

Mr. Emad Moore

Bloxwich Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 13 December 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

Bloxwich Dental Centre has four dentists; two who work full time and two who work part time (this includes the two owners of the practice), five qualified dental nurses who are registered with the General Dental Council (GDC), two trainee dental nurses, a practice manager and a receptionist. The practice's opening hours are 9am to 5pm on Monday to Thursday and 8.30am to 1pm on Friday. The practice closes for lunch each day between the hours of 1pm to 2pm.

Bloxwich Dental Centre provides mainly NHS dental treatments to patients of all ages but also offers private treatment options. The practice has one dental treatment room on the ground floor and two on the first floor. Cleaning, sterilisation and packing of dental instruments takes place in a separate decontamination room. There is a reception with adjoining waiting area and a separate waiting area on the first floor.

Before the inspection we sent Care Quality Commission comments cards to the practice for patients to complete to tell us about their experience of the practice. We received comments from 51 patients by way of these comment cards and during the inspection we spoke with one patient.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.

Summary of findings

- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
 - Patients were treated with dignity and respect.
 - The practice was visibly clean and well maintained.
 - Infection control procedures were in place with infection prevention and control audits being undertaken recently. Staff had access to personal protective equipment such as gloves and aprons.
 - There was appropriate equipment for staff to undertake their duties, however records were not available to demonstrate that all fire safety equipment was serviced or maintained. The practice manager notified us the day following this inspection that an external professional has been booked to complete this on 22 December 2016.
 - Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
 - Staff had been trained to deal with medical emergencies and the provider had emergency equipment in line with the Resuscitation Council (UK) guidelines. However not all medicines were available in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. The practice manager confirmed that the missing medicine would be ordered as a matter of priority and confirmation was received that this had been ordered.
 - There was no signage in place identifying that X-ray machinery was located in the room and critical examination packs for each of the X-ray sets were not available for review. X-ray signage was put in place the day following out inspection.
 - The appointment system met the needs of patients and waiting times were kept to a minimum.
 - The governance systems were effective.
 - The practice was well-led and there were clearly defined leadership roles within the practice. Staff told us they felt supported, involved and they all worked as a team.
- There were areas where the provider could make improvements and should
- Review the practice's systems to ensure that they are in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
 - Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
 - Review the practice's consent policies and procedures giving due regard to the Mental Capacity Act 2005 (MCA) and ensure staff obtain a good understanding of processes involved in consent.

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.

Staff told us that they were confident about reporting incidents, accidents and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and systems were in place for recording events and accidents.

Emergency medical equipment was available on the premises in accordance with the Resuscitation Council UK guidelines. The practice manager confirmed that one emergency medicine would be purchased to ensure that the practice met the requirements of the British National Formulary (BNF). Staff had received training in responding to a medical emergency.

Staff were suitably qualified for their roles and the practice had undertaken relevant recruitment checks to ensure patient safety.

Decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use. Infection control audits were being undertaken on a six monthly basis.

No action



Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. Referrals were made to secondary care services if the treatment required was not provided by the practice.

The practice used oral screening tools to identify oral disease. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. Patients' dental care records confirmed that staff were following recognised professional guidelines.

Staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

No action



Are services caring?

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

We observed the staff to be welcoming and caring towards the patients. Staff treated patients with kindness and respect and they were aware of the importance of confidentiality. Patient's privacy and confidentiality was maintained on the day of the inspection.

We received feedback from 52 patients who commented that staff were friendly and helpful. Patients also commented that the staff were polite, caring and always tried to accommodate their needs when booking appointments.

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.

Patients had good access to treatment and urgent care when required. The practice had a ground floor treatment room. Ramped access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference. Staff were familiar with the complaints procedure.

No action



Are services well-led?

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

There were good governance arrangements and a clearly defined management structure in place. Systems were in place to share information with staff by means of monthly practice meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us that the culture within the practice was open and transparent.

No action



Bloxwich Dental Centre

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.

