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# 261 Dental Care

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 25 August 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**

261 Dental Care is a dental practice providing general dental services on a NHS and private basis. The service is provided by five dentists (one of whom is currently on maternity leave) and two hygienists. They are supported by five dental nurses (one of whom is a trainee), a practice manager and a receptionist. All of the dental nurses also carry out reception duties. A sixth dentist visits the practice on a monthly basis to provide orthodontic treatment. The practice had also recruited an independent practice advisor who visited the practice on an ad hoc basis to assist with its management.

The practice is located on a main road near local amenities and bus routes. There is wheelchair access to the practice and car parking facilities. The premises consist of a waiting room, a reception area, two offices, kitchen, staff room and one treatment room on the ground floor. The first floor comprises of a decontamination room, a storage room, three treatment rooms and toilet facilities. There is also an area for taking X-rays. The practice opened at 8:15am on Monday to Friday and closing times varied between 4:15pm and 7:30pm. The practice also opened on alternate Saturdays between 8:15am and 12:15pm.

The provider is registered with the Care Quality Commission (CQC) as an individual. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

# Summary of findings

Thirty-one patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients. The information from patients was generally complimentary. Patients were positive about their experience and they commented that staff were friendly, professional and welcoming.

## **Our key findings were:**

- The practice was organised and appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patients told us they found the staff polite and friendly. Patients were able to make routine and emergency appointments when needed.
- An infection prevention and control policy was in place. We saw the decontamination procedures followed recommended guidance.
- The practice had systems to assess and manage risks to patients, including health and safety, safeguarding, safe staff recruitment and the management of medical emergencies.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Practice meetings were used for shared learning.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review the flooring in one treatment room and consider replacing it with a smooth impervious covering with coving as part of their future refurbishment programme. The practice should also arrange to promptly replace a torn foot cover on one dental chair.
- Review the X-ray equipment and consider fitting a rectangular collimator to any new X-ray equipment that is installed in future. This was already present on some of the equipment at the practice but not all due to the old design of some of the equipment.
- Review all fire exits and ensure that clear signage is displayed.

# 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.

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

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

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit which centred around future refurbishment plans to update the flooring and dental chair in one treatment room.

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

No action



### Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

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

No action



### Are services caring?

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

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

No action



# Summary of findings

## Are services responsive to people's needs?

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

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

The practice had an effective complaints process.

The practice offered access for patients with limited mobility.

No action



## Are services well-led?

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

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

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

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

No action



# 261 Dental Care

## Detailed findings

### Background to this inspection

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

We inspected 261 Dental Care on 25 August 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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

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

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

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

# Are services safe?

## Our findings

### Reporting, learning and improvement from incidents

The practice had systems in place for staff to report accidents and incidents. The last accident was recorded in March 2016. We saw records of incidents and accidents and these were completed with sufficient details about what happened and any actions subsequently taken. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice responded to national patient safety and medicines alerts that affected the dental profession. We saw that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The practice manager was responsible for obtaining information from relevant emails and forwarding this information to the rest of the team. Although this had been discussed in staff meetings, there was some doubt amongst staff regarding this process. The provider was not aware of the practice's arrangements for staff to report any adverse drug reactions.

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

The practice had child protection and vulnerable adult procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local safeguarding teams. The practice manager was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. Training records showed staff had completed level three (enhanced) training in June 2016.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists

for effective isolation of the root canal, operating field and airway. We saw rubber dam kits at the practice and were told that all dentists used them when carrying out root canal treatment whenever practically possible.

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

Staff we spoke with were aware of the duty of candour regulation. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

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

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

### Medical emergencies

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

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

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and AED and monthly checks of the emergency medicines. The

# Are services safe?

emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge and the temperature was monitored and documented on a daily basis.

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

## Staff recruitment

The practice had a recruitment policy for the safe recruitment of staff. We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of employment contracts, curricula vitae, staff identity verification, written references and induction plans. Where relevant, the files contained copies of staff's dental indemnity and General dental Council (GDC) registration certificates.

There were also Disclosure and Barring Service (DBS) checks present for two staff members. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults. The provider had applied for DBS checks for all staff and had completed written risk assessments for staff that did not hold previous DBS certificates.

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

## Monitoring health & safety and responding to risks

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

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. Fire safety training was carried out by an external contractor a few days before our visit and the provider told us this would be repeated annually. We saw evidence that the fire extinguishers had been serviced in January 2016 and they were visually checked and documented every week by staff at the practice. Fire drills took place every six months to ensure staff were rehearsed in evacuation procedures. Staff carried out and recorded weekly fire

alarm tests and an external contractor serviced these annually. There were two fire exits on the ground floor but only one of these had clear signage to show where the evacuation point was. The provider told us that they had additional signs and will display these in a prominent position so that all fire exits are clearly marked.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to contain risk assessments for most relevant substances. Risk assessments for blood and saliva were not contained within the COSHH file but staff promptly added these once this was brought to their attention.

## Infection control

There was an infection control policy and procedures to keep patients and staff safe. The policy was reviewed annually and was dedicated to the practice. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. However, some improvements were required and these had already been identified by the practice's own auditing system. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be visually clean. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition; however, one treatment room required some improvements. The provider was aware of this and we saw evidence that they had contacted an external contractor about this. The provider told us they planned to prioritise this as part of future refurbishment plans although no dates had been arranged yet for this. The protective foot cover on the dental chair was torn in one treatment room. The provider told us that this will be replaced soon. The metalwork on one dental chair was partly rusty and stained. The provider was aware of this and told us the chair itself was robust with a powerful unit. As part of future



## Are services safe?

refurbishment plans, the dental chair would be replaced but the provider would arrange to carry out some cosmetic work to improve the appearance of the metalwork until then.

