

Smile Stylist Ltd

# Soho Road Dental Practice

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 22 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

#### **Our findings were:**

##### **Are services safe?**

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

##### **Are services effective?**

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

##### **Are services caring?**

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

##### **Are services responsive?**

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

##### **Are services well-led?**

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

#### **Background**

Soho Road Dental Practice has two dentists who work full time, three qualified dental nurses who are registered with the General Dental Council (GDC) a practice manager, assistant practice manager and a receptionist. The registered manager and practice management team work between two dental practices and spend some time at each location. The practice's opening hours are 9am to 5.30pm on Monday to Friday and 9am to 1pm on a Saturday (by prior appointment only).

Soho Road Dental Practice provides NHS and private dental treatment for adults and children. The practice has two dental treatment rooms on the ground floor and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area.

The registered manager was present during this inspection. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We

# Summary of findings

received feedback from 32 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

## 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 were in place with infection prevention and control audits being undertaken on a three monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Staff had been trained to deal with medical emergencies.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice was well-led and staff felt involved and worked as a team.
- Governance arrangements were in place for the smooth running of the practice and there was a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography.

# 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 significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). Emergency medical equipment was also available and documentation was available to demonstrate that checks were being made to ensure equipment was in good working order and medicines were within their expiry date. Staff had received training in responding to a medical emergency. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. The practice followed procedures for the safe recruitment of staff, this included carrying out disclosure and barring service (DBS) checks, and obtaining references.

Infection control audits were being undertaken on a three monthly basis which is over and above the recommendations of Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05)'. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

### **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. The practice used up to date national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

The practice used oral screening tools to identify oral disease. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. Patients' dental care records confirmed this and it was evident that staff were following recognised professional guidelines.

Staff received professional training and development appropriate to their roles and learning needs. Qualified staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

### **Are services caring?**

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. Feedback from patients was overwhelmingly positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful.

# Summary of findings

## **Are services responsive to people's needs?**

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

Patients had good access to treatment and urgent care when required. The practice had ground floor treatment rooms and toilet which had been adapted to meet the needs of patients with a disability. Ramped access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

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

## **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 an effective management structure in place. Regular staff meetings were held and systems were in place to ensure all staff who were unable to attend the meeting received an update about topics of discussion. Staff said that they felt well supported and could raise any issues or concerns with the registered manager.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

# Soho Road Dental Practice

## 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 inspection took place on 22 March 2016 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 and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with seven members of staff, including the registered manager. 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 and patient dental health education programme.

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. We were told that there had been no patient or staff accidents since the practice opened. Significant events had been reported but these mainly related to maintenance events such as a roof leak and blocked toilet. A member of staff had been appointed as the significant events lead and staff spoken with were aware who held this role. We saw that there was a significant events policy which had been reviewed on an annual basis. There was a significant event audit statement and an audit had been completed on all significant events that had occurred at the practice and details of any action taken following the outcome of the audit were recorded. Practice meeting minutes for February 2015 demonstrated that the reporting of accidents and incidents and the policies in place for staff to refer to had been discussed.

Discussions with the practice manager and registered manager demonstrated that they were aware of when to contact the Care Quality Commission regarding any incidents that occurred at the practice. All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) and forms were available to enable staff to report incidents under RIDDOR regulations if necessary. We were told that there had been no events at the practice that required reporting under RIDDOR.

Systems were in place to ensure that all staff members were kept up to date with any national patient safety and medicines alerts. The practice received these alerts via email and any that were relevant were forwarded to all staff at the practice; a copy was printed off and kept in a medical alerts log and copies were also kept on the computer system. Staff signed and dated documentation to confirm that they had read and understood these safety alerts. We saw evidence in the practice meeting minutes of December 2015 that a safety alert had been discussed during this meeting.

We saw a Duty of Candour policy on display in the waiting room. This informed patients that they would be informed when things went wrong, when there was an incident or accident and would be given an apology.

### Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. Details of how to report suspected abuse to the local organisations responsible for investigation were available. For example details of how to make a referral to the Birmingham safeguarding adult's board were kept on file. A member of practice staff had been identified as lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. We were told that there had been no safeguarding issues to report. We saw evidence that all staff had completed the appropriate level of safeguarding training. On-line training was available to all staff. Leaflets and posters regarding child protection and adult safeguarding were on display in the reception area. These gave the contact details for the local authority responsible for investigation of incidents. The practice meeting minutes for March 2016 demonstrated that child protection, adult safeguarding and mental capacity were discussed.

