Care Quality Commission

Kyrle Street Dental Practice

Kyrle Street Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 November 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

Kyrle Street Dental Practice is situated close to Hereford city centre. It provides mainly NHS dental treatment for all age groups and a small amount of private dental treatment. There has been a dental practice at the premises for over 40 years. The practice has been operated by the current partnership of two dentists for over 20 years.

In January 2016 the Department of Health (DH) announced the launch of a prototype process as the next stage in the reform of NHS dentistry. Kyrle Street Dental Practice is one of 82 practices in England selected to take part in the Dental Prototype Agreement Scheme. They are testing new ways of providing NHS dental care with an increased emphasis on preventing future dental disease.

One of the two partners 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.

The practice has seven dentists (including the two partners), a dental hygienist, nine dental nurses and three trainee dental nurses. The registered manager and clinical team are supported by a practice manager, two reception staff and an accounts administrator.

The practice has six dental treatment rooms and a separate decontamination room for the cleaning, sterilising and packing of dental instruments. The waiting

Summary of findings

room is separate from the reception area which helps provide privacy when staff are dealing with patients at the reception desk or on the telephone. Areas of the practice used by patients are all on the ground floor with level access into and around the building. The nearby public car park has designated spaces for patients with disabilities and the practice has space for patients with disabilities to park immediately in front of the building. There is sufficient space within the building for patients who use wheelchairs including in the patient toilet. The practice provides a wheelchair to support patients if required during their visit?

The practice is open from 8.30am to 5pm Monday to Friday and closes for lunch from 1pm to 2pm.

Before the inspection we sent Care Quality Commission comment cards to the practice so patients could give us their views about Kyrle Street Dental Practice. We collected 23 completed cards. Two patients contacted us direct by email. Patients spoke highly of the service they received and described the practice team as professional, efficient, caring and respectful. Patients who commented on being involved in planning their treatment said their treatment met their needs and that their dentist listened to them. Those who commented on cleanliness confirmed that the practice was clean and tidy. The results of the practice's NHS Friends and Family Test forms for 2016 to date were positive and showed that 91% of the patients who took part were extremely likely or likely to recommend the practice. Only three of the 66 patients who responded said they would not recommend the practice.

Our key findings were:

- The practice was visibly clean and feedback from patients confirmed this was their experience. National guidance for cleaning, sterilising and storing dental instruments was followed.
- The practice had suitable safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- The practice had arrangements for dealing with medical emergencies.
- Dental care records provided clear information about patients' care and treatment and patients received written treatment plans where necessary.
- Staff received training appropriate to their roles and were supported to meet the General Dental Council's continuous professional development requirements.
- Patients were able to make routine and emergency appointments when needed and were gave us positive feedback about the service they received.
- The practice used the NHS Friends and Family Test, to enable patients to give their views about the practice. Staff had opportunities to contribute their views through daily discussions, staff meetings and annual appraisals.
- The practice had policies and procedures to help them manage the service. Some record keeping needed consolidation to make information easier to access for monitoring and management purposes.
- Recruitment arrangements did not ensure that all the required information was always obtained for staff employed. The practice established a new recruitment policy and process immediately.
- The practice used audit as a means to monitor quality in a range of areas and used repeat audits to ensure improvements had taken place.

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

- Review the availability of a policy regarding the Duty of Candour to support the practice in providing appropriate information to patients directly affected by adverse incidents.
- Review the availability of information about translation services for patients who do not speak English as their first language or who use British Sign Language.
- Review the recording arrangements for some aspects of practice management including incoming safety alert information, fire safety arrangements and staff records.

