

Ward End Dental Practice

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Inspection Report

554 Wash Wood Heath Road
Ward End
Birmingham
B8 2HF
Tel: 0121 327 0578

Date of inspection visit: 2 August 2016
Date of publication: 22/09/2016

Overall summary

We carried out an announced comprehensive inspection on 2 August 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Ward End Dental Practice is a dental practice providing general dental services on a NHS and private basis. The service is provided by six dentists. They are supported by seven dental nurses (five of whom are trainees), a practice manager and a receptionist. The practice manager is also a qualified dental nurse.

The practice is located on a busy road close to local amenities and several bus routes. There is a large car park with a dedicated bay for patients with disabilities. There is ramp access to the premises for people that use wheelchairs, pushchairs and bicycles. The premises consist of a waiting room, a reception area, two treatment rooms, an office, a kitchen, a decontamination room, a private consultation room and accessible toilet facilities on the ground floor. The first floor comprises of a second kitchen, additional toilet facilities, two treatment rooms, a disused treatment room and two storage rooms. There was also a locked room that was rented to a therapist who carried out beauty treatments. Opening hours are from 9am to 6pm from Monday to Friday.

The practice manager 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.

Summary of findings

Thirteen patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with four patients. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff were friendly and polite.

Our key findings were:

- The practice appeared clean and tidy on the day of our visit. Many patients commented that this was also their experience.
- Feedback from patients described the service as friendly and polite. Patients were able to make routine and emergency appointments when needed, although some commented that waiting times needed to be improved.
- The practice carried out effective infection control procedures in line with current guidance. Some shortfalls were identified and most were resolved promptly.
- The practice had systems to monitor and manage risks to patients, staff and visitors. This included infection prevention and control, health and safety, safeguarding, safe staff recruitment and the management of medical emergencies. Some improvements were required and most were actioned promptly.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines and current legislation.
- 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.

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

- Review availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK) and the British National Formulary.
- Review stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock. They should also review their processes for identifying when essential equipment maintenance checks are due so that they are carried out in a timely manner.
- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the 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.

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. Some improvements were required and these were actioned promptly.

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

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'. Some shortfalls were identified and most were resolved in an efficient and effective manner.

Staff told us they felt confident about reporting accidents and incidents. Staff we spoke with 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). Some improvements were required and staff assured us that they would make the necessary changes with immediate effect.

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.

No action



Summary of findings

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

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 appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Some patients commented about the long waiting times for appointments.

The practice had an effective complaints process.

The practice offered access for patients with limited mobility this included a permanent ramp, accessible toilet facilities and a dedicated area in the waiting room for wheelchair users.

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 infection control audits. The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

The practice regularly carried out audits in infection control to help improve the quality of service. These audits had documented learning points with action plans. The practice also completed audits in dental care record keeping and X-rays.

No action



Ward End 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.

We inspected Ward End Dental Practice on 2 August 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice and we reviewed this information from them. 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 one of the providers and their husband (who was a dentist), the practice manager, two dentists, two dental nurses and the receptionist. 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 arrangements for staff to report accidents and incidents. The last accident was recorded in July 2015. The last incident was recorded in 2012. We discussed events with the practice manager and were told that no significant incidents had taken place since then. We were told that learning was shared by discussing with staff individually and in staff meetings too. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

All staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. The practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The registered manager was responsible for obtaining information from relevant alerts and forwarding this information to the rest of the team. We saw evidence that this had taken place in staff meetings. The registered manager also described the practice's arrangements for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for local safeguarding teams and these were accessible to all staff. The registered manager was the safeguarding lead in the practice and had completed enhanced training in October 2014. 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. In-house safeguarding training took place at the practice every December and we saw records to confirm this. We were told that all staff members had copies of safeguarding information in their personnel files.

Staff told us that the dentists routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular 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. The practice held only one rubber dam kit and staff told us they avoided booking two or more endodontic treatments simultaneously and/or consecutively. This had the potential to cause access issues and the registered manager decided to order another kit.

