

## BST Partnership

# Hockley Heath Dental Care

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 19 January 2017 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**

Hockley Heath Dental Care is a dental practice providing general dental services on a NHS and private basis. The service is provided by seven dentists, four of which attend on a regular basis. The other three dentists (the providers) attend on an occasional basis to provide dental implants and emergency cover when required. They are supported by three dental nurses (one of whom is the practice manager), an area manager (who is the registered manager) and a hygienist. All of the dental nurses also carry out reception duties.

The practice is located on a main road near local amenities and bus routes. There is wheelchair access to the practice and car parking facilities. The premises consist of a waiting room, a reception area, an office and two treatment rooms on the ground floor. One of the treatment rooms contains a dedicated area for decontamination procedures. The first floor is for staff use only and comprises of a kitchen, an office, a meeting room and toilet facilities for staff. There are toilet facilities for patients on the ground floor but these are not wheelchair-accessible. The practice opened from 8:30am to 5:30pm on Monday to Thursday and from 8:30am to 3:30pm on Fridays.

The area manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

# Summary of findings

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.

Fourteen patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was overwhelmingly positive about the care they received from the practice. They described staff as caring, efficient and professional. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were sensitive to their needs.

## Our key findings were:

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

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

- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development.
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance. This includes following guidance surrounding audits, storage of sterilised instruments and ventilation arrangements in the decontamination area.
- Review the protocols for completing accurate, complete and detailed records relating to the recruitment of staff. This includes ensuring recruitment checks, including proof of identification and immunisation, are suitably obtained and recorded.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

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

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff. We identified some necessary improvements and these were actioned promptly.

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

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit.

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

No action



### Are services effective?

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

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

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

No action



### Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was overwhelmingly positive about the care they received from the practice. Patients described staff as caring, professional and efficient. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here.

No action



# Summary of findings

## Are services responsive to people's needs?

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

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

The practice had an effective complaints process.

The practice offered access for patients with limited mobility.

No action



## Are services well-led?

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

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

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

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. Improvements were required to ensure, where applicable, audits had documented learning points with action plans and that they were in line with current guidance.

No action



# Hockley Heath Dental Care

## Detailed findings

### Background to this inspection

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

We inspected Hockley Heath Dental Care on 19 January 2017. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

During the inspection we toured the premises, spoke with the registered manager, the practice manager (who was also a qualified dental nurse), two dentists and two dental nurses. We also reviewed CQC comment cards which patients had completed and spoke with patients. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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

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

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

# Are services safe?

## Our findings

### Reporting, learning and improvement from incidents

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

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reportable incidents had taken place at the practice in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We saw that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The area manager and practice manager were both responsible for obtaining information from relevant emails and forwarding this information to the rest of the team. They emailed the dentists directly and discussed the alerts with all staff too. The area manager described recent alerts that were relevant to dental practice. The area manager was aware of the practice's arrangements for staff to report any adverse drug reactions.

There was a policy present for the Duty of Candour regulation but not all staff demonstrated an awareness of this regulation. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Within two working days, the registered manager informed us that further training had been completed with the relevant staff to update their knowledge about this regulation.

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

The practice had child protection and protection of vulnerable adult policies and procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with

suspected abuse. Staff had access to contact details for local safeguarding teams. The area manager and one of the providers were the safeguarding leads in the practice. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. Training records showed that most staff members had completed appropriate training within the past year. However, the practice manager was already aware that their training was overdue. We did not see records of training for one dentist and for the area manager (who was one of the safeguarding leads). Within two working days, the registered manager sent us evidence that all staff were up to date with the relevant training in this area.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We were told that all dentists used them when carrying out root canal treatment whenever practically possible. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

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

Never events are serious incidents that are wholly preventable. Staff members we spoke with were aware of 'never events' and the practice had written processes to follow to prevent these happening.

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

### Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies in the practice were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). However, the practice did not hold any oropharyngeal airways. These are medical devices used to maintain or open a patient's airway. Staff told us

# Are services safe?

that they received training in this area and the person carrying out the training advised them they no longer needed to hold the oropharyngeal airways. However, this was not in line with current guidance. Within two working days, the registered manager informed us that the airways had been ordered and were due to arrive within one week of our visit.

The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an automated external defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

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

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented weekly checks of the emergency oxygen, AED and the emergency medicines. The emergency medicines were all in date and stored securely. Glucagon was stored in the fridge and the temperature was monitored and documented on a daily basis. A glucagon injection kit is used to treat episodes of severe hypoglycemia which is defined as having low blood glucose levels.

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

Bodily fluid spillage, eyewash and mercury spillage kits were available to deal with any incidents.