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 assist in the safe management of the service including the care and treatment provided to patients. This included processes to discuss and make improvements when things went wrong. There were policies and risk assessments for important aspects of health and safety. These included infection prevention and control, clinical waste management, dealing with medical emergencies, dental radiography (X-rays) and fire safety. Staff recruitment procedures were not supported by a policy to provide robust guidance and procedures regarding the information needed for new staff. The practice addressed this within 36 hours of the inspection. Some aspects of record keeping in respect of fire safety needed to be reviewed. Medicines and equipment for responding to medical emergencies were available. Staff were aware of their responsibilities for safeguarding adults and children. The practice had safeguarding policies and procedures and contact information for local safeguarding professionals was readily available for staff to refer to if needed.	**No action** ✓
Are services effective? We found that this practice was providing effective care in accordance with the relevant regulations. The practice assessed patients' and care and treatment in a personalised way taking into account current legislation, standards and evidence based guidance. The practice was involved with an NHS project exploring new ways of providing NHS dental care. They said this had enhanced their ability to practice preventative dentistry. They provided patients with written treatment plans where necessary and patient feedback confirmed that their care was discussed with them clearly and thoroughly. Referrals to other dental or NHS services were made in line with relevant guidance when this was necessary and the practice worked in partnership with other health professionals. Clinical staff were registered with the General Dental Council and completed continuous professional development to meet the requirements of their professional registration Staff understood the importance of obtaining informed consent and worked in accordance with relevant legislation and guidance relating to children, young people and adults regarding this.	**No action** ✓
Are services caring? We found that this practice was providing caring services in accordance with the relevant regulations. The patient feedback we reviewed was positive and showed that patients were pleased with the care and treatment they received. Patients told us that the practice team were professional and caring and provided a kind and attentive service. This view was supported by the practice's NHS Friends and Family Test monthly results for 2016 showing that 91% of patients who completed a form were extremely likely or likely to recommend the practice.	**No action** ✓

Summary of findings

The practice was aware of the importance of confidentiality and this was covered in practice policies and staff training. During the inspection we saw that staff dealt with patients professionally and were helpful, welcoming and polite. Patient feedback confirmed that the dentists took time to give patients the information they needed about their treatment.	
Are services responsive to people's needs? We found that this practice was providing responsive care in accordance with the relevant regulations. The patient feedback we reviewed confirmed that patients received a personalised service that met their needs. Areas of the practice used by patients were all on the ground floor with level access into and around the building. The nearby public car park had designated spaces for patients with disabilities and the practice had space for patients with disabilities to park immediately in front of the building. There was sufficient space within the building for patients who used wheelchairs including the patient toilet. The practice provided a wheelchair for patients who needed one during their visit. The practice had out of hours arrangements so patients could obtain urgent as well as routine treatment when they needed. All but one patient who mentioned obtaining appointments said the practice were good at fitting them in at short notice in an emergency. The practice had a complaints procedure and responded to complaints promptly and constructively. Information about this was available in the practice information leaflet.	**No action** ✔
Are services well-led? We found that this practice was providing well-led care in accordance with the relevant regulations. The practice had policies, procedures and risk assessments to support the management of the service. Audits were used to assist the partners in managing and monitoring the quality of the service. Dental nurses and reception staff received annual appraisal and had personal development plans to identify and plan their learning needs. Staff told us they were well supported by the partners. The practice team worked together well. The practice used the NHS Friends and Family Test to monitor patient satisfaction and obtain their views about the service. The practice used a mixture of informal communication and structured staff meetings to discuss the management of the practice and the care and treatment provided.	**No action** ✔

Care Quality Commission

Kyrle Street Dental Practice

Detailed findings

Background to this inspection

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

The inspection was carried out on 2 November 2016 by a CQC inspector and a dental specialist adviser. We reviewed information we held about the provider and information that we asked them to send us in advance of the inspection.

During the inspection we spoke with both partners and other dentists, dental nurses and reception staff. We looked around the premises including the treatment rooms. We viewed a range of policies and procedures and other documents and read the comments made by 23 patients in comment cards provided by CQC before the inspection. Two patients contacted us direct by email to provide their positive views about the practice. The practice provided their 2016 NHS Friends and Family Test results.

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 a critical incident/significant event policy and recording forms for staff to use. We reviewed six significant event forms completed during the last year. These related to clinical and non-clinical events. We saw that the practice had acted on these and made changes where necessary. For example, they purchased a wheelchair in response to two incidents where people with mobility difficulties had difficulties during their visits to the practice.

The practice was aware of the requirement under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and had guidance for staff to refer to. Suitable accident record forms were used. The practice had recorded three unrelated accidents in the last year. These had not been recorded as significant events to help ensure a full overview of all incidents where learning could take place.

