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Bhandal Dental Practice - 148 High Street

Inspection Report

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Date of inspection visit: 27 January 2016
Date of publication: 17/03/2016

Overall summary

We carried out an unannounced comprehensive inspection on 27 January 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

Bhandal Dental Practice has 17 dentists, 30 qualified dental nurses who are registered with the General Dental Council (GDC) and three dental therapists. A number of dental nurses work as 'bank' staff and may be required to work at other Bhandal dental surgeries. The practice's opening hours are from 7.30am to 6pm Monday, Tuesday, Wednesday and Friday, 7.30am to 8pm on Thursday and 7.30am to 1pm on Saturday. The practice is closed between 1pm and 2pm Monday to Friday.

Bhandal Dental Practice provides NHS and private treatment for adults and children. The practice is situated in a converted property. There are twenty dental treatment rooms; seven on the ground floor and 13 on the first floor. There are two separate decontamination rooms for cleaning, sterilising and packing dental instruments. There is also a reception and a main waiting area on the ground floor with other seating areas available on the first floor.

Summary of findings

One of the practice owners is the registered manager. 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.

This was an unannounced inspection visit. We spoke with six patients during the inspection to obtain their views and details of their experience of the practice. These provided a generally positive view of the services the practice provides. All of the patients commented that the quality of care was 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.
- 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 practice kept up to date with current guidelines when considering the care and treatment needs of patients.
- Infection prevention and control systems were in place, and audits were completed on a six monthly basis.
- Options for treatment were identified and explored and patients said they were involved in making decisions about their treatment.
- Patients' confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Health promotion advice was given to patients appropriate to their individual needs such as smoking cessation or dietary advice.
- Some staff from within the practice visited local schools to provide oral health and hygiene advice to children.

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

- Establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to both verbal and written complaints by service users.
- Establish and operate an effective staff appraisal system which enables to staff to raise issues or concerns and to receive feedback about their work at the practice. Personal development plans should be included within the appraisal process.
- Implement a system to demonstrate which staff have undertaken fire drills.

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.

There were systems in place to help ensure the safety of staff and patients. The practice had robust arrangements for infection control, clinical waste control, maintenance of equipment,the premises and dental radiography (X-rays). There were sufficient numbers of suitably qualified staff working at the practice. The practice had undertaken the relevant recruitment checks to ensure patient safety. Staff had received training in safeguarding patients and knew the signs of abuse and who to report them to. Staff were trained to deal with medical emergencies and all emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines

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. Patients' dental care records provided comprehensive information about their current dental needs and past treatment The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Consent for treatment was obtained before treatment began. Staff were knowledgeable about the principles of the Mental Capacity Act (MCA) 2005 and its relevance when attempting to obtain consent from patients who may not have capacity to provide consent.

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 that staff were professional and caring. We were told that the quality of care was good.

Staff explained that enough time was allocated in order to ensure that the treatment and care was fully explained to patients in a way which they understood. Patients confirmed that they were made aware of treatment options.

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. There were vacant appointments slots for urgent appointments each day. Patients confirmed that they had good access to treatment and urgent care stating that urgent appointments were always available on the day that they phoned the practice.

Seven dental treatment rooms were available on the ground floor enabling ease of access into the building for patients with mobility difficulties and families with prams and pushchairs.

Summary of findings

There was a procedure in place for responding to patients' complaints The practice's complaints policy was available to patients in the waiting room. We saw that formal written complaints had been acknowledged, investigated and responded to in writing. However there was no documentary evidence to demonstrate that verbal complaints had been addressed to the satisfaction of the complainant.

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. The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

There were arrangements in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend. Staff said that they felt well supported and could raise any issues or concerns with the registered manager. Not all staff that we spoke with were aware that minutes of staff meetings were available for review.

Bhandal Dental Practice - 148 High Street

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection on 27 January 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

We informed NHS England area team that we were inspecting the practice, however there were no immediate concerns from them.

During our inspection visit, we reviewed policy documents and staff records. We spoke with ten members of staff, including the management team. We looked at the storage arrangements for emergency medicines and equipment.

