practice manager was very supportive, advice could also be sought from the lead nurse if required. We were told that weekly in-house training sessions were being introduced, a lunch and learn session had been arranged for the day of our inspection.

We were told that discussions were held with staff about continuing professional development (CPD) on an ongoing basis. We were shown staff CPD files. CPD is a compulsory requirement of registration as a general dental professional. We saw evidence to demonstrate that staff had undertaken core CPD training such as safeguarding (including mental capacity), infection control and basic life support. Staff had also completed training in other specific dental topics such as decontamination, impression taking, sedation, fluoride varnish application and dental radiography.

Records seen confirmed that professional registration with the GDC was up to date for all relevant staff and monitoring systems were in place to ensure staff maintained this registration.

Appraisal systems were in place. Staff told us that appraisal meetings were held on an annual basis. We were told that the principal dentist and practice manager were in attendance at these meetings which were used to discuss training needs, working practices and any issues or concerns. We saw that personal development plans (PDP) were available for staff.

Working with other services

The practice made referrals to other dental professionals if the treatment required was not provided by the practice.

Referrals were made by way of the computer system and emailed over a secure email or referrals could be sent by post. The practice also ensured any urgent referrals were dealt with promptly such as referring for suspicious lesions under the two-week rule. The two-week rule was initiated by NICE in 2005 to enable patients with suspected cancer lesions to be seen within two weeks. This ensured that referrals were received and could be actioned in a timely fashion.

Consent to care and treatment

The practice had developed a consent policy which had been reviewed on an annual basis; reference was made to the Mental Capacity Act 2005 (MCA) in this policy. 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 had recently received in-house training regarding the MCA. There were no examples of patients where a mental capacity assessment or best interest decision had been needed.

Dentists we spoke with described to us the process they used to ensure they had obtained full, valid and informed consent. Informed consent is a patient giving permission to a dental professional for treatment with full understanding of the possible options, risks and benefits. We were told that patients were given verbal and written information to support them to make decisions about treatment. Information leaflets were available to assist with the decision making process. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment. Patient care records we were shown contained records of detailed discussions held with patients and there was evidence that consent was obtained.



Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Music was played in the waiting area and we were told that this could also be played in treatment rooms; this helped to distract anxious patients. Staff said that they could speak to patients in the room behind reception if patients needed to speak with staff in private.

The practice did not keep paper records, reducing the opportunity for confidential information to be overseen. Computers were password protected and regularly backed up to secure storage. Staff had access to a policy which detailed information about backing up computer information. If computers were ever left unattended they would be locked to ensure confidential details remained secure. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. We were told that staff took their time to fully explain treatment, options, risks and fees. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. Clear treatment plans were given to patients which also detailed possible treatment and costs. The patient information folder contained information for patients regarding treatments and the practice website also provided information for patients.

Information about NHS costs was available in the waiting area for patients to review.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided mainly NHS treatment with private treatment options available. NHS costs were clearly displayed in the waiting room. At the time of our inspection the practice were taking on new NHS patients and a new patient appointment could be secured within a few days of the initial contact.

Patients were able to make appointments over the telephone or in person. We discussed appointment times and scheduling of appointments. We were told that there was a longer wait for patients to see a 'named dentist' as some dentists at the practice worked part time, however, we were told that the practice operated a short notice cancellation list. This enabled patients to secure an earlier appointment at short notice should a cancellation occur.

We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. The appointment system enabled patients in pain to be seen in a timely manner. Although dedicated emergency appointments were not set aside for the dentists each day that the practice was open; we were told that there were always some vacant slots available. When these were filled patients would be asked to sit and wait to see the dentist.

Tackling inequity and promoting equality

The practice had a portable hearing induction loop for use by people who were hard of hearing. This was available at reception and could be transported into treatment rooms for use whilst treatment was being conducted. Staff spoken with told us that they did not have difficulty communicating with patients who were hard of hearing but contact details for an external company to provide assistance with communication via the use of British sign language was available if required.

We asked about communication with patients who were not able to speak or understand English. We were told that some staff at the practice could speak Polish, Punjabi or Urdu and contact details were available for a translation service which was used as required.

This practice was suitable for wheelchair users, having ground floor treatment rooms with level access to the front

of the building and an adapted toilet to meet the needs of patients with a disability. There was a car parking space at the front of the building which was marked for use only by disabled patients.

Purity is a dementia friendly practice and had joined a dementia action group. We were told that all information for patients was available in large print

Access to the service

The practice was open from 9am to 8pm on Monday and Tuesday, 9am to 5.30pm Wednesday to Friday and 8am to 12pm on Saturday. The practice was closed between 1pm to 2pm on a Wednesday). The opening hours were recorded on the practice website.