The registered manager explained that historically they had received national alerts about safety issues relating to medicines, equipment and medical devices from local commissioners, checked which were relevant to them and took action when needed. In discussion with one of the partners we found that they were not aware of recent alerts regarding a recall of a medicine used to treat diabetic patients with low blood sugar or one about a defibrillator fault. They checked their defibrillator and the batch numbers of the recalled medicine immediately and confirmed that theirs were not involved. They immediately registered to receive safety alerts direct from the government website GOV.UK to ensure no other alerts were missed. Although previous alerts had been stored for future reference the practice did not have a structured system to record that they monitored, checked and acted on these.

We noted from the way that the practice had dealt with a significant event and with complaints that the practice was open with patients and apologised if an adverse event affected them. However, this approach was not supported by a policy regarding the legal requirement, the Duty of Candour. This legislation requires health and care professionals to tell patients the truth when an adverse incident affects them.

Reliable safety systems and processes (including safeguarding)

The practice team were aware of their responsibilities regarding potential concerns about the safety and well-being of children, young people and adults living in challenging circumstances. The practice had child and adult safeguarding policies and procedures based on local and national safeguarding guidelines. One of the partners was the practice’s lead for safeguarding. Up to date contact details for the relevant safeguarding professionals in Herefordshire were readily available for staff to refer to. Information leaflets about child and adult safeguarding arrangements in Herefordshire were available in the waiting room.

Staff had completed safeguarding training at a level suitable for their roles. This was provided as on line training and by a member of the local NHS safeguarding team. Staff described examples of concerns about the well-being of some children and adults when they had liaised with health and safeguarding professionals to ensure they were safe.

We saw evidence to confirm that the dentists used a rubber dam during root canal treatment in accordance with guidelines issued by the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient’s mouth and airway during treatment.

The practice was working in accordance with the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the EU Directive on the safer use of sharps which came into force in 2013. We confirmed that dentists and the dental hygienist used either single use ‘safer sharps’ syringes or traditional syringes with a suitable device for needle removal to minimise the risk of injury to dentists and dental nurses.

Medical emergencies

The practice had arrangements to deal with medical emergencies at the practice. 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. We saw evidence that staff completed annual training relevant to their role including management of medical emergencies, basic life support training and training in how to use the defibrillator.

Are services safe?

The practice had the emergency medicines as set out in the British National Formulary (BNF) guidance. However, they had the medicine used to treat patients experiencing an epileptic seizure in injectable form rather than as an oromucosal solution which is applied direct to a patient's gums as set out in the BNF. They ordered this before the end of the inspection.

The practice had a supply of adrenaline which is used to treat severe allergic reactions. The BNF states this should be held in injectable form and the practice had this. They also had a supply of auto-injectors, these are pre-prepared devices which deliver a dose of adrenalin in variable doses. To avoid confusion in an emergency, staff should have clear guidance regarding the availability of both options with reference to information available in the BNF and from Resuscitation Council (UK).

Oxygen and most other related items such as face masks were available in line with the Resuscitation Council (UK) guidelines. There was no size 1 airway for use with children or spacer to use with the asthma inhaler. The practice said they would order these. Staff carried out weekly checks of the emergency medicines and equipment including the oxygen and defibrillator to monitor that they were available, in date, and in working order. We saw the records they kept to confirm they had done these checks. We observed duplicate items of some emergency equipment which could make it harder to find specific items rapidly.

Staff recruitment

The practice did not have a structured a recruitment policy to ensure the practice obtained all of the information required when they appointed new staff.

We looked at the recruitment records for three staff appointed in the last year. All three were school leavers and had therefore not worked in health or social care settings previously. This meant the practice had not needed to obtain satisfactory evidence of employment in a healthcare related setting or some other details such as reasons for gaps in employment. We looked at some other staff records and noted that photographic evidence of identity was not available for all staff although other proof of identity including General Dental Council registration certificates was.

The practice had carried out Disclosure and Barring Service (DBS) checks for all clinical staff. 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 adults who may be vulnerable. They had not completed DBS checks for their two non-clinical staff both of whom had been at the practice for many years.