We were told that there had been no sharps injuries at the practice. The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist. A sharps injury risk assessment had been completed. This listed all of the equipment which could cause a needle stick injury and any actions required to reduce the risk of injury. The risk assessment was reviewed on an annual basis. Sharps information was on display in treatment rooms and other locations where sharps bins were located.

We asked about the instruments which were used during root canal treatment. The registered manager explained that these instruments were single use only. 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). 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

# Are services safe?

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support and emergency equipment was available and checked regularly to ensure it was in good working order. 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. Records confirmed that emergency medical equipment was checked regularly by staff.

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 were regularly checked to ensure they were within date for safe use. We saw that the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF).

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. Records were available to demonstrate that equipment in the first aid box was regularly checked to ensure it was available and within its expiry date. One of the dentists was the designated first aider and had completed first aid training in 2013; update training would be required in October 2016.

## Staff recruitment

The practice had a robust recruitment policy that described the process to follow when employing new staff. This policy included details of the pre-employment information to obtain, interview processes and equal opportunities policy to follow for both part time and full time staff. The policy had been dated and signed with dates of implementation and review.

We discussed the recruitment of staff and looked at two recruitment files in order to check that recruitment procedures had been followed. We saw that both files contained pre-employment information such as proof of identity, written references details of qualifications and registration with professional bodies. Staff had also completed a pre-employment medical questionnaire and an equality form which was used to monitor diversity, identify disabilities in order that the practice could provide assistance as required to staff. Recruitment files also

contained other information such as contracts of employment, job descriptions and copies of policies and procedures such as data protection, confidentiality, health and safety, recruitment and induction.

We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The 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. Dentists or dental nurses from another local practice would also be asked to provide cover at times of need. (The sister practice with the same registered manager, practice and deputy practice manager). A weekly duty rota detailed where dental nursing staff would be working. For example on reception or it recorded the name of the dentist they would be working with. This was available on the practice's computer system and all staff had access. There were enough staff to support dentists during patient treatment. We were told that all dentists worked with a dental nurse.

## Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. Numerous risk assessments had been completed and risk management policies were in place. For example, we saw risk assessments for use of the basement, partially sighted/blind patients, fire, radiation, sharps injury, hepatitis B non-immunised staff or non-responder, bacterial micro-organisms and a general practice risk assessment. Risk assessments were reviewed on an annual basis. We saw that the practice had developed a health and safety policy which had been reviewed on an annual basis and updated as required. A health and safety poster was on display in the decontamination room. We saw documentary evidence to demonstrate that all staff completed a health and safety risk assessment as part of their induction training. This helped staff to identify risks and helped to ensure that appropriate action had been taken to reduce the risk. The practice manager was the named lead regarding health and safety. All staff spoken with said that they could speak with the practice manager for health and safety advice if required.



# Are services safe?

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire risk assessment was completed in August 2013 and had been reviewed on an annual basis thereafter. Issues for action had been identified which had all been assessed as low risk. The registered manager was able to describe in detail and show evidence to demonstrate that all required actions had been taken.

Records seen confirmed that fire safety equipment such as fire extinguishers; fire alarms and smoke alarms were subject to routine maintenance by external professionals. We saw that a fire safety audit checklist had been completed in July 2015 and we were told that this would be reviewed on an annual basis. A weekly fire safety checklist was completed. This included checks of fire doors and exit pathways, fire extinguishers and smoke alarms. Staff spoken with were aware of the muster point for staff and visitors. Fire drills took place on a six monthly basis and this involved a full evacuation of the premises.

A well organised COSHH file was available. Details of all substances used at the practice which may pose a risk to health were recorded in alphabetical order in a COSHH file. An itemised list was available which had been reviewed and updated when new products were used at the practice. All staff had signed documentation to demonstrate that they had read and understood the information in the COSHH file.

## 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. Patient feedback also reported that the practice was always clean and tidy. Dental nurses who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area.