We were shown the decontamination procedures for dental instruments and computer system that supported the patient treatment records and patient dental health education programme. We spoke with six patients.

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

Significant event, accident and incident policy documents and reporting forms were available on the practice's computer system. We saw that dental treatment rooms each had two computer screens. A dental nurse told us that policies were easily accessible to all staff via the computers in each treatment room. We saw that the significant event policy recorded a review date to demonstrate that they had been reviewed and updated as required. Staff spoken with were aware of the procedure for reporting significant events. We saw that three significant events had been recorded within the last 12 months. Evidence of action taken and learning points discussed with staff were recorded.

We discussed the reporting of injuries, diseases or dangerous occurrences (RIDDOR). We saw that guidance about RIDDOR regulations and reporting forms were available for staff on the computer system. There had been no incidents reported under RIDDOR regulations.

Accident books demonstrated that any accidents at the practice were recorded and action taken. The practice kept accident investigation/significant event analysis and prevention forms and these recorded actions taken to reduce the risk of reoccurrence of accidents and significant events. Learning points were recorded.

We saw that Medicines and Healthcare products Regulatory Agency alerts regarding patient safety were a standard agenda item for practice meetings. A log of alerts was kept and we were told that these were available for staff if required.

A 'being open' policy was available. This detailed the practice's expectation of openness and transparency towards patients and between staff members in the event of an incident.

Reliable safety systems and processes (including safeguarding)

The registered manager acted as the practice's safeguarding lead and was the point of referral should members of staff encounter a child or adult safeguarding issue. Staff we spoke with were aware of who within the practice was the safeguarding lead. A policy was in place for staff to refer to in relation to children and adults who might be the victim of abuse or neglect. Other documents available to staff on the practice's computer system included a face injury map, child protection guidance and a child protection flow chart. Staff had access to this information on each computer at the practice. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Information was displayed in the staff room that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.

We spoke to staff about the prevention of needle stick injuries. They explained that the treatment of sharps and sharps waste was in accordance with the current EU Directive with respect to safe sharp guidelines, thus protecting staff against blood borne diseases. The practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. The dentists were responsible for ensuring safe recapping using a 'scoop' method, a recognised way of recapping a used needle using one hand. They were also responsible for disposing of the used needles into the appropriate sharps' bin. Staff we spoke with were able to explain the practice protocol in detail should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked about the instruments that were used during root canal treatment. Staff explained that these instruments were single patient use only.

A dentist we spoke with explained that root canal treatment and other treatment where appropriate 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 can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. There was 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. Staff had received training in how to use this equipment with all staff receiving update training in 2015. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen were all in date and stored in central locations known to all staff. The expiry dates of medicines and equipment were monitored using a monthly check sheet that enabled staff to replace out of date medicines and equipment promptly.

Staff recruitment

We discussed staff recruitment, looked at the recruitment policy and at four staff files. We saw that staff files contained pre-employment information such as written references, proof of identity and their curriculum vitae. Information was available regarding the staff member's professional registration and also copies of their training certificates. Robust systems were in place to ensure that appropriate pre-employment checks were undertaken for all staff prior to employment. Computerised records recorded details of disclosure and barring service checks (DBS). These 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. Staff signed an annual update to confirm that there had been no change to their DBS status. Computerised records also recorded the immunisation status for each member of staff and details of their registration with their professional body. A system was in place to remind staff when updates were required and to provide support if required.

There were enough staff to support the dentists and therapist during patient treatment. Staff said that they had to book annual leave in advance and this and any unplanned absences were covered by bank or part time staff working additional hours. We were told that managers were flexible and always tried to grant leave at short notice if possible. A policy regarding annual leave was available for all staff to review. Sufficient numbers of staff were on duty to ensure that the reception area was not left unstaffed at any time.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. The practice carried out a number of risk assessments including a fire and separate legionella risk assessment undertaken by an external specialist company. A well-maintained Control of Substances Hazardous to Health (COSHH) file was available and other assessments seen included radiation and health and safety.