Within 36 hours of the inspection the practice sent us a comprehensive written recruitment policy and procedure which included job application and reference request forms. These provided the basis for a more structured approach to future staff recruitment which reflected relevant legislation. The policy stated that all staff working at the practice would have DBS checks and would be asked to register for the DBS update service which the practice would pay for. This included any non-clinical staff who might have chaperone type contact with patients.

The practice had evidence that the clinical staff were registered with the General Dental Council (GDC) and that their professional indemnity cover was up to date. This as checked this as part of staff appraisals each year.

Monitoring health & safety and responding to risks

The practice had a variety of health and safety related policies and risk assessments. These covered general workplace and specific dentistry related topics and were stored on the practice computer system where all staff could look at them.

The practice had information about the control of substances hazardous to health (COSHH). This included risk assessments and manufacturers' data sheets for relevant dental products and for household products such as cleaning materials.

The practice had latex free disposable gloves available to remove the risk to patients or staff who may be allergic to latex.

The practice had a fire risk assessment originally completed by the practice in 2010. The document had been reviewed annually by the partners. They told us that they recognised that it would be sensible to conduct a full re-assessment of the premises and were intending to use a suitable experienced external person to do this. Emergency lighting, smoke detectors and emergency exit signs were fitted. A fire procedure was displayed in reception and in various other rooms including the decontamination room.

The practice did not have a fire log to record routine daily, weekly and monthly checks in respect of fire safety

Are services safe?

precautions at the practice. We saw stickers on the fire extinguishers showing that they had been checked by a specialist contractor in April 2016. A specialist company tested and serviced the fire alarm system, most recently in May 2016.

The practice had a business continuity plan describing how the practice would deal with a wide range of events which could disrupt the normal running of the practice. This included details of relevant contacts to help staff manage a significant disruption to the service.

Infection control

The practice was visibly clean and tidy and patients who commented on the subject confirmed this. Cleaning equipment was available and stored appropriately. The practice employed a cleaner to carry out general cleaning of non-clinical areas at the practice and used cleaning schedules to monitor that the various cleaning tasks were completed.

The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections.

The practice had an infection prevention and control (IPC) policy and one of the dental nurses was the IPC lead for the practice.

We saw that the practice completed twice yearly IPC audits using a recognised format from the Infection Prevention Society (IPS). The most recent audit in August 2016 showed a score of 97%.

We reviewed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. We found that they met the HTM01-05 essential requirements for decontamination in dental practices.

Decontamination of dental instruments was carried out in the separate decontamination room by the dental nurses who took it in turns to be the decontamination nurse each day. The separation of clean and dirty areas in the decontamination room and treatment rooms was clear. The practice had suitable arrangements for transporting, cleaning, checking, sterilising and storing instruments.

We saw the practice packaged, dated and stored equipment appropriately. Staff confirmed that they used single use instruments whenever possible in line with HTM01-05 guidance and did not re-use items designated as single use only. Instruments were colour coded using rubber bands or coloured tape so that they were returned to specific dentists. We highlighted that the area under the band or tape may not be adequately sterilised. The partners considered this during the inspection and told us they had decided to stop doing this. The practice kept records of the expected decontamination processes and checks that equipment was working correctly using paper records and by downloading electronic data.

Some of the dentists carried out dental implants, a surgical procedure which requires specific hygiene and decontamination standards. We discussed this with the IPC lead. They confirmed that separate instruments and equipment, including dental handpieces, sterile saline and protective drapes were kept for these processes.

The practice had personal protective equipment (PPE) such as heavy duty and disposable gloves, aprons and eye protection available for staff and patient use. We saw that staff working in the decontamination room used eye protection to protect them from splashes. The treatment rooms and decontamination room had designated hand wash basins for hand hygiene with liquid soap and paper towels.

Suitable spillage kits were available to enable staff to deal mercury spillage and with any loss of bodily fluids safely.

The practice had an up to date Legionella risk assessment carried out by a specialist company every two years. Legionella is a bacterium which can contaminate water systems in buildings. The most recent assessment was completed in February 2016. We saw that staff carried out routine water temperature checks and kept records of these. The practice used an appropriate chemical to prevent a build-up of potentially harmful biofilm, such as Legionella, in the dental waterlines. Staff confirmed they carried out regular flushing of the water lines in accordance with current guidelines and the chemical manufacturer's instructions. They used a testing regime certified by the manufacturer of the chemical used.