Systems were in place to reduce the risk and spread of infection within the practice. There were hand washing facilities in each treatment room and in the decontamination room. Signs were in place to identify that these sinks were only for hand wash use. Posters describing hand washing techniques were on display above these

sinks. Adequate supplies of liquid soaps and paper hand towels were available throughout the premises. Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. PPE stored in the decontamination room was very well organised with systems in place to ensure sufficient stock was always available. 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.

The practice had developed an infection control folder; all of the contents of this folder were reviewed on an annual basis with the last review taking place in November 2015. This folder contained various infection prevention and control related policies, for example decontamination processes, infection control training, sharps and blood spillage policy. A general infection prevention and control policy statement was on display in the decontamination and treatment rooms. This recorded the names of the clinical and non-clinical lead for infection control. These staff members were responsible for ensuring infection prevention and control measures were followed.

Infection prevention and control audits were completed on a three monthly basis. The last audit was undertaken in January 2016 and the practice achieved an assessment score of 99%. The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. The practice was therefore exceeding these requirements. We looked at some of the recent audits and saw that outcomes, improvements and action plans were recorded. A member of staff had reviewed information and put the results into diagram form for ease of understanding by staff. Infection prevention and control was discussed at staff meetings and we saw that the results of the recent audit were on the agenda for discussion at the next practice meeting scheduled to take place in April 2016.

Records demonstrated that all staff had undertaken training in August 2015 and February 2016 regarding the principles of infection control. In-house training had been provided by a dentist at the practice. The practice had developed their own training manual for infection control; this was a picture booklet used for staff induction or refresher training for staff.

We looked at the procedures in place for the decontamination of used dental instruments. A separate



# Are services safe?

decontamination room was available for instrument processing. The decontamination room had dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). Systems were in place to ensure that instruments were safely transported between treatment rooms and the decontamination room. The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with the latest HTM 01-05 guidelines. 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. Services safe

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). Staff 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 in November 2015. The only issues for action related to routine temperature monitoring checks. We saw records to confirm that these checks were taking place. In addition to this an external organisation completed annual water sampling tests.

We discussed clinical waste with the practice manager; we looked at waste transfer notices and the storage area for clinical and municipal waste. We were told that clinical waste was collected every few weeks. Clinical waste storage was in an area where members of the public could not access it. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Sharps bins were fixed to walls in appropriate locations which were out of the reach of children. Needle stick policies were on display in each treatment room. There were no contact details for the local occupational

health department on these posters. We were told that this information was available for staff but had not been recorded on the poster. The practice had conducted a needle stick injury assessment; this was an internal audit on the potential causes for needle stick injuries. Any issues identified had been recorded, addressed and ways for prevention were highlighted.

## Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, dental chairs, fire safety equipment, the ultra-sonic cleaner and the autoclave. Records seen demonstrated the dates on which the equipment had most recently been serviced. Compressors had been serviced in November 2015. All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in November 2015. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine could be stored at room temperature with a shortened expiry date. However, the practice's preference was to store this medicine in the fridge. We saw that records were kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. Staff completed and signed records every day and these were on display on the fridge. The practice had developed a policy for storage of dental medicines in the fridge.

Prescription pads were securely stored and a log of each prescription issued was kept. This recorded details of the date, prescription number and patient code. A log of the number of prescriptions used was also recorded at the end of each working day.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients. We were told that this practice did not dispense medicine.

## Radiography (X-rays)

The registered manager told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure equipment was operated

## Are services safe?

safely and by qualified staff only. We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety. One of the dental nurses had also undertaken training to enable them to take radiographs. 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 that an emergency contingency plan was displayed in the treatment room by the emergency cut of switch. Cut-off switches were also located outside of the treatment room.