A health and safety policy was available to staff on the practice's computer and a health and safety at work poster was on display in the ground floor staff kitchen. We saw that fire safety checks were undertaken on a weekly or monthly basis as necessary. An external agency provided fire protection equipment servicing. We saw that staff had undertaken fire drills and details of the fire drills undertaken were recorded on the practice meeting minutes. Although there were no records available to demonstrate which staff had attended practice meetings. It was therefore difficult to identify if all staff had undertaken fire drills.

Infection control

There were effective systems in place to reduce the risk and spread of infection within the practice. A review of practice protocols showed that HTM 01 05 (national guidance for infection prevention control in dental practices') Best Practice Requirements for infection control were being met. It was observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines. This was dated January 2106.

The dental treatment rooms, waiting and reception areas and toilets we saw were clean, tidy and clutter free. Clear zoning demarking clean from dirty areas was apparent in all treatment rooms. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed.

A dental nurse and a decontamination technician described to us the end-to-end process of infection control procedures at the practice. They explained the cleaning of the general treatment room environment following the treatment of a patient. They explained how the working surfaces, dental unit and dental chair were cleaned.

The drawers of a treatment room were inspected by us in the presence of the dental nurse. These were clean, well

ordered and free from clutter. All of the instruments were pouched and it was obvious which items were single use and these items were clearly new. Each treatment room had the appropriate personal protective equipment such as protective gloves and visors available for staff use.

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), the lead dental nurse described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor and documentary evidence was available for inspection. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

The practice had two separate decontamination suites one on each floor. These consisted of a separate dirty and clean room with a wall hatch enabling instruments to be passed from the dirty to the clean room. Each room was organised, clean, and tidy and clutter free. Dedicated hand washing facilities were available in each room. The dental nurse and decontamination technician described the decontamination process from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

The practice used a combination of manual scrubbing and a washer disinfector as part of the initial cleaning process, following inspection with an illuminated magnifier, instruments were placed in an autoclave (a machine used to sterilise instruments). When instruments had been sterilized, they were pouched and stored appropriately until required in the treatment room. All pouches were dated with an expiry date in accordance with current guidelines. The lead nurse described how the autoclaves and washer disinfector used in the decontamination process were working effectively. These included the various daily and weekly checks. We were shown the records of these tests; they were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps' containers, clinical waste bags and municipal waste were properly maintained and was in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and this was stored in a separate locked location adjacent to the practice prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example, the four autoclaves had been serviced and calibrated in February 2015. The practice X-ray machine had been serviced and calibrated in January 2016. Electrical testing had been carried out in February 2015.The batch numbers and expiry dates for local anaesthetics and dose and amount of medicines prescribed were recorded in patient dental care records.

These medicines were stored securely for the protection of patients. We found that the practice stored prescription pads in a lockable metal cabinet in the treatment room to prevent loss due to theft. We observed that the practice had equipment to deal with first aid problems such as minor eye problems and body fluid and mercury spillage. We found that there was a recording system for the prescribing and recording of medicines used in the provision of conscious sedation (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation); this included the reversal agent for the sedative medicine.

There was a robust written system of stock control and storage for the medicines used in intravenous sedation that was demonstrated to us. We also saw that equipment used in the provision of conscious sedation had been properly maintained. This included the pulse oximeters (used for measuring blood pressure, oxygen saturation of the blood and pulse) had been calibrated during January 2015 and the two relative analgesia machines in August 2015

Radiography (X-rays)

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). A

Are services safe?

well-maintained radiation protection file in line with these regulations was observed. Included in the file were the critical examination packs for each of the 20 X-ray sets along with the three yearly maintenance logs and a copy of the local rules. The file also contained the X-ray set inventory, risk assessment, quality assurance process and notification to the Health and Safety Executive

A copy of the most recent radiological audit was available for inspection this demonstrated that a very high percentage of radiographs were of a high standard of quality. Dental care records where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured every time. The X-rays we observed were of a high quality. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentist we spoke with carried out consultations, assessments and treatment in line with recognised general professional guidelines. They described to us how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and any signs of mouth cancer. 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.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

Dental care records we saw showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. 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).These were carried out where appropriate during a dental health assessment.