The practice had a system for raising concerns. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

The practice manager was aware of the duty of candour regulation and planned to discuss this with all staff at the next staff meeting. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment.

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

Medical emergencies

The practice had arrangements in place to deal with medical emergencies and these were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). We highlighted some shortfalls and these were promptly resolved.

The practice had access to emergency oxygen and medicines. The practice did not have an automated external defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal

Are services safe?

heart rhythm. There was a fire station situated two buildings away from this practice and they had an agreement with them that enabled them to use the AED in an emergency situation. A code would be provided to the practice if they called the emergency services and this would enable staff to remove the AED from the fire station.

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in this area. All equipment and medicines were stored in a secure area. Staff also received internal training every December as a refresher.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and monthly checks of the medicines. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge but the fridge temperature was not monitored. As a result, the expiry date for this medicine must be adjusted and reduced (the practice must refer to the purchase invoice to show that 18 months have not elapsed since delivery). The practice manager adjusted this accordingly and ordered new glucagon on the day of our visit.

The practice did not have a self-inflating bag for children. Within 24 hours, the practice sent us evidence that this order had been placed.

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

Staff recruitment

The practice had a 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, staff identity verification and curricula vitae. All staff had written references but some had two and some had one. The registered manager told us they would amend their recruitment policy to clarify this process. Within 24 hours, we received an amended policy that clearly stated the number and type of references that would be requested for prospective employees. Where relevant, the files contained copies of staff's dental

indemnity and General dental Council (GDC) registration certificates. One staff member had recently qualified and we saw evidence that they had applied for indemnity insurance.

There were also Disclosure and Barring Service (DBS) checks present for all staff files we reviewed. 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 practice had a system in place to monitor the professional registration of its clinical staff members. The registered manager kept copies of all current GDC certificates.

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. The plan was specific to the practice but did not contain all relevant contact details in the event of an emergency. The registered manager told us they would amend this and make it more comprehensive.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that the fire extinguishers had been serviced in August 2015. We saw evidence that the fire alarms were tested monthly. Fire drills took place at each staff meeting. Fire safety plans were present and emergency action plans were clearly displayed. The practice manager was the fire marshal and this information was displayed in the reception area.

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 be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice mostly followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in

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primary care dental practices (HTM 01-05)'. However, some improvements were required. The practice had a nominated infection control lead who was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of clinical staff files and saw evidence that the immunisation status for Hepatitis B had been tested to ensure the safety of patients and staff. However, some of these results required some clarification. Within 24 hours, the practice manager emailed us to clarify some of these results once they had spoken with the occupational health team at the local hospital. Two staff members' results required further clarification and the practice manager told us they were awaiting their blood results before taking action, if required. Clinical staff had undertaken training in infection control in December 2015.

We observed the treatment rooms and decontamination room to be visually clean and hygienic. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were clean and free from clutter. Dental chairs were covered in non-porous material which aided effective cleaning. One of the labels on the bracket table on the dental chair was adhesive but had partially worn on one side which could pose an infection control risk. There was also a small tear on the side of the dental chair - this should be repaired or covered to aid infection control measures. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable.

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

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

Sharps bins were appropriately located and out of the reach of children. They were signed and dated but not wall mounted. A sharps bin in one treatment room was almost full and we observed a sharp implement sticking out of the bin. This posed a significant risk to staff in the treatment room. We discussed this with the practice manager and they assured us they would monitor this carefully. We were

told that staff would monitor these every time they were in the treatment rooms and the practice manager would double-check these on a weekly basis too. We observed waste was separated into safe and lockable containers for weekly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

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

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

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place. At the time of our visit, they were not documenting the pressure and temperature checks for the autoclaves. On the same day, the practice manager amended the daily checklists for the dental nurses so that these checks were also documented.

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

Are services safe?