## Staff recruitment

The practice had a recruitment policy for the safe recruitment of staff. We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of employment contracts, written references and induction plans. Some of the records also had curricula vitae. All but one of the files contained evidence of staff identity verification. Schedule 3 (Health and Social Care Act 2008) requires proof of identity for all staff. The area manager told us they requested and saw this for the individual but must have forgotten to take a copy of

it. Within two working days, the registered manager informed us they had requested and received this from the relevant staff member and it was now held on their file. Where relevant, the files contained copies of staff's dental indemnity and General Dental Council (GDC) registration certificates.

There were also Disclosure and Barring Service (DBS) checks present for two staff members. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults. The third staff member did have one but they could not find this in their records.

The practice had a system in place to monitor the professional registration and dental indemnity of its clinical staff members. One of the staff members had not yet given a copy of their updated GDC certificate to the area manager but we saw evidence that they held current registration.

## Monitoring health & safety and responding to risks

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

The practice had arrangements in place to monitor health and safety. There was a general risk assessment for the practice to help identify potential hazards. This included areas such as manual handling and slips, trips and falls.

We reviewed several risk management policies. An internal fire risk assessment had been carried out by the practice manager in January 2017. Staff were encouraged to carry out online training on an annual basis and we saw certificates to confirm completion. We saw evidence that the fire extinguishers had been serviced in December 2016 and they were visually checked and documented every week by staff at the practice. Fire drills took place every week to ensure staff were rehearsed in evacuation procedures. Staff carried out and recorded weekly checks of the fire alarms. Information about fire safety was displayed throughout the building for staff and patients. The fire exits on the ground floor had clear signage to show

# Are services safe?

where the evacuation point was apart from one door. Within two working days, the registered manager told us that they had ordered an additional sign which would be displayed in a prominent position.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to contain risk assessments for most relevant substances. A risk assessment for amalgam was not contained within the COSHH file but this was added within two working days.

## Infection control

There was an infection control policy and procedures to keep patients and staff safe. The policy was reviewed in January 2016 and was dedicated to the practice. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. However, some improvements were required. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff. One staff member's immunisation record was present but not all details were present to confirm they had adequately responded to the course of immunisation. Within three working days, the registered manager forwarded us information from the staff member's occupational health physician and this confirmed that they were immune. Another staff member's immunisation records were not held at the practice and these were emailed to us within two working days. However, the record that was sent to us did not confirm they had adequately responded to the course of immunisation.

We observed the treatment rooms and the decontamination area to be visually clean. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition; however, the skirting board in one treatment room was scuffed in one area.

Dental chairs were covered in non-porous material which aided effective cleaning. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Hand washing protocols were displayed appropriately in various areas of the practice.

Decontamination procedures were carried out in a dedicated area but this was not a separate room. It was separated from one of the treatment rooms by an alcove. In accordance with HTM 01-05 guidance, staff described a dirty-to-clean workflow system in this area and there was clear signage to demarcate the clean and dirty zones. An instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination area.

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

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged and stored in accordance with current HTM 01-05 guidelines. However, not all of the instruments were date stamped as required by HTM 01-05. Where instruments are to be stored, the date by which they should be used or by which they are subject to a further decontamination cycle should be clearly indicated on the packaging. Within two working days, the registered manager informed us that this was carried out for all instruments and that email reminders had been sent to all staff.

There appeared to be sufficient instruments available and staff confirmed this with us. Staff we spoke with were aware of disposable items that were intended for single use only and there was also a policy present.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually

# Are services safe?

with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

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

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument. This was easily accessible as it was displayed in the decontamination area. Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

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

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. Audits had been carried out but these were not collective practice audits. Staff members were carrying these out individually. This was not in line with current guidance. Within two working days, the registered manager informed us that they had completed an audit.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We reviewed the Legionella risk assessment and this was carried out by a specialist contractor in February 2015. We saw evidence that the practice recorded quarterly checks of

the water temperature to ensure that the temperature remained within the recommended range. They also carried out quarterly dipslide tests to ensure that the quality of the water was satisfactory.

The decontamination area did not have a window or a mechanical ventilation system to provide airflow as set out in HTM01-05. The registered manager informed us they had arranged an appointment with an external contractor to discuss the installation of mechanical ventilation. This meeting was scheduled for the week after our visit.

## Equipment and medicines

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

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in June 2016 and these tests were repeated annually by a specialist company. One of the dental nurses carried out visual checks daily at the practice.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked. All prescriptions were stamped only at the time of issue.

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

Stock rotation of all dental materials was carried out on a weekly basis by the dental nurse and all materials we viewed were within their expiry date. There was no system in place for ensuring that all processed packaged instruments were within their expiry date as most dental instruments did not have expiry dates recorded on the packaging.

## Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used digital X-rays.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure

## Are services safe?

that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed and these were reviewed in April 2016.