The provider carried out intra-venous sedation at the practice for patients who were very nervous of dental treatment and required complex dental treatment such as the provision of dental implants. We found that the provider had put into place robust governance systems to underpin the provision of conscious sedation (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The systems and processes we observed were in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.

The governance systems supporting sedation included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training.

We found that patients were appropriately assessed for sedation. We saw clinical records that showed that all patients undergoing sedation had important checks made prior to sedation this included a detailed medical history, blood pressure and an assessment of health using a recognised system in accordance with current guidelines. The records demonstrated that during the sedation procedure important checks were recorded at regular intervals using specialised equipment including a pulse oximeter that measures the patient's heart rate and oxygen saturation of the blood. Blood pressure was measured using a separate blood pressure monitor. The dentist carrying out sedation was supported by appropriately trained nurses on each occasion. This was also recorded in the dental care records with details of their names. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practise.

The nurses supporting the dentist were confident and assured about their roles during sedation we asked them to explain their role in supporting the dentist. This reflected the quality of the ongoing training, supervision and mentoring that the nurses received from the dentist. This ongoing support was to be supplemented by a structured training day that the nurses were due to attend in January 2016.

Health promotion & prevention

The practice used effective skill mix to deliver health promotion and prevention to patients at the practice and to surrounding schools and nurseries. For example, dental nurses were trained to provide oral health education to

Are services effective?

(for example, treatment is effective)

young children and adults who are at a higher risk of dental decay and gum disease. Two nurses from the practice visited local schools and provided an activity to groups of children. During this activity, they provided oral hygiene instruction and advice on healthy eating. At the end of each session, they provided a dental pack to each child that included a brushing chart and toothpaste and a certificate of attendance. Members of staff within the group had put together an illustrated story booklet for children called 'Ralphie and the achy tooth'. This explained to children in age appropriate language a patient journey through a dental practice and advice on how to maintain a healthy mouth.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The dentists and dental therapists explained tooth brushing and interdental cleaning techniques to patients in a way they understood and dietary, smoking and alcohol advice was given to them. Dental care records we saw all demonstrated dentists had given tooth brushing instructions and dietary advice to patients. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. Dental care records we observed demonstrated that the dentist had given oral health advice to patients.

Staffing

The registered manager told us that the practice ethos was that all staff should receive appropriate training and development. The practice used a variety of ways to ensure staff development including internal training and staff meetings as well as attendance at external courses and conferences. The practice provided a rolling programme of professional development. This included training in cardio pulmonary resuscitation infection control, child protection and adult safeguarding, dental radiography (X-rays) and other specific dental topics. All staff had access to the provider's website which contained e-learning. A training matrix was available which recorded details of training undertaken; a colour coding system enabled management to remind staff when update training was required.

Staff told us that they were supported to attend training courses appropriate to the work they performed and 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 was up to date for all relevant staff.

The development of extended duty dental nurses showed effective use of skill mix in the practice. The practice also used three dental therapists for the provision of routine preventive maintenance care for patients; this included the placement of fillings and the provision of gum treatments and other preventive care. This enabled the dentists to concentrate on providing care to patients whose needs were more complex whilst the dental nurses and dental hygienists provided routine care and advice.

We were told that annual appraisal took place for all staff and we saw some records to confirm this. However, not all staff files we saw contained copies of appraisal documents and others only recorded pre-appraisal information. We were told that although systems were in place improvements were being considered to further develop the appraisal process.

Working with other services

One of the practice managers we spoke with explained how the practice would work with other services. Dentists were able to refer patients to a range of specialists in primary and secondary services if the treatment required was not provided by the practice. The practice used referral criteria and referral forms developed by the local managed clinical networks for providers such as oral surgery, orthodontic providers and special care dentistry. This ensured that patients were seen by the right person at the right time. We saw examples of other types of referral that did not involve specific referral proformas. In these cases a referral letter was prepared and sent to the hospital with full details of the dentists findings and was stored in the practices' records system. A policy was in place that reflected this process. When the patient had received their treatment, they would be discharged back to the practice for further follow-up and monitoring. A copy of the referral letter was always available to the patient if they wanted this for their records. The practice manager reported that there were no patients' complaints relating to referrals to specialised services. We noted the practice used a referral tracking system to monitor referrals in and out of the practice.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

We asked a dentist how they implemented the principles of informed consent for routine dental treatment; they had a very clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. This particular dentist also provided intra-venous conscious sedation, they explained the process involved in this complex area of care. We found the process robust and followed the practices' policy in relation to conscious sedation.

