Mr. Jaspal Singh

Cannock Road Dental Practice

Inspection Report

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Overall summary

We carried out this announced inspection on 28 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a specialist dental adviser.

We told the NHS England area team that we were inspecting the practice. They did not provide any information.

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 form the framework for the areas we look at during the inspection.

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

Summary of findings

Cannock Road Dental Practice is in Wednesfield, Wolverhampton and provides NHS treatment to children and patients exempt from NHS charges. Private treatment is also provided for patients of all ages.

There is ramped access for people who use wheelchairs and pushchairs. The practice does not have a car park but parking is available on nearby side roads.

The dental team includes three dentists, five dental nurses, three of whom mainly work on reception. The practice has three treatment rooms, one on the ground floor and two on the first floor.

The practice is owned by an individual who is the principal dentist there. They have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the practice is run.

On the day of inspection we collected 41 CQC comment cards filled in by patients and spoke with three other patients. This information gave us a positive view of the practice.

During the inspection we spoke with three dentists, one dental nurse, one receptionist and the oral health educator. We looked at practice policies and procedures and other records about how the service is managed.

The practice is open:

Monday to Friday 9am to 1pm and 2pm to 5.30pm.

Our key findings were:

- The practice was clean and well maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with emergencies. Not all of the appropriate life-saving equipment was available although missing items were ordered during this inspection.
- The practice had systems to help them manage risk and risk assessments in place were reviewed on an annual basis.
- The practice had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The practice had thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment system met patients' needs.
- The practice had effective leadership. Staff felt involved and supported and worked well as a team.
- The practice asked staff and patients for feedback about the services they provided.
- The practice dealt with complaints positively and efficiently.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had systems and processes to provide safe care and treatment. They used learning from incidents and complaints to help them improve.

Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.

Staff were qualified for their roles and the practice completed essential recruitment checks.

Premises and equipment were clean and properly maintained. The practice followed national guidance for cleaning, sterilising and storing dental instruments.

The practice had suitable arrangements for dealing with medical and other emergencies. Some items of missing medical equipment were purchased on the day of inspection.

Are services effective?

No action

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

The dentists assessed patients' needs and provided care and treatment in line with recognised guidance. Patient dental care records did not include any risk assessments regarding caries risk, periodontal disease, oral cancer risk and tooth wear. Following this inspection we were forwarded confirmation that the template used in patients' dental care records would be amended to include this information.

Patients described the treatment they received as professional, efficient and gentle. The dentists discussed treatment with patients so they could give informed consent and recorded this in their records.

The practice had clear arrangements when patients needed to be referred to other dental or health care professionals.

The practice supported staff to complete training relevant to their roles and had systems to help them monitor this.

Are services caring?

No action

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

We received feedback about the practice from 44 people. Patients were positive about all aspects of the service the practice provided. They told us staff were caring, friendly and kind. They said that they were given detailed, helpful, explanations about dental treatment, and said their dentist listened to them. Patients commented that they made them feel at ease, especially when they were anxious about visiting the dentist.

We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.

Summary of findings

Are services responsive to people's needs?

No action

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

The practice's appointment system was efficient and met patients' needs. Patients could get an appointment quickly if in pain.

Staff considered patients' different needs. This included providing facilities for disabled patients and families with children. The practice had access to telephone and face to face interpreter services and had arrangements to help patients with sight or hearing loss.

The practice took patients views seriously. They valued compliments from patients and responded to concerns and complaints quickly and constructively.

Are services well-led?

No action

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

The practice had arrangements to ensure the smooth running of the service. These included systems for the practice team to discuss the quality and safety of the care and treatment provided. There was a clearly defined management structure and staff felt supported and appreciated.

The practice team kept complete patient dental care records which were clearly written or typed and stored securely.

The practice monitored clinical and non-clinical areas of their work to help them improve and learn. This included asking for and listening to the views of patients and staff.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had policies and procedures to report, investigate, respond and learn from accidents, incidents and significant events. Staff knew about these and understood their role in the process.

The practice recorded, responded to and discussed all incidents to reduce risk and support future learning. Separate incident reporting forms were available, for example a medical device advice incident reporting form and a significant event audit/adverse incident meeting report form. Other incidents were recorded in a log book. Evidence was available to demonstrate that incidents were discussed during practice meetings.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). Relevant alerts were discussed with staff, acted on and stored for future reference. Safety alerts recorded details of any action taken as appropriate.

Reliable safety systems and processes (including safeguarding)

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The practice had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. The principal dentist was the safeguarding lead at the practice and staff we spoke with were aware of this. We saw evidence that staff received safeguarding training. Staff knew about the signs and symptoms of abuse and neglect and how to report concerns. A log was available which recorded details of any safeguarding concerns and the action taken regarding these. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.