We saw that the practice had notified the Health and Safety Executive that they were planning to carry out work with

ionising radiation. This notification was displayed in the reception area. Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the recommended interval of three years.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. We saw a recent X-ray audit completed in February 2016. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

We spoke with dentists about oral health assessments. We were told that following completion or update of medical history records, an examination of the patient's teeth, gums and soft tissues was completed. During this assessment dentists looked for any signs of mouth cancer. The practice used a proforma on their computer to record details of their assessment of soft tissue. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE), particularly in respect of lower wisdom teeth removal and antibiotic prescribing. NICE guidance was also used to determine recall intervals for patients. Each dentist took risk factors such as diet, oral cancer, tooth wear, dental decay, gum disease and patient motivation to maintain oral health into consideration to determine the likelihood of patients experiencing dental disease. Patient care records demonstrated that risk factors had been documented and discussed with patients. The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines. Patient dental care records that we saw demonstrated that all of the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

Dentists we spoke with told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. Fluoride varnish was applied to the teeth of all children aged three to 18 and to adults with a high dental caries risk. High concentration fluoride was prescribed for adults as required and advice and guidance was given about dental hygiene procedures.

### Health promotion & prevention

We discussed 'The Delivering Better Oral Health Toolkit' with the registered manager. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). The practice placed a high emphasis on preventative care. High concentration fluoride toothpastes were prescribed when required. Medical history forms completed by patients included questions about smoking and alcohol consumption. We saw entries in dental care records that detailed patients' oral health, discussions that had taken place with patients regarding improving oral health. During appointments the dentist and dental nurse explained tooth brushing and interdental cleaning techniques to patients in a way they understood. Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption when needed.

Stop smoking information was in the practice folder which was available for patients in the waiting room. Health promotion leaflets and posters were on display in the waiting room to support patients to look after their teeth. Free samples of toothpaste and toothbrushes were available in treatment rooms.

### Staffing

Practice staff included a registered manager, practice manager, deputy practice manager (who worked between two dental practices on alternative days), two full time dentists, three full time dental nurses and a part time receptionist.

We discussed staff training with the practice manager and with staff. Staff told us that they were encouraged to attend training courses and supported to develop their skills. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Records showed professional registration with the GDC were up to date for all relevant staff and registration was monitored by the practice manager. We saw evidence in staff recruitment files that staff had undertaken safeguarding, mental capacity, fire safety, infection control and basic life support training. We also saw that some staff had received training in other specific dental topics such as advanced preventative dentistry, decontamination, and dental radiography.

The practice manager confirmed that they monitored staff continuing professional development (CPD) to ensure staff

# Are services effective?

(for example, treatment is effective)

met their CPD requirements. CPD is a compulsory requirement of registration as a general dental professional. We were told that discussions were held with staff about CPD and training during appraisal meetings. Training was provided to staff via attendance at courses, in-house and on-line training. Staff had individual log on details for on-line training and the practice manager was also able to monitor the amount of on-line training that staff had completed via the computer system. The on-line training provider sent reminders to the practice manager when training updates were required for staff.

Appraisal systems were in place. We were told that the practice manager and deputy practice manager had completed training to enable them to conduct staff appraisals. We saw that personal development plans were available for staff.

## **Working with other services**

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required sedation, oral surgery or community services. A computerised referral log was set up for each patient, a copy of the referral letter was kept and patients were offered a copy. Systems were in place to ensure referrals were received in a timely manner; referrals would be sent by fax, secure email and post. The computerised referral log remained 'open' until the dentist had confirmed that the referral had been received and treatment completed.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. These were comprehensive, and dentists followed Federation of General Dental Practice (FGDP) guidelines when making notes for these referrals.

## **Consent to care and treatment**

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The practice displayed guidance on the principles of the MCA and staff spoken with were aware of the MCA and best interest decisions. We were told that support would be obtained from the Birmingham Community Dental Service where patients were unable to give consent. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. A consent policy had been implemented and reference was made to the MCA in this policy. We saw that consent was reviewed as part of a recent record card audit.

Staff confirmed individual treatment options were discussed with each patient. We were told that patients were given verbal and written information to support them to make decisions about treatment. We were shown entries in dental care records where treatment options were discussed with patients. Any risks involved in treatment were also recorded. There was evidence in records that consent was obtained. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment. We saw that leaflets were available in the waiting area explaining some treatments.

# 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. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. Music was played in the waiting area, this helped to distract anxious patients and also aided confidentiality as people in the waiting room would be less likely to be able to hear conversations held at the reception desk. Staff said that they would ask patients to write down personal sensitive information or there was an area at the side of the reception desk where confidential discussions could be held.

Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. The computer screens at the reception desks were not overlooked which helped to maintain confidential information at reception. If computers were ever left unattended then 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. 32 patients provided overwhelmingly positive feedback about the practice on comment cards which were completed prior to our inspection. Patients commented that staff were professional, friendly, helpful and caring.

### **Involvement in decisions about care and treatment**

The practice provided patients with information to enable them to make informed choices. Clear treatment plans were given to patients which detailed possible treatment and costs. 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. Posters detailing both NHS and private costs were on display in the reception area. 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.

We spoke with the registered manager about the Gillick competency test. The test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions about their care and treatment. The registered manager demonstrated a good understanding of Gillick principles.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice provided NHS and private treatment and treatment costs were clearly displayed in the waiting area. Information was available about appointments on the practice's website. This included opening times, how to book appointments, details of the staff team and the services provided. The practice's website described the range of NHS treatments offered to patients and informed patients that purely cosmetic treatment such as tooth whitening or white fillings could be completed on a private fee paying basis. The practice was open until 5.30pm each night Monday to Friday and was open from 9am to 1pm on a Saturday. This helped to ensure that those patients with work commitments during Monday to Friday were still able to receive an appointment with a dentist.

We discussed appointment times and scheduling of appointments. 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. There were vacant appointment slots to accommodate urgent appointments. Staff told us that patients were usually able to get an appointment on the day that they telephoned and were always able to get an appointment if they were in dental pain. Feedback confirmed that patients were rarely kept waiting beyond their appointment time.

### Tackling inequity and promoting equality

The practice had policies on disability and equal opportunities to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services.

The practice had a hearing induction loop for use by people who were hard of hearing. We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

We asked about communication with patients for whom English was not a first language. We were told that some staff were able to communicate with patients who spoke Punjabi or Bengali and a translation service was available for use if required.

This practice was suitable for wheelchair users, having ground floor treatment rooms with ramp access to the front of the building, and a toilet adapted to meet the needs of patients with restricted mobility. The practice undertook a disability access audit on an annual basis; action was taken to address any issues identified.

### Access to the service

The practice was open from 9am to 5.30pm Monday to Thursday and 9am to 5pm on Friday (closed between 1pm to 2pm). The practice was also open on alternate Saturdays from 9am to 1pm for patients with pre-booked appointments only. The opening hours were displayed in the practice, on the practice's website and in the quarterly newsletter available in the waiting area. A telephone answering machine informed patients that the practice was closed between 1pm to 2pm each day and appropriate signage was placed on the entrance door to the practice during this time. The telephone answering machine also gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone or in person. Staff we spoke with told us that patients could access appointments when they wanted them. Emergency appointments were set aside for each dentist every day; this ensured that patients in pain could be seen in a timely manner. We were told that these patients would always be seen within 24 hours of calling the practice. Patients commented that they were able to see a dentist easily in an emergency. Patients could access care and treatment in a timely way and the appointment system met their needs.

### 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 also recorded contact details such as NHS England and the General Dental Council. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. Staff spoken with were knowledgeable about how to handle a complaint. Staff told us that any complaints received would be sent to the practice manager or in their absence the deputy practice manager. Guidance was available regarding the action to take when a complaint was received, for example

# Are services responsive to people's needs?

(for example, to feedback?)

completion of a complaint log sheet. The complaint policy confirmed this. We were told that no complaints had been received at the practice. Staff spoken with 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.

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, the practice leaflet also

gave patients information on how to make a complaint and a specific complaint leaflet was available from the reception desk. Patients were also able to complain through the practice website if they preferred. We saw that information regarding 'Duty of Candour' was on display in the waiting area. This recorded that patients would be informed of any incident that affected them; they would be given feedback and an apology.



# Are services well-led?

## Our findings

### Governance arrangements

Systems were in place for monitoring and improving the quality of services provided for patients. Comprehensive risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, health and safety and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints, safeguarding, and infection control policies. Staff had been given a number of policies during their induction to the practice. For example staff had copies of the information governance, confidentiality and whistleblowing policies. Staff had also signed a document to confirm that they had received a copy of the employee handbook.