The practice's arrangements for segregating and storing dental waste reflected current guidelines from the Department of Health. The practice used an appropriate contractor to remove dental waste from the practice. We saw the necessary waste consignment and duty of care documents and that the practice stored waste securely before it was collected.

The practice had a process for staff to follow if they accidentally injured themselves with a needle or other sharp instrument. This was available for staff to refer to and they were aware of what to do. In the event of a member of staff being injured by an instrument used during a treatment there was an information leaflet for patients. This explained that the practice might ask them to have a blood test. The practice also had a consent form regarding this. The practice assured us that they had documented information about the immunisation status of each member of staff but were unable to locate the information for some of them during the inspection. Within 36 hours of the inspection the practice confirmed that they had established a spreadsheet to help them record and monitor essential information about staff, including information about their immunisation status. Appropriate secure boxes for the disposal of sharp items were used.

Equipment and medicines

We saw the maintenance and revalidation records for the X-ray equipment and the equipment used to sterilise instruments. We saw that the portable electric appliances had stickers showing they had been tested for safety during the last year as did the fire extinguishers.

The registered manager confirmed that the practice's insurance policy included appropriate pressure vessel insurance for the compressor and equipment used to sterilise instruments and showed us the current pressure vessel inspection documentation.

NHS prescription pads were stored securely and the practice had clear records of stock held including serial numbers. Individual prescriptions were not endorsed with the practice stamp until a dentist had filled them in and signed them. Emergency medicines were stored securely and no other medicines (such as antibiotics or painkillers) were held at the practice.

We confirmed that the dentists recorded the dose and type of local anaesthetic used in patients' records. They also kept records in each treatment room of the batch numbers of local anaesthetics used by each dentist. They explained this was so local anaesthetics could be traced to patients depending on the date of their appointment and which dentist had treated them.

Radiography (X-rays)

We looked at records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). The practice had a radiation protection file containing the required information. This included the local rules, the names of the Radiation Protection Adviser and the Radiation Protection Supervisor and the notification to the Health and Safety Executive that radiography equipment was used at the premises. The records showed that the practice had arrangements for maintaining the X-ray equipment and that relevant annual checks were up to date.

We confirmed that the dentists' IRMER training for their continuous professional development (CPD) was up to date. The practice had provided in-house refresher training for dental nurses during 2016 regarding aspects of radiography they needed to be aware of in their role.

The practice used beam aiding devices and rectangular collimators (equipment attached to X-ray machines) to reduce the dose of X-rays patients received and to help maximise the accuracy of images. The X-ray equipment was digital which eliminated the need for staff to handle chemicals used to develop traditional X-rays.

We saw evidence that the practice justified, graded and reported on the X-rays they took. We saw and audit of X-ray quality in December 2015 which took an overview of 770 X-rays taken across the practice but did not identify which dentists the X-rays related to. The partners explained that this was because they wanted to get a general picture at that stage. The audit showed a good level of accuracy but did not analyse the cause of the lower quality X-rays. The practice had recently completed another X-ray audit which had looked at over 1000 X-rays. This was more detailed and analysed which dentists X-rays related to. The practice was in the process of examining the 10% of X-rays scored as grade 2 and the 1% scored as grade 3 so they could develop a practice wide and dentist specific action plan.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice team were aware of and took into account published guidelines such as those from National Institute for Health and Care Excellence (NICE), the Faculty of General Dental Practice (FGDP) and other professional and academic bodies. This included NICE guidance regarding antibiotic prescribing, wisdom tooth removal and dental recall intervals.

The partners explained to us that they were taking part in a dental prototype scheme led by the Department of Health to look at new ways of providing NHS dental patients with the care needed to improve oral health. A fundamental difference was that under the prototype scheme the practice was paid according to the number of patients registered rather than according to the treatment provided. The dentists told us had enhanced their ability to practice preventative dentistry.