The practice manager informed us that environmental cleaning of all clinical and non-clinical areas was carried out daily by an external cleaner. The practice had a dedicated area for the storage of their cleaning equipment.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every six months in line with current guidance. Action plans were documented. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings. We reviewed the most recent audit and highlighted two errors made by staff completing it. This was brought to the attention of the practice manager and they informed us they would check through the 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 saw evidence that a Legionella risk assessment was carried out by an external contractor in February 2011 and there was a certificate from December 2015 which stated that the water quality was satisfactory. The competent person that carried out the risk assessment recommended testing the water temperature on a monthly basis to check that the temperature remained within the recommended range. However, this was not being carried out. Therefore, this was in not in accordance with the recommendations as per the risk assessment.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels and autoclaves. Historically, these were not always serviced within the recommended timeframe but the practice manager told us that they now record this in the practice planner to prevent a recurrence of this.

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 had PAT on an annual basis and we saw evidence this was valid until January 2017.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The prescription number was recorded in the patients' dental care records. The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked. All prescriptions were stamped only at the point of issue. The practice dispensed antibiotics and these were stored securely.

A fridge was used for the storage of some dental materials and an emergency medicine. The temperature was not monitored on a daily basis.

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records and corroborated what they told us by viewing a sample of records.

A stock rotation system was in place for ensuring that all processed packaged instruments were within their expiry date. However, we found several dental materials that had expired. This was discussed with the practice manager and they agreed that immediate action was required to prevent a recurrence. The dental nurses have a daily checklist and this is a comprehensive list of actions that need to be completed every day. The practice manager added an action that included the checking of all dental materials/stock to ensure that they remain within their expiry date.

Radiography (X-rays)

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

A machine was present which previously enabled the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a two-dimensional representation of these. However, this was now clearly marked 'out of use' as it had not been maintained. This would serve as a reminder to all staff to prevent the accidental use of the machine. We were told that they were not planning to undertake any maintenance work on the machine and would dispose of it accordingly in future.

Are services safe?

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

Employers planning to carry out work with ionising radiation are required to notify the Health and Safety Executive (HSE) and retain documentation of this. This was not held in the radiation protection file. Within 24 hours, the practice contacted the HSE about this and forwarded us evidence of the notification shortly after.

The practice held maintenance reports from 2012 and further tests were recommended in 2015. These took place only a few weeks before our visit and the practice manager was awaiting the certificates for this. The practice manager told us that this was overlooked because they previously relied upon the company to remind them when the next tests were due. However, they now recorded this on the practice's planner to prevent a recurrence.

The X-ray equipment in two treatment rooms was fitted with a removable part called a rectangular collimator. This is good practice as it reduces the radiation dose to the patient. The practice manager told us that there were four collimators but two had been accidentally misplaced/disposed of. Currently, the dentists were sharing these collimators. This was not ideal and the practice manager ordered two new collimators on the day of our visit so that all treatment rooms contained one each.

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

We reviewed X-ray audits and saw that these were carried out every three months and included X-rays taken by all dentists. The findings were discussed with the relevant dentist and they signed the audits to confirm this. 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.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date 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). Audits of the records were carried out monthly for all dentists.

We spoke with the dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. We found that these 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 all of the records we viewed. This should be updated and recorded for each patient every time they attend.

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.

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 dentists were recording the BPE for all patients that were age 12 and above. The guidelines recommend that all children above 7 years old have their BPE checked and documented. Within 24 hours, the practice manager emailed us to state that written information would be given to all dentists about this guidance and that it would be discussed at the next staff meeting (which was due to be held the following week).

Health promotion & prevention

Staff told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. However, not all of the dentists were routinely recording this in the patients' dental care records. There were oral health promotion leaflets available in the practice to support patients in looking after their health. Examples included information on oral cancer, diet and gum disease.

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 and topical fluoride applications. Information about this toolkit was clearly displayed in the treatment rooms.

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 confidentiality and X-rays.

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. Some of the dental nurses worked on a part-time basis and had the flexibility to work additional hours when required. Therefore, the practice did not utilise locum dental nurses as their own staff were able to increase their hours.

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.

Working with other services

Are services effective?

(for example, treatment is effective)

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. We viewed three referral letters and noted they were comprehensive to ensure the specialist services had all the relevant information required.