This inspection took place on 13 December 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with five members of staff. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records.

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

Detailed systems were in place to enable staff to report incidents and accidents. An accident book and significant event reporting forms were available. Staff spoken with were aware of the location of accident and incident records and they told us that they took responsibility for completion of these forms which were then passed on to the practice manager. We were told that incident reporting forms were available in each treatment room, from reception or these were available on each computer desktop. The practice manager told us that staff were encouraged to complete incident forms and the information would be used to aid learning and to prevent such incidents from re-occurring.

We saw that 19 incident forms had been completed. Incidents recorded were varied. For example an error message on the autoclave or a staff sharps injury. Reporting forms were comprehensive and included details of the incident, summary of action taken, lessons learnt, details of changes implemented as a result and the date of the staff meeting in which the incident was discussed.

We were shown a copy of the incident policy and separate documentation available to guide staff regarding immediate actions to be taken in the event of an adverse incident.

We were shown accident records and saw that there had been three staff or patient accidents within the last 12 months with the date of the last accident being 16 November 2016.

We saw that accidents and incidents were a standard agenda item for discussion at practice meetings. The practice manager told us that the policies and procedures were reviewed whenever there was an incident or accident; however the date of last review was not recorded on the policy. The practice manager was aware of this and confirmed that they were in the process of addressing this issue.

Information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) was

available for staff. Staff spoken with were aware of what issues required reporting under RIDDOR regulations. We were told that there had been no events at the practice that required reporting under RIDDOR.

We discussed national patient safety and medicines alerts with the practice manager. We were told that they had not received many for this practice recently. However they were receiving these for the sister practice where the practice manager also worked and which was owned by one of the dentists who owned this practice. We discussed recent alerts and found that the practice had been informed about the majority of these. The practice manager confirmed that they would re-register to ensure that the practice received all of the necessary alerts.

The practice had developed a Duty of Candour policy and discussions had been held with staff regarding duty of candour. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff we spoke demonstrated a clear understanding of the principles of candour.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. Contact details for the local organisations responsible for child protection and adult safeguarding investigations were available. The practice manager confirmed that they reviewed these details a few times a year to ensure that they were up to date. We saw that the date of review was recorded on the document.

The practice manager had been identified as safeguarding lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. We were told that there had been no safeguarding issues to report.

We saw evidence that the majority of staff had completed the appropriate level of safeguarding training. Update training was booked for some staff in March 2017 and one member of staff had not completed any safeguarding training recently. On-line training was available to all staff.



Are services safe?

Leaflets and posters regarding safeguarding and domestic abuse were on display in the waiting room.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 21 April 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed sharps injuries with the practice manager and we looked at the practice's sharps policies. We were told that there had been one sharps injury at the practice. Needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist.

The practice had developed an inoculation injuries policy which was on display in the decontamination room. A copy was also available in each treatment room in a folder giving easy access for staff to this information. Contact details for the local occupational health department were recorded on these policies. Sharps bins were stored in appropriate locations which were out of the reach of children.

We asked about the instruments which were used during root canal treatment. We found that although a rubber dam kits were available, they were not used routinely by all dentists who worked at the practice. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work).

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support either on 4 January 2016 or 5 May 2016.

Emergency equipment including two oxygen cylinders and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available. We saw records to demonstrate that weekly checks were made on this equipment to ensure that it was in good working order. We saw that oropharyngeal airways (these are available in five sizes and support the airway in an unconscious or semi-conscious patient) were missing from the medical emergency equipment. We were told that the practice had been advised to dispose of these pieces of

equipment. However the Resuscitation Council UK guidelines records that this equipment should be available. There was no signage to demonstrate that oxygen was in use at the practice. The practice manager ordered the sign and medicine during the inspection and following this inspection we received confirmation that these had been received at the practice.