We did not see evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this. The registered manager notified the HSE and was awaiting acknowledgement from them at the time of writing this report.

The X-ray equipment in one treatment room only was fitted with a part called a rectangular collimator. Using these is good practice as it reduces the radiation dose to the

patient. Within two working days, the registered manager informed us that they had ordered another rectangular collimator and this was to be fitted in the second treatment room.

Essential training is required in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The practice did not hold evidence of this training for one dentist. Within two working days, we received evidence that the training had been completed to an appropriate level since our visit.

We saw evidence that the practice carried out an X-ray audit in December 2016. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that the results were analysed and reported on.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

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

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

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

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

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

### Health promotion & prevention

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

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

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

### Staffing

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

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

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that dental nurses were often transferred from the providers' other local practices and staff were happy to travel between the two locations if required. Some of the existing staff had recently taken maternity leave and the practice manager was currently in the process of recruiting additional dental nursing staff.

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

We were told that the dental nurses were encouraged to carry out further training. One of the dental nurses was considering additional training which would enable them to take dental X-rays.

# Are services effective?

(for example, treatment is effective)

A dental nurse always worked with each dentist and hygienist. The General Dental Council (GDC) recommends that dental staff are supported by an appropriately trained member of the dental team at all times when treating patients.

## **Working with other services**

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist dental services for complex oral surgery and dental implants. We viewed one referral letter and noted that it was comprehensive to ensure the specialist services had all the relevant information required. One of the dentists had a special interest in root canal treatment and the practice would receive referrals from dentists outside the practice. We reviewed one letter that was sent to the referring dentist on completion of treatment and noted this also included all relevant information.

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

## **Consent to care and treatment**

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

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Information about the MCA was readily available in the kitchen for staff. One of the dentists we spoke with was due training in the MCA although they displayed good knowledge of its core principles. Within two working days, the dentist had completed training in the MCA and sent us a copy of the certificate to verify this.

Staff members we spoke with were familiar with the concept of Gillick competence regarding 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.

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

# Are services caring?

## Our findings

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

Fourteen patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was overwhelmingly positive about the care they received from the practice. They described staff as caring, efficient and professional. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were sensitive to their needs.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. There was a confidentiality clause in all of the staff employment contracts. Staff told us they had individual

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

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

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

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment (where applicable) was discussed with them and this information was also provided to them in the form of a customised written treatment plan.

Examination and treatment fees were displayed in the waiting room.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as the treatment rooms were on the ground floor. There was car parking available for patients with physical disabilities near the main entrance to the practice. There were toilet facilities available on the ground floor but these were not wheelchair-accessible.

A practice leaflet was available for patients and this included information about dentists, opening hours, emergency arrangements, etc. The leaflet stated that the practice offered a hearing induction loop and toilet facilities that were wheelchair-accessible, however, this was not the case. Within two working days, the registered manager informed us that the leaflet had been amended to reflect the current situation at the practice.

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

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

Patient feedback confirmed that the practice was providing a good service that met their needs.

### Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients.

The practice recognised the needs of different groups in the planning of its services. The practice did not have an audio loop system for patients who might have hearing impairments. However, the practice used various methods so that patients with hearing impairments could still access the services. Also, the practice had access to sign language interpreters, if required.

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

### Access to the service

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

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment via the telephone answering service. Patients also had the option to access the providers' local practice on Saturday mornings for urgent treatment.

The practice opened from 8:30am to 5:30pm on Monday to Thursday and from 8:30am to 3:30pm on Fridays.

### Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and accessible to patients.

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

# Are services well-led?

## Our findings

### Governance arrangements

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

### Leadership, openness and transparency

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

The practice had policies regarding the Duty of Candour although not all of the staff were familiar with this policy. There was a whistleblowing procedure for staff to follow if they identified concerns at the practice.

### Learning and improvement

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

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays) and dental care record keeping. The record keeping audit did not include

the hygienist's records but the registered manager informed us that all future audits would include the hygienist's records too. The infection control audits were not in line with current guidance from HTM 01-05.

Staff meetings took place monthly. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date.

All staff (including the dentists) received annual appraisals and we reviewed four of these during our visit. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. An example of this included the refurbishment of some areas of the practice in response to suggestions made by patients. Additionally, they were in the process of obtaining quotes to refurbish the reception area and waiting room. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. The results were not analysed and reported upon so it may be difficult to identify common trends. There was a suggestions box in the waiting room for patients. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. Surveys were carried out for waiting times and patient satisfaction and the results of these were displayed in the waiting room.

Patients had not made any comments on the NHS Choices website at the time of writing this report.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires. The providers had invested in a microscope for the dentist who had a special interest in root canal therapy. The use of magnification may increase success rates for this type of treatment.