We looked at the practice's arrangements for safe dental care and treatment. These included risk assessments which staff reviewed every year. The practice followed relevant safety laws when using needles and other sharp dental items. The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

The practice undertook some domiciliary visits to local nursing homes. We were told that during these visits staff mostly completed oral examinations and fixed and made dentures. A dental nurse always accompanied the dentist on these visits. The dental nurse acted as a chaperone and was responsible for infection prevention and control procedures. The practice had not completed a risk assessment of the premises that they were visiting and had not assessed the individual circumstances to determine which emergency medicines and equipment might be required to be taken on these visits.

The practice had a business continuity plan describing how the practice would deal events which could disrupt the normal running of the practice. On the day of our inspection the practice had cause to use the business continuity plan as they were having difficulties with their internal server for their computer systems.

Medical emergencies

Staff knew what to do in a medical emergency and completed training in emergency resuscitation and basic life support every year, the date of the last training completed was 3 October 2017. Staff kept their knowledge up to date by completing medical emergency scenarios on a regular basis. Not all of the emergency equipment was available as described in recognised guidance. For example the practice did not have any oropharyngeal airways or a spacer device for inhaled bronchodilators. We were told that at a recent basic life support training session the practice had been advised to dispose of these items. Following this inspection the principal dentist provided evidence that this equipment had been ordered and was due for delivery at the practice. Emergency equipment was stored on top of a cupboard and might not be easily accessible to all staff in case of emergency.

Staff kept records of their checks to make sure emergency equipment and medicines were available, within their expiry date, and in working order.

Staff recruitment

The practice had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the

No action

Are services safe?

relevant legislation. We looked at four staff recruitment files. These showed the practice followed their recruitment procedure. Disclosure and barring service checks had been completed on each staff member. Clinical staff were qualified and registered with the General Dental Council (GDC) and had professional indemnity cover.

Monitoring health & safety and responding to risks

The practice's health and safety policies and risk assessments were up to date and reviewed to help manage potential risk. These covered general workplace and specific dental topics. For example we saw that risk assessments had been completed regarding trainee dental nurses and we saw a practice health and safety risk assessment. A health and safety checklist was used annually to check compliance with requirements such as checking to ensure the health and safety poster was displayed, fire exits being checked and electrical wiring checked.

The practice had completed a fire risk assessment which required updating. We saw records to confirm that the practice had four smoke alarms but the risk assessment recorded that only two were in place. The practice's fire policy stated that smoke alarm batteries were to be changed on an annual basis. There were no written records to demonstrate that this had been completed. Records were available to demonstrate that smoke alarms were checked on a weekly basis and following this inspection we were forwarded confirmation that smoke alarm batteries would be changed on an annual basis and records kept to demonstrate this.

The practice had current employer's liability insurance and checked each year that the clinicians' professional indemnity insurance was up to date.

A dental nurse worked with the dentists when they treated patients.

Infection control

The practice had an infection prevention and control policy and procedures to keep patients safe. They followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health. The practice had completed a review of essential quality requirements in October 2017 and the practice's infection control policy was reviewed on an annual basis. Staff completed infection prevention and control training every year.

The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments in line with HTM01-05. The records showed equipment staff used for cleaning and sterilising instruments was maintained and used in line with the manufacturers' guidance.

The practice carried out infection prevention and control audits twice a year. The latest audit showed the practice was meeting the required standards.

The practice had procedures to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment which was completed on 3 May 2017. Water temperatures were being monitored and recorded on a monthly basis as recommended in the legionella risk assessment.

We saw cleaning schedules for the premises. The practice was clean when we inspected and patients confirmed this was usual. We identified a small rip in the material of one of the dental chairs. Following this inspection we were forwarded confirmation that the dental chair would be re-upholstered and we received evidence to support this.

Equipment and medicines

We saw servicing documentation for the equipment used. For example the autoclaves and compressor were serviced in September 2017. Maintenance contracts were seen for other equipment such as X-ray sets and dental chairs. Portable electrical appliances were being checked by an external professional on a regular basis and were last checked in May 2017. Staff carried out checks in line with the manufacturers' recommendations.

The practice had suitable systems for prescribing and storing medicines. Regular stock checks were completed to ensure out of date stock was removed.

The practice stored and kept records of NHS prescriptions as described in current guidance.

Radiography (X-rays)

No action

Are services safe?

The practice had suitable arrangements to ensure the safety of the X-ray equipment. They met current radiation regulations and had the required information in their radiation protection file.

We saw evidence that the dentists justified, graded and reported on the X-rays they took. The practice carried out X-ray audits every month which is over and above the recommendations of current guidance and legislation.

Clinical staff completed continuous professional development in respect of dental radiography.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice's dental care records did not contain any risk assessment for example regarding patients' caries risk, periodontal disease, oral cancer risk and tooth wear. Following this inspection we were forwarded confirmation that the template used in patient's dental care records would be amended to ensure the risk assessment information was included.