The practice explained that they had always worked to keep suitable detailed records about patients' dental care and treatment and had assessed each patient's risk of tooth decay and gum disease. They told us that involvement in the prototype scheme was strengthening their approach to this. They described how the scheme enabled and encouraged them to take a more preventative approach to each patient's dental care using detailed assessment protocols and patient questions specified for use as part of the scheme

Dental records included the condition of the patient's gums using the basic periodontal examination (BPE) scores. The BPE is a simple and rapid screening tool that is used to indicate the level of treatment needed in relation to a patient's gums. The dentists referred patients who needed ongoing advice, support and treatment in relation to their gum health to the practice's dental hygienist or carried out this work themselves.

The dentists also checked patients' general oral health including monitoring for possible signs of oral cancer.

The practice asked all patients to fill in a medical history form and checked and updated this information at each check-up appointment. The prototype scheme required the practice to request additional information from patients including questions about their health, diet and smoking.

The overall process of completing medical history forms and the patient needs assessment took longer than the practice's previous processes. Staff told us that that most examination appointments were therefore longer.

Health promotion & prevention

The practice explained that they had always viewed health promotion and preventative work as an important aspect of general dentistry. They told us that involvement in the dental prototype scheme had resulted in a greater emphasis on this element of their work. This was an integral element of the assessment framework they were using for the scheme.

The practice was in an area which did not have fluoridated water. The practice had concentrated fluoride toothpaste available and prescribed this if a patient's risk of tooth decay indicated this would be beneficial. Similarly, they used fluoride varnish for children in accordance with guidance in the Delivering Better Oral Health Tool-kit from the Department of Health. This was an area of dental care that was also specifically highlighted in the dental prototype scheme.

A range of dental care products were available for patients to buy.

Staffing

We confirmed that clinical staff undertook the required for their registration with the General Dental Council (GDC). The practice had evidence that clinical staff held current GDC registration. The practice held copies of staff training certificates and we saw evidence that staff kept records of their individual CPD. We highlighted that the organisation of staff files made it time consuming to check or confirm specific information. Within 36 hours of the inspection the practice informed us that they had set up a spreadsheet to help them monitor all aspects of information relating to staff.

The practice completed annual appraisals for staff which included identifying personal development plans (PDPs). For example, we noted one dentist's appraisal which set out areas of clinical practice where they planned to develop their experience and knowledge.

Are services effective?

(for example, treatment is effective)

The appraisal process was structured and included a self-assessment questionnaire to help staff prepare for their appraisal. The appraisal documentation specifically reminded staff of the General Dental Council Standards for the Dental Team. It also included a section to confirm staff had met their continuous professional development (CPD) declaration requirements

In addition to training in clinical topics staff also completed training in other essential areas. These included safeguarding, management of medical emergencies, basic life support and defibrillator training and information governance. The practice did not have a structured process to help them maintain an overview of training completed by the staff team. Three of the dental nurses had completed additional training to enable them to assist during implant procedures.

The practice had a structured induction checklist for new staff. We were unable to see these completed for the three trainee staff because they kept these themselves.

Working with other services

The practice referred patients, including children, to NHS dental services including hospitals and access clinics or to private dental practices when needed. This was usually because a patient needed specific specialist treatment that they did not provide. However, the dentists carried out all but the most complex care and treatments themselves at the practice. The dentists also referred patients to the dental hygienist at the practice.

The practice referred patients for investigations in respect of suspected oral cancer in line with NHS guidelines. This included making referrals under the national two week wait arrangements.

The dentists told us they gave patients a copy of their referral letters if they requested one. There was a referral tracking process to ensure referrals were followed up.

Consent to care and treatment

Members of the team we discussed this with understood the importance of obtaining and recording patients' consent to treatment. Written consent was obtained for private and NHS treatment provided at the practice. Consent for NHS treatment was recorded using the appropriate NHS forms. Information we reviewed from patients confirmed that they received information to assist them to make informed decisions about their treatment.

The practice had a written consent policy which referred to the Mental Capacity Act (MCA) 2005 and contained detailed information about how this should be applied in practice. Staff were aware of and could explain the relevance of this legislation to the dental team. 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.