The practice had clear lines of responsibility and accountability. The management team consisted of the registered manager who was supported by a practice manager and deputy practice manager. Two full time dentists were in charge of the day to day running of the practice. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. These included three monthly infection prevention and control audits, audits regarding clinical record keeping, health and safety, hand hygiene, radiography and confidentiality. A patient safety and quality assurance audit had also been completed. This was an audit to identify whether all audits had been completed, for example to check whether audits had been completed regarding radiography, quality assurance systems and safeguarding. We saw evidence to demonstrate that all audits and risk assessments were reported on and action plans completed.

### Leadership, openness and transparency

The culture of the practice was open and supportive. Staff told us that they worked well as a team, provided support for each other and were praised by the management team

for a job well done. There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff were aware of who held lead roles within the practice such as complaints management, safeguarding and infection control. Staff said that the practice manager and assistant practice manager worked at the practice on alternate days to ensure staff always had a member of management staff on the premises to provide advice and support. Complaints systems encouraged candour, openness and honesty. Duty of candour information was on display in the waiting room for patients to see.

We saw that there was a policy in place regarding staff meetings. According to the policy staff were to be notified a week in advance of staff meetings and minutes of these meetings were to be circulated to all staff following the meeting. Where any policies were discussed during staff meetings; all staff were to be given a copy of the policy. Staff we spoke with confirmed that this took place. Staff said that if they were unable to attend the meeting they received a copy of the minutes and were briefed upon the discussions held. Staff signed a register to confirm that they had attended the meeting. We were told that at the end of each topic of discussion confirmation was obtained from staff that they understood the discussion. Minutes of meetings were signed to confirm this.

Staff told us that the registered 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.

### Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a three monthly basis and the practice achieved 99% compliance at the last audit. Other audits included radiography, record card, disability access audit, environmental cleaning audit, ethical audit (measuring the cultures and behaviours of the organisation and determining the extent to which the company's values were embedded); hand hygiene, health and safety, medical history, patient feedback and numerous other audits were completed. Action plans were recorded as required and we saw evidence to demonstrate that the findings of audits were discussed with staff. There was a designated lead for clinical audit at the practice and clinical staff spoken with were aware who held this lead role.

# Are services well-led?

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 monitored to ensure staff were up to date with their CPD requirements and staff said that support was provided to enable them to complete training required. Annual appraisal meetings were held and personal development plans were available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

Regular practice meetings were held where learning was disseminated. These meetings were minuted. Staff said that they found these meetings useful, they were kept up to date with any changes at the practice and felt that they were well informed. Staff had completed an evaluation form regarding staff meetings. Staff were asked how worthwhile they found the meeting, did the meeting meet their expectations, asked how often they would like to attend meetings, what they thought was the most useful form of communication and asked about the main things learned from the sessions. The aim of this exercise was to make staff meetings a more productive, beneficial use of time at the practice.

## **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. Patients had various avenues available to them to provide feedback, for example; a suggestions box and the friends and family test (FFT) box in the waiting room. The friends and family test is a national programme to allow patients to provide feedback on the services provided. Patients were able to contact the practice via their website to leave comments or ask questions. We were told about a patient questionnaire that had recently been

developed but not as yet implemented at the practice. Satisfaction surveys were given to patients on a continual basis; the results were reviewed and correlated on a six monthly basis.

We saw that posters regarding the FFT were on display in the waiting room. The practice had received positive feedback from the FFT and so the poster on display recorded some of the positive comments made and gave a response from the practice thanking patients for their positive comments. We looked at the FFT results for April to June 2015 and September 2015 to March 2016. All responses were extremely positive, with the large majority of patients recording that they were very satisfied in response to questions asked such as confidentiality of information and the manner in which they were welcomed. The registered manager told us that the results from satisfaction surveys, FFT and suggestions were discussed at staff meetings.

Staff we spoke with told us that they felt supported and involved at the practice. A staff survey was undertaken in April 2015 and we were told that this survey would be undertaken on an annual basis. We were told that there were no major issues identified in the survey and an audit of the survey would be completed in the near future. Staff said that they would speak with the practice manager or another member of the management team if they had any issues they wanted to discuss. We were told that the management team were open and approachable and always available to provide advice and guidance.

We saw that a quarterly newsletter was produced at the practice. This was available in the waiting room. The newsletter gave information about the practice such as opening times, information about new staff and details of preventative dental care such as sugar intake in food and drink.