The practice audited patients' dental care records to check that the dentists recorded the necessary information. Shortcomings were identified in the last audit. Following this inspection we were told that a further record keeping audit would be completed in January 2018.

Health promotion & prevention

The practice believed in preventative care and supporting patients to ensure better oral health in line with the Delivering Better Oral Health toolkit.

The dentists told us they prescribed high concentration fluoride toothpaste if a patient's risk of tooth decay indicated this would help them. They used fluoride varnish for children based on an assessment of the risk of tooth decay for each child. The practice employed an oral health educator. We were shown records to demonstrate oral health education sessions were provided to the local community on a voluntary basis. For example visits to local schools, a Sikh temple, healthy living centres, libraries and day care centres. We were told that there was at least one visit per quarter. A stand would be set up, for example during a parents' evening at a local school or staff would speak to children during assembly and ask them to do oral health quizzes. Free samples and information about local NHS dental practices was available. The practice kept records of these visits including how many people attended, venue details, issues discussed and any feedback.

The dentists told us they discussed smoking, alcohol consumption and diet with patients during appointments. The practice had a selection of dental products for sale and provided health promotion leaflets to help patients with their oral health.

Staffing

Staff we spoke with confirmed that when first employed they received a period of induction training. We were shown induction records which included a tick list to confirm when training had been completed. Induction records did not demonstrate that the staff member had received training and was deemed competent and neither the person providing nor by the person receiving the training had signed these records. Following this inspection we received evidence to demonstrate that induction records had been amended to include a signature of the staff conducting the induction training to demonstrate that they deemed the new staff member to be competent and a signature from the new staff member to confirm that they have received and understood the training.

We confirmed clinical staff completed the continuous professional development required for their registration with the General Dental Council.

Staff told us they discussed training needs at annual appraisals. We saw evidence of completed appraisals and personal development plans.

Working with other services

Dentists confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide. This included referring patients with suspected oral cancer under the national two week wait arrangements. This was initiated by NICE in 2005 to help make sure patients were seen quickly by a specialist. The practice monitored urgent referrals to make sure they were dealt with promptly.

Consent to care and treatment

The practice team understood the importance of obtaining and recording patients' consent to treatment. The dentists told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions. Patients confirmed their dentist listened to them and gave them clear information about their treatment.

The practice's consent policy included information about the Mental Capacity Act 2005. The team understood their responsibilities under the act when treating adults who might not be able to make informed decisions. The policy also referred to the legal precedent by which a child under the age of 16 can consent for themselves and the dentists were aware of the need to consider this when treating

No action

Are services effective?

(for example, treatment is effective)

young people under 16. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

No action

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.

Patients commented positively that staff were helpful, patient and understanding. We saw that staff treated patients in a kind, respectful manner and were friendly towards patients at the reception desk and over the telephone.

Nervous patients said staff were compassionate and understanding.

Staff were aware of the importance of privacy and confidentiality. We found the layout of reception and the combined waiting area on the ground floor meant that privacy was difficult to maintain when reception staff were dealing with patients both face to face and on the telephone. We saw that staff took great care not to breach patients' confidentiality. Staff told us that if a patient asked for more privacy they would take them into another room. The reception computer screens were not visible to patients might see it.

Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Music could be played in the treatment rooms and there were magazines in the waiting room.

Involvement in decisions about care and treatment

The practice gave patients clear information to help them make informed choices. Patients confirmed that staff listened to them, did not rush them and discussed options for treatment with them. A dentist described the conversations they had with patients to satisfy themselves they understood their treatment options.

Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

The practice's website provided patients with information about the range of treatments available at the practice. These included general dentistry and treatments for gum disease and more complex treatment such as implants, veneers and orthodontics.

Each treatment room had a screen so the dentists could show patients photographs and X-ray images when they discussed treatment options. The dentist said that they gave detailed explanations to patients to enable them to make choices and patients we spoke with confirmed this.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients described high levels of satisfaction with the responsive service provided by the practice.

The practice had an efficient appointment system to respond to patients' needs. Staff told us that patients who requested an urgent appointment were seen the same day. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

Staff told us that they currently had some patients for whom they needed to make adjustments to enable them to receive treatment. For example anxious patients were given a longer appointment time to enable the dentist to spend extra time reassuring the patient. The practice had treatment rooms on both the ground and first floor. Those patients who were unable to use the stairs would be seen in the ground floor treatment room.

Promoting equality

The practice had made some reasonable adjustments for patients with disabilities. These included step free access and a portable hearing loop. Two patient toilets were provided on the ground floor of the practice, however neither of these were a disability access toilet with hand rails and a call bell.