The practice consent policy also referred to decision making where young people under the age of 16 may be able to make their own decisions about care and treatment and was based on national guidance.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We gathered patients' views from 23 completed CQC comment cards and emails direct to us from two patients. Patients told us that the practice team were professional and caring and provided a kind and attentive service. This view was supported by the practice's NHS Friends and Family Test monthly results for 2016 showing that 91% of the patients who took part were extremely likely or likely to recommend the practice. Only three of the 66 patients who responded said they would not recommend the practice.

The waiting room was separate from reception. This helped provide privacy when reception staff were dealing with patients. Staff told us that if a patient needed or wanted more privacy to discuss something they would take them into another room. The position of the reception computer screens meant that they could not be seen by patients at the desk. No personal information was left where another patient might see it.

The practice had a confidentiality and information governance policies and these were included in staff induction and ongoing training. Reception staff understood their responsibility to take care when dealing with patients' information in person or over the telephone. There was information about how the practice protected patients' personal information in the practice information leaflet and on the wall in reception.

Involvement in decisions about care and treatment

We saw that the practice recorded information about patient's treatment options, and that they discussed the risks and benefits of these with them. We discussed this with a dental nurse who confirmed that the dentists did this. Patients needing treatment were given a written treatment plan. In the case of NHS patients the practice used the appropriate NHS form for this.

Several patients commented that their dentist gave them clear information about their treatment so they understood the treatment they received and why this was needed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We gathered patients' views from 23 completed CQC comment cards and emails direct to us from two patients. All the information we reviewed provided a positive picture of a service which worked to meet patients' needs. Some patients described being a patient at the practice for many years and told us they had always been happy with the care and treatment they received.

We discussed the appointment booking system with reception staff. They explained that check-up appointments were booked for 15 - 20 minutes and that appointments for treatment were booked according to the treatment needed; the dentists used the instant messaging on the computer system or hand written notes to let them know how much time they should book.

The practice had a patient information leaflet and additional information was available in the waiting room. Patients were provided with written information about the fees for private and NHS treatment.

Tackling inequity and promoting equality

Areas of the practice used by patients were all on the ground floor with level access into and around the building. The nearby public car park had designated spaces for patients with disabilities and the practice had space for patients with disabilities to park immediately in front of the building. There was sufficient space within the building for patients who used wheelchairs including in the patient toilet. The practice provided a wheelchair for patients who may need one during their visit. The patient toilet was accessible for patients using wheelchairs. It had grab rails, a low level wash basin and low level mirrors. The hand towels could be reached from a sitting position. There was no call bell installed. The patient toilet had a baby changing table to assist patients who needed to bring babies and young children with them to the practice.

Staff told us that they did not have any patients who were unable to manage a conversation in English. They did not have current details for translation services, including British Sign Language, should they need this. Although they did not believe they had any patients who needed these at present the partners agreed to source the necessary information. The practice had an induction hearing loop to assist patients who used hearing aids but no sign to inform patients of this.

Information was provided for patients about NHS charges and arrangements for patients who were exempt from paying these. Staff described a sensitive approach to discussions with patients about this.

The practice had equality and diversity and disability policies.

Access to the service

The practice was open from 8.30am to 5pm Monday to Friday and was closed for lunch between 1 and 2pm. One patient commented that it could be difficult to make appointment sat short notice but others confirmed they were able to make appointments easily, including at short notice. Staff told us that each dentist had an hour kept free each day to see patients with pain or other dental emergencies.

The practice information leaflet advised patients to use the NHS 111 telephone number if they needed emergency treatment when the practice was closed. This information was also provided on the practice's telephone answerphone message. We learned from staff and some patients that the dentists occasionally provided an emergency contact number in particular circumstances such as a difficult tooth extraction or other complex treatment. Some patients told us about times when the practice had seen them in an emergency outside normal practice hours, including at weekends.

Concerns & complaints

The practice had a complaints policy and procedure based on national guidance from organisations such as the General Dental Council (GDC) and British Dental Association (BDA). It included contact details for the General Dental Council, local NHS commissioners and the Dental Complaints Service (for private patients). Basic information about making a complaint was included in the practice information leaflet. This explained that the practice manager would look into any concerns patients might have about the service they had received at the practice. Reception staff told us that if a patient raised a concern with them they took details and arranged for the practice manager to deal with this.