The practice website provided patients with information about opening times, the staff team, services provided. The website informed patients that purely cosmetic treatment such as tooth whitening or white fillings could be completed on a private fee paying basis. Patients were also able to make contact with the practice or complete an online appointment booking request.

A telephone answering gave emergency contact details for patients with dental pain when the practice was closed including during the evening, weekends and bank holidays.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. The policy recorded contact details such as NHS England and the Parliamentary and Health Service Ombudsman. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. Patients were given information on how to make a complaint. We saw that a copy of the complaints policy was on display in the waiting area and in the patient information folder, the practice had also developed a complaint leaflet to give to patients if required. A Health watch statement regarding dental complaints was also on display for patients to view.

We saw that seven complaint had been received during 2016 and two during 2017. Details of the complaint, correspondence and any action taken were recorded on the complaint file.



Are services responsive to people's needs? (for example, to feedback?)

Staff told us that they would record details of any complaints received, initially offer an apology and pass details of the concerns to the practice manager who was the complaint lead. Patients were asked to put their concerns in writing and a form could be used to do this. Staff said that they aimed to resolve all complaints immediately and complainants were always offered an apology and a meeting with the practice manager.

Staff we spoke demonstrated a clear understanding of the principles of candour. Staff felt that by being open and honest, offering an initial apology and immediate assistance to sort out any problems mitigated the risk of receiving complaints.



Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service with support provided by the practice manager and lead nurse. Staff were aware of their roles and responsibilities and who to go to within the practice for help, advice and support.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference in the practice manual. Staff had not signed documentation by each policy to confirm that they had read and understood the policy. We were told that staff were reading and discussing these policies at practice meetings. Following this inspection the practice manager confirmed that policies and procedures would be discussed with staff during lunch time when the practice would be closed. Staff would then sign to confirm that they have read and understood them. Policies were kept on the practice's computer system and also in the 'library' which was located off the reception area.

Systems were in place to monitor quality and to make improvements. For example regular audits were undertaken to assess the quality of the radiographs or dental care records. Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, sharps, infection prevention and control, radiography and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

Leadership, openness and transparency

We spoke with staff about communication within the practice. We were told that the practice manager was always available to provide assistance and advice. Staff told us that the practice manager was approachable and helpful. They said that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately. Full practice meetings had previously taken place on a weekly basis, some of which were informal and some which were formal minuted meetings. A copy of any minutes of meetings was sent via email to all staff.

We asked about how feedback was obtained from staff who worked at the practice. We were told about the weekly meetings that took place; the practice manager held a weekly meeting with reception staff, the lead nurse with dental nurses and the principal dentist with all dentists. Staff said that separate meetings helped staff feedback about their individual issues and concerns and staff said that they were able to make suggestions for improvement.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. As well as regular scheduled risk assessments, the practice undertook clinical audits. The lead nurse was the lead for all clinical audits. We were shown the recent audits completed within the last 12 months regarding clinical record keeping (6 June 2016), medical history (5 April, 8 July and 12 October 2016), sedation (March to June 2016 and June to September 2016), infection control (November 2016) and radiography (January to June 2016). We saw that previously infection control audits had been completed on an annual basis. The practice manager showed us paperwork which had been prepared for the next audit which was planned to take place in May 2017 – six months following the last audit. We saw evidence to demonstrate that all audits and risk assessments were reported on and actions taken recorded. For example the record keeping audit identified strengths, weaknesses, actions and comments.

In December 2016 the clinical lead observed all staff whilst undertaking hand hygiene. Where any issues were identified staff were shown the correct procedure and observed on a more frequent basis.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The practice manager had introduced a system of monitoring to ensure staff were up to date with their CPD requirements. Staff confirmed that support was provided to enable them to complete any training required. Annual appraisal meetings were held and staff confirmed that they were encouraged to undertake training.

The practice sought feedback from patients who had decided to register with another dental practice. This information was used to try and learn from this feedback and improve the way the practice operates.



Are services well-led?

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. We saw that a suggestions box and the Friends and Family Test (FFT) was available to capture feedback from patients. The practice had developed a satisfaction survey to give to patients to complete. We were told that each dentist would be required to give out five satisfaction surveys and five FFT feedback forms to patients each week. The results of the newly developed satisfaction survey were to be displayed in the waiting room and we were shown the patient information board which was in the process of being developed to display this information. We were told that information would be updated on the board on a monthly basis.

The FFT which is a national programme to allow patients to provide feedback on the services provided. We were shown the results of the FFT from May 2016 to January 2017 (no results for November 2016). We saw that the percentage of patients who were either extremely likely or likely to recommend the practice ranged from 91% to 100%, with the practice reaching a 100% score in four of these months.

Staff spoken said that they would speak with the practice manager if they had any issues they wanted to discuss. We were told that the practice manager was open and approachable and always available to provide advice and guidance and staff at Purity Dental Practice worked well together as a team.