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

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance, an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

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

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

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

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

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

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

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out in line with current guidance. We reviewed the audit from June 2016 and this highlighted some areas of improvements. An action plan was devised and this led to improvements and further training. It also highlighted that some surfaces in the treatment rooms were not ideal. Action plans were documented subsequent to the analysis of the results. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in August 2016 and this concluded that the practice was low risk. We saw evidence that the practice recorded water temperature on a monthly basis (between June and August 2016) to check that the temperature remained within the recommended range.

### Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves.



# Are services safe?

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

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The prescription number was recorded in the patients' dental care records. The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked. All prescriptions were stamped only at the point of issue. The practice dispensed antibiotics and these were stored securely. The practice maintained a log of all medicines that had been dispensed, however, this did not include the quantity of remaining medicines. Within two working days, the provider emailed us a copy of an amended log sheet that included this information.

There was a separate fridge for the storage of medicines and dental materials. The temperature was monitored and recorded daily.

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

## **Radiography (X-rays)**

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used traditional X-rays and equipment to take these was present in one treatment room on the ground floor and in one designated area on the first floor.

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

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

The X-ray equipment in the treatment room was fitted with a part called a rectangular collimator which is good practice as it reduces the radiation dose to the patient. However, the other X-ray machine did not have a collimator. The provider contacted us after discussing this with the appointed RPA. The RPA commented that the X-ray machine at the practice was an older design and they encountered various issues when considering retro-fitting a rectangular collimator to this. The RPA felt that it was likely that the machine would need to be replaced in the near future and concluded that a rectangular collimator should be fitted to the new machine.

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

We saw evidence that the practice carried out an X-ray audit in August 2016. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that the results were analysed and reported on. The audit highlighted that improvements were required, particularly for one staff member. Within two working days, the provider emailed us a copy of correspondence sent to the staff member about the audit results. It was mentioned that further training may be appropriate but the priority was to improve the quality of the X-rays taken.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

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

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

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

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentists told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

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

### Health promotion & prevention

The dentists we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

There were oral health promotion leaflets available in the practice to support patients in looking after their health. Examples included information on stopping smoking, gum disease and oral cancer.

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

### Staffing

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

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

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

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

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

### Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the

# Are services effective?

(for example, treatment is effective)

patient. For example, referrals were made to specialist dental services for complex oral surgery. We viewed one referral letter and noted that it was comprehensive to ensure the specialist services had all the relevant information required. Patients were given the option of receiving a copy of their referral letter.

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

## **Consent to care and treatment**

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

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

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

# Are services caring?

## Our findings

### **Respect, dignity, compassion & empathy**

Thirty-one patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was mostly positive about the care they received from the practice. They described staff as friendly, welcoming and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and others praised the staff for their child-friendly approach. Several patients commented that they had attended this practice for many years, even decades.

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

information was stored. There was a room available for patients to have private discussions with staff. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

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

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

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

Examination and treatment fees were displayed in the waiting room.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as one treatment room was on the ground floor. There was a car parking bay for patients with physical disabilities near the main entrance to the practice. The practice had a portable ramp that was used for patients attending the practice in a wheelchair. There were no toilet facilities on the ground floor and staff told us that all new patients to the practice were made aware of this when booking an appointment.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were usually seen on time and that it was easy to make an appointment. Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We reviewed the appointment system and saw that dedicated emergency slots were available on a daily basis to accommodate patients requiring urgent treatment. If these slots became unavailable, the practice was able to accommodate patients by utilising a 'sit and wait' policy.

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

### Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services. The practice did not have an audio loop system for patients who might have hearing

impairments. However, the practice used various methods so that patients with hearing impairments could still access the services. Also, the practice had access to sign language interpreters, if required.

The practice had access to an interpreting service for patients that were unable to speak fluent English but the practice had only needed to use this service on one occasion.

### Access to the service

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

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment via the telephone answering service. There were also details for patients that sought private emergency treatment.

The practice opened at 8:15am on Monday to Friday and closing times varied between 4:15pm and 7:30pm. The practice also opened on alternate Saturdays between 8:15am and 12:15pm. The provider told us that the opening hours were currently under review and they were planning on extending the opening hours further in the near future.

### Concerns & complaints

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

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. There was a designated complaints lead and all verbal complaints were documented too. We found that complainants had been responded to in a professional manner. We were told that any learning identified was cascaded personally to team members and also discussed in staff meetings. We saw examples of changes and improvements that were made as a result of concerns raised by patients.

# Are services well-led?

## Our findings

### **Governance arrangements**

The practice manager was in charge of the day to day running of the service. The provider also had telephone availability on all working days. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments. The practice also had risk assessments for areas such as the autoclaves, waste disposal and display screen equipment.

### **Leadership, openness and transparency**

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

### **Learning and improvement**

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

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

Staff meetings took place two or three times per month. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as confidentiality, consent and infection control had been discussed in the last six months.

The practice manager and provider told us about their plans for all staff to receive appraisals every six months. We reviewed a selection of staff files and saw that some staff had already received appraisals. Plans were in place for remaining staff to have these in August and September 2016. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. There was a suggestions box in the waiting room for patients. Patients were invited to complete satisfaction surveys in July 2016. The provider told us they were in the process of collating the results from these. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. There was a dedicated book in the waiting area for patients' testimonials.

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