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the records of the two complaints the practice had received about the service during 2016 and at some from 2015. These showed the practice responded promptly and constructively to concerns raised. The complaints records included comprehensive notes of the investigations completed by the practice together with any evidence gathered and a chronology of the action taken. The practice used a front sheet to record outcomes and learning points for the practice as a whole and for individual staff.

Are services well-led?

Our findings

Governance arrangements

The partners and practice manager shared responsibility for the day to day management of the service. The partners provided clinical leadership at the practice.

The practice had policies, procedures and risk assessments to support the management of the service. These were based on national guidance from organisations such as the General Dental Council (GDC) and the British Dental Association (BDA).

The practice held structured staff meetings which took place approximately every six to eight weeks. Notes of the meetings were made for future reference so staff who were not present could keep up to date. We looked at the minutes for the meetings held in June, July and August which showed that a wide range of subjects had been discussed. These included safeguarding, training, audits, information governance, health and safety related topics, infection control and premises issues. There had also been discussions about arranging a staff social event. The minutes showed that when a problem or concern was identified action was taken to address this. For example, at the July meeting a concern was raised that recent resuscitation and defibrillator training for staff did not include first aid training. The August staff meeting minutes showed that one of the partners had subsequently completed a first aid course.

The practice was registered with the Information Commissioner and had provided information for patients about their personal information was protected. We identified that the storage arrangements for some patient information may not be sufficiently secure.

Leadership, openness and transparency

During the inspection we observed that the practice team worked well together and were friendly and cheerful. Staff we asked told us the registered manager was supportive and approachable.

The practice had a policy detailing their commitment to staff and a bullying and harassment policy. There was a whistleblowing procedure for staff to follow if they identified concerns at the practice. This included information about external contacts if they felt unable to report their concerns internally.

We noted from the way that the practice had dealt with a significant event and with complaints that the practice was open with patients and apologised if an adverse event affected them. However, this approach was not supported by a policy regarding the legal requirement, the Duty of Candour. This legislation requires health and care professionals to tell patients the truth when an adverse incident affects them.

Management lead through learning and improvement

The partners explained to us that they were taking part in a dental prototype scheme led by the Department of Health to look at new ways of providing NHS dental patients with the care needed to improve oral health. The practice had put themselves forward to take part in the project and was one of 80 practices involved in England. One of the partners was a member of the Local Dental Committee and another was a postgraduate tutor for the West Midlands Deanery. They therefore both took an interest in dental sector developments.

Dentists, other members of the clinical team and reception staff had annual appraisals and personal development plans identifying learning needs. There was an appraisal policy and a structured appraisal format was used. We saw evidence that the clinical staff maintained their continuous professional development (CPD) by doing a mixture of on-line and face to face training.

We saw that practice carried out a variety of audits. Audits are intended to help dental practices monitor the quality of treatment and the overall service provided. The audits we saw included grading of X-rays, infection prevention and control and clinical record keeping. We looked at the X-ray audits from 2015 and 2016. Both audits looked at a large number of X-rays, (770 and over 1000 respectively). The 2016 audit was more comprehensive and detailed and formed the basis for ongoing work by the practice to further improve the quality of their X-rays.

We looked at clinical records audits completed in January and March 2016. These were done before and during participation in the prototype scheme and included a selection of each dentist's records. The audits showed an improvement in the recording of medical histories from 60% to 100% and recording of basic periodontal examinations from 83.4% to 100%.

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

Are services well-led?

The practice used the NHS Friends and Family Test to obtain patients views about the practice. The results for 2016 to date were positive and showed that 91% of the patients who took part were extremely likely or likely to recommend the practice. Only three of the 66 patients who responded said they would not recommend the practice. The practice was looking into establishing a patient forum as another way to gather patient views and involve them in future developments at the practice.

Throughout the inspection we saw that the partners and other members of staff worked well together as a team. Staff were positive about working at the practice told us they felt supported and listened to by the partners and practice manager. The practice also used annual appraisals and staff meetings to provide staff with opportunities to contribute.