Staff said that they had access to interpreter/translation services which included British Sign Language and braille. Staff at the practice could also communicate with patients who spoke Punjabi and Hindi. Staff were aware that some information was available in languages other than English. For example information regarding after care following an extraction was available in Punjabi.

Access to the service

The practice displayed its opening hours in the premises, their information leaflet and on their website.

We confirmed the practice kept waiting times and cancellations to a minimum.

The practice was committed to seeing patients experiencing pain on the same day and we were told that each dentist kept two appointments free for same day appointments. They took part in an emergency on-call arrangement with some other local practices. The website, information leaflet and answerphone provided telephone numbers for patients needing emergency dental treatment during the working day and when the practice was not open. Patients confirmed they could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Concerns & complaints

The practice had a complaints policy providing guidance to staff on how to handle a complaint. The practice information leaflet explained how to make a complaint. The principal dentist was responsible for dealing with these. Staff told us they would tell the principal dentist about any formal or informal comments or concerns straight away so patients received a quick response.

Staff told us that complainants were given a copy of the complaints handling policy for information. We saw copies of letters sent to complainants and an apology was always offered in these letters. Information regarding duty of candour was on display in the waiting room. Staff told us that patients were encouraged to speak out and explanations and an apology were always given. The principal dentist told us they aimed to settle complaints in-house and invited patients to speak with them in person to discuss these. Information was available about organisations patients could contact if not satisfied with the way the practice dealt with their concerns.

We looked at comments, compliments and complaints the practice received within the last 12 months. These showed the practice responded to concerns appropriately and discussed outcomes with staff to share learning and improve the service. The practice recorded details of complaints received on a log. The complaint log recorded details of the complaint, action taken and details of any follow up action. Copies of all correspondence regarding complaints were also available.

Are services well-led?

Our findings

Governance arrangements

The principal dentist had overall responsibility for the management, clinical leadership and day to day running of the practice. Staff had been given some lead roles and those staff we spoke with knew the management arrangements and their roles and responsibilities.

The practice had policies, procedures and risk assessments to support the management of the service and to protect patients and staff. These included arrangements to monitor the quality of the service and make improvements.

The practice had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.

Leadership, openness and transparency

Staff were aware of the duty of candour requirements to be open, honest and to offer an apology to patients if anything went wrong.

Staff told us there was an open, no blame culture at the practice. They said the principal dentist encouraged them to raise any issues and felt confident they could do this. They knew who to raise any issues with and told us the principal dentist was approachable, would listen to their concerns and act appropriately. The principal dentist discussed concerns at staff meetings and it was clear the practice worked as a team and dealt with issues professionally.

The practice held meetings where staff could raise any concerns and discuss clinical and non-clinical updates. We were shown the minutes of practice meetings and saw that discussions were held regarding information recorded in the incident book, audit feedback, complaint feedback, patient satisfaction survey results, policy updates and any other business in which staff were able to raise any issues for discussion. A member of staff told us that when they were unable to attend the practice meetings, they received detailed feedback and had access to the minutes of meetings. Staff were able to add items for discussion to the agenda. Separate meetings were also held with dentists on a regular basis. Immediate discussions were arranged to share urgent information.

Learning and improvement

The practice had quality assurance processes to encourage learning and continuous improvement. These included audits of dental care records, X-rays and infection prevention and control. They had clear records of the results of these audits. We noted that issues had been identified in the dental care records audit and no evidence of action taken to make improvements recorded. Following this inspection we were told that a re-audit would be completed in January 2018.

The practice telephoned patients who did not attend (DNA) their appointments to identify the reason for non-attendance. Audit records seen did not record any action taken to try and reduce the number of patients who DNA their appointments. We discussed this with staff who were able to discuss the actions taken to try and reduce DNA rates at the practice.

The practice was a member of the BDA good practice scheme and had been a member since 2008.

The principal dentist showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. The whole staff team had annual appraisals. They discussed learning needs, general wellbeing and aims for future professional development. We saw evidence of completed appraisals in the staff folders.

Staff told us they completed mandatory training, including medical emergencies and basic life support, each year. The General Dental Council requires clinical staff to complete continuous professional development. Staff told us the practice provided support and encouragement for them to do so.

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

The practice used patient surveys and verbal comments to obtain staff and patients' views about the service. Ten patient satisfaction surveys were completed for each dentist during every two months. The results were correlated and discussed with staff during practice meetings. We looked at the results of the surveys between May to October 2017, the practice had received positive feedback. We saw examples of suggestions from patients the practice had acted on, for example patients had requested hand sanitizer to be made available and we saw that containers of hand sanitizer had been fitted to the wall in various areas throughout the practice.

Are services well-led?

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. The results of the August, September and October 2017 FFT were on display on the noticeboard in the reception. In September 75% would be extremely likely and 25% likely to recommend the practice, whilst in August and October, 100% of respondents would be extremely likely to recommend the practice.