The dentist explained how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. If there was any doubt about their ability to understand or consent to the treatment, then treatment would be postponed. They went on to say they would involve relatives and carers if appropriate to ensure that the best interests of the patient were served as part of the process. This followed the guidelines of the Mental Capacity Act 2005. They were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The treatment rooms in the practice were situated off the various waiting areas. 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 this protected patient's privacy. Patients' clinical records were stored electronically and in paper form. Computers were password protected and regularly backed up to secure storage with paper records stored in lockable cabinets. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. Staff we spoke with were aware of the importance of providing patients with privacy and maintaining confidentiality. On the day of our visit we witnessed patients being treated with dignity and respect by the reception staff when making appointments or dealing with other administrative enquiries.

Involvement in decisions about care and treatment

The practice provided clear treatment plans to their patients that detailed possible treatment options and indicative costs. A poster detailing NHS and private treatment costs was displayed in the waiting area. The dentist we spoke with paid particular attention to patient involvement when drawing up individual care plans. We saw evidence in the records we looked at that the dentist recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment-planning forms for dentistry where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We discussed appointment times and scheduling of appointments. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. The practice offered early morning opening and was open on Saturday mornings which offered flexibility of appointment times to people who might have commitments during normal working hours. We observed the clinics ran smoothly on the day of our inspection and patients were not kept waiting.

The practice's website described the range of services offered to patients which included general dentistry, orthodontics and dental implants. The practice provided NHS and private treatment. NHS treatment costs were clearly displayed in the waiting area.

Tackling inequity and promoting equality

The practice was located on the ground and first floor of a converted building. There was no car park and patients used roadside parking or one of the nearby pay and display car park if required.

The practice had an equality, diversity and human rights policy which was available to all staff on the practice's computer system. We were told that the majority of patients registered at the practice could speak English. However a translation service had been used in the past and staff were aware of contact details if this service were required in the future.

The practice had carried out a disability discrimination audit and documentation was available for a re-audit to be completed if any changes were made at the practice. There was a hearing loop at the reception area and the practice was suitable for wheelchair users. Seven of the treatment rooms were on the ground floor with level access to the front of the building, and a disabled toilet. There were also 13 treatment rooms on the first floor and a male and female toilet on the ground floor.

Access to the service

The practice was open from 7.30am to 6pm on Monday, Tuesday, Wednesday and Friday, 7.30am to 8pm on Thursday (closed between 1pm to 2pm) and 7.30am to 1pm on Saturday. When the practice was closed patients were directed to call NHS 111.

Appointments were booked by telephoning the practice or in person by attending the practice. Staff told us that patients were usually able to get an appointment within a day or two of their phone request. However emergency appointments were available on the same day that patients telephoned the practice. Patients we spoke with were aware of how to access appointments both during opening hours and outside of opening hours. Patients told us that they could get an appointment at a time to suit them and said that they did not have difficulty getting through to the practice on the telephone. One patient we spoke with told us that they had telephoned the practice that morning and asked for a lunch time appointment and was given an appointment as 12.20pm. We were told that the practice was very accommodating. We were told that an email and a text reminder service was available for patients. This helped to reduce the number of patients who did not attend their appointment.

Patients we spoke with told us that they were generally seen within a few minutes of their appointment time. Staff said that if they were aware that the dentist was running late they would inform patients in the waiting room.