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 documented in the clinical records.

Staff members we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Staff members 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. Written treatment plans were available for all patients. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Thirteen patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with four patients during our visit. Patient feedback was mostly positive about the care they received from the practice. They described staff as friendly, caring and professional. Nervous patients said they felt at ease here and the staff were attentive.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. 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 option of being referred to an external practice for dental treatment under sedation but we were told that most nervous patients were treated in-house.

Conscious sedation involves techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. Methods used by the practice included booking longer appointments for anxious patients so they had ample time to discuss their concerns with staff. The dentist would plan treatment so that simplest procedures were carried out initially. Patients also had the option of seeing a male or female dentist.

The computer system at the practice had a feature that enabled nervous patients to be identified quickly by all staff. This would enable staff to adopt their approach towards the management of anxious patients, if deemed appropriate and necessary.

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. All patients (adults and children) received written treatment plans.

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 two treatment rooms were on the ground floor. There were toilet facilities available on the ground floor and these were wheelchair-accessible. Baby changing facilities were also available at the practice. There was a car parking bay near the entrance for patients with physical disabilities. There was a large waiting room and there was a dedicated area for patients with wheelchairs.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were not always seen on time but they felt the wait was not too long. We were told it was easy to make an appointment but some patients commented that they had to wait a few weeks sometimes for non-urgent appointments. 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 a high proportion of patients failed to attend their appointment. Courtesy calls were made to all patients to remind them of an upcoming appointment. These were made four weeks in advance and, also, one day in advance. Despite this, we saw that there was a high rate of failed attendance. Due to this, dedicated emergency slots were not available but the dentists were able to accommodate patients requiring urgent treatment due to the non-attendance of other patients. The practice had tried using dedicated emergency slots but this had been unsuccessful as most patients requiring urgent treatment do not call the practice but tend to arrive at the practice throughout the working day.

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 such as speaking slowly so that patients could lip read.

The practice regularly used an interpreting service for patients that were unable to speak fluent English as they welcomed patients from different ethnic groups. Several staff members spoke different languages relevant to patients such as Punjabi, Urdu, Romanian and Bengali. Leaflets explaining the NHS charges and exemptions were available in several different languages, including Somalian, French and Urdu.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

Access to the service

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

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

Opening hours were from 9am to 6pm from Monday to Friday.

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 clearly displayed. This included details of external organisations in the event that patients were dissatisfied with the practice's response. Information was also available in the practice information leaflet.

One written complaint had been received in the last 12 months. We saw evidence that this had been appropriately recorded, analysed and investigated. We found that

Are services responsive to people's needs?

(for example, to feedback?)

complainants had been responded to in a professional and timely manner. The practice had a designated complaints lead. We were told that complaints were discussed during staff meetings.

Patients had made comments on the NHS Choices website. The practice had not responded to the positive or negative

entries on the website but were documenting, monitoring and analysing these regularly to identify any common themes. The practice manager told us they planned to respond to individual entries on the website in future.

Are services well-led?

Our findings

Governance arrangements

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

Learning and improvement

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

Staff audited areas of their practice as part of a system of continuous improvement and learning. These included audits of infection control. All of the audits we reviewed had been reported on and had action plans. All audits should have documented learning points so that the resulting improvements can be demonstrated.

Staff meetings took place on a monthly basis. The minutes of the staff meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as complaints, infection control and fire procedures had been discussed in the last 12 months.

The practice manager told us that all dentists received appraisals every two years and all other staff annually. We reviewed a selection of staff files and saw that staff had received appraisals within the last two years. 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. Examples included changing the way that appointments were booked to reduce waiting times for patients. This was carried out in response to suggestions made by patients. We saw that views and suggestions were cascaded to all members of the practice team in staff meetings. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. Patient satisfaction surveys were available for patients to complete but the practice had received a low response rate from patients. The practice made attempts to improve response rates by giving patients pre-paid envelopes to return the surveys but this was not successful. We saw evidence that the results were analysed every month.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires. The practice manager told us they were considering the introduction of written feedback forms for all staff.