Concerns & complaints

The practice had received four written complaints within the last 12 months. We saw that details of these complaints along with any correspondence to and from the complainant were kept in a complaint file. There was a complaints' manager at the practice. Staff were aware that any complaints received would be immediately forwarded to this person. We spoke with the complaints manager who told us that patients were always offered a meeting with Mr Bhandal and/or the complaint manager. All complaints were forwarded to Mr Bhandal for review. We were told that verbal complaints were acted upon immediately and these were not recorded in the complaint log. There was no written evidence to demonstrate the number of verbal complaints received or any action taken regarding these. There were no systems in place to monitor complaints to identify trends and learn from issues identified.

Are services responsive to people's needs?

(for example, to feedback?)

We were told that complaints were discussed at informal meetings as and when they were received at the practice and would also be discussed at practice meetings. There were no minutes of informal meetings and no evidence of lessons learnt.

The practice's complaint policy was available on the computer system. We saw that the complaint information was available in six languages other than English.

Information for patients about how to complain was on display in the waiting area. This gave the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example NHS England, the Independent Complaints Advocacy Service or the Parliamentary and Health Service Ombudsman).

Are services well-led?

Our findings

Governance arrangements

The practice owner and the two practice managers were responsible for the day-to-day running of the practice. We saw that the practice had in place a well-developed system of policies, procedures and risk assessments covering all aspects of clinical governance in dental practice. For example, infection control, health and safety and radiation. We also found a very robust governance system in place for supporting the safe delivery of conscious sedation. This system included pre and post sedation treatment checks, emergency equipment requirements, medicines management, sedation equipment checks, personnel present, patient's checks including consent, monitoring of the patient during treatment, discharge and post-operative instructions and staff training. We found that policies and processes were regularly review by the practice owner and the managers. Staff were aware of where these policies were held and we saw that they were readily accessible.

The practice held staff meetings every month which were minuted to ensure that any staff not present could be made aware of topics which had been discussed. We saw that a copy of the minutes was on display in the staff kitchen. However, not all of the staff that we spoke with were aware of this.

Leadership, openness and transparency

The practice had experienced and empowered practice managers who demonstrated a firm understanding of the principles of clinical governance in dentistry. They were well supported in this role by the registered manager. Staff told us that the registered manager was approachable and helpful.

The culture of the practice was open and supportive. Staff we spoke with told us they enjoyed working at the practice and received the support they needed. The clinicians we spoke with told us they supported each other and provided clinical advice and support as necessary.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern.

Learning and improvement

The registered manager and practice managers provided enthusiastic leadership and the staff we met described them as very approachable. For example, both the dentist and the dental therapist we spoke with described how the registered manager was supportive in their professional development. They explained how the registered manager was always on hand to provide direct clinical supervision and advice should the need arise. We saw evidence of systems to identify staff learning needs. For example, results of clinical audits were used to identify additional training or clinical supervision needs and improve confidence and competence in particular clinical techniques. The registered manager explained that the practice was aiming to gain centre of excellence status as a training practice for dental nurses in conscious sedation.

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

We spoke with staff about the methods used to obtain feedback from patients and from staff who worked at the practice. We were told that there was suggestions/ comments box in the waiting room. The Friends and Family Test (FFT) had been introduced and the results of a recent FFT were available on the NHS Choices website; we saw that 100% of people who completed this survey would recommend this dental practice (52 patients). The friends and family test is a national programme to allow patients to provide feedback on the services provided.

We discussed the systems in place to feedback or receive feedback from staff. We were told that practice meetings were held on a monthly basis. We saw the minutes of the practice meetings held in 2015. The minutes of the last meeting were on display in the staff kitchen. Those staff who were unable to attend the meeting were able to look at the minutes to update themselves regarding the discussions held. However, not all of the staff that we spoke with were aware that the practice meeting minutes were available for them to view.

Staff said that they were able to speak with any of the management team or Mr Bhandal at any time if they had any concerns. Patients spoken with said that staff were friendly and approachable; none of the patients spoken with could remember being asked to complete a survey about the practice. However an annual satisfaction survey was conducted. We saw the results of the 2015 survey.

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Twenty patients had completed a survey, the majority of the results were positive. We also saw the results of the March, June and September 'vital signs' NHS England survey regarding waiting times.