The majority of emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. However, we saw that the practice did not have a supply of buccal midazolam in line with BNF guidance. Buccal midazolam is a medicine used to stop seizures and is given into the buccal cavity (the side of the mouth between the cheek and the gum). The practice manager confirmed that they would order this medicine as a matter of priority. The day following our inspection we received email confirmation that this medicine had been ordered. Records confirmed that emergency medicines were checked weekly by staff.

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. Records were available to demonstrate that equipment in the first aid box was also checked on a monthly basis to ensure it was available and within its expiry date.

The practice manager was the designated first aider and we were shown evidence to demonstrate that they had completed first aid training in March 2014; this was due for update in March 2017.

Staff recruitment

We discussed the recruitment of staff and were shown staff recruitment files. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary and a Disclosure and Barring Service (DBS) check (or a risk assessment if a DBS was not needed). We looked at four staff recruitment files and saw that the information required was available. A standard layout was used in each file for ease of access to information.



Are services safe?

We were told that one member of staff required a DBS check which had been applied for and checks had already been completed for all other staff. We saw evidence of this in the staff recruitment files that we reviewed. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that the practice had developed a health and safety policy which had been reviewed on an annual basis. The principal dentist and co-owner were the named leads regarding health and safety. All staff spoken with said that they could speak with either of these people or the practice manager for health and safety advice if required. A health and safety poster was on display in the office area behind the reception.

The practice manager had recently completed health and safety training and confirmed that they were aware that risk assessments were now slightly overdue for review but a new system was being implemented. We were told that the practice manager intended to complete all of the practice's risk assessments again using a new format and documentation. Numerous risk assessments had been completed such as a practice risk assessment, radiation, sharps and a fire risk assessment.

We discussed fire safety with staff and looked at the practice's fire risk assessment. The fire risk assessment was completed on 19 October 2015 and would be reviewed as part of the new system of risk assessments being introduced. We saw records to confirm that smoke alarms were tested on a weekly basis and that fire drills were completed on a six monthly basis.

Records seen confirmed that fire extinguishers were subject to routine maintenance on 10 May 2016 by external professionals. There were no records to demonstrate that emergency lighting or smoke alarms had been serviced and there were no records to demonstrate regular testing of emergency lighting. The practice manager said that this had not taken place but confirmed that they would contact an external professional to service this equipment as soon

as possible. Following this inspection we received email confirmation that an external professional company were attending the practice on 22 December 2016 to complete servicing of firefighting equipment.

A well organised COSHH file was available. Details of all substances used at the practice which may pose a risk to health were recorded in alphabetical order in a COSHH file. We were told that any new products were discussed at a staff meeting before being introduced for use at the practice. Documentation seen demonstrated that this file was checked on an annual basis by the practice manager. Staff had signed documentation to demonstrate that they had read and understood the information in the COSHH file.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and staff and patient toilets were visibly clean, tidy and uncluttered. An external cleaning company were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. This company provided all cleaning equipment which was not kept at the practice.

Infection prevention and control policies and procedures had been developed to keep patients safe. These were kept in an infection control folder; all of the contents of this folder were reviewed on an annual basis with the last review taking place in December 2016. This folder contained various infection prevention and control related policies, for example decontamination processes, infection prevention and control, hand hygiene and a blood borne virus policy.

Staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff and records were available to demonstrate this.

Infection prevention and control audits were completed on a six monthly basis. The decontamination lead from Walsall Health Care Trust had completed an audit on an annual basis with the date of the last audit being January 2016. An annual in-house audit was also completed by staff at the practice. The last audit completed was 4 December 2016 and the practice achieved an assessment score of 99%. We



Are services safe?

looked at some of the recent audits and saw that outcomes, improvements and action plans were recorded. Infection prevention and control was discussed at staff meetings.

Records demonstrated that all staff had undertaken training regarding the principles of infection control. All staff completed annual training and we saw evidence of online training and external courses attended.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. PPE stored in the decontamination room was well organised and a log was kept to ensure sufficient stock was always available. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

We looked at the procedures in place for the decontamination of used dental instruments. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). Decontamination of used dental instruments took place in a separate decontamination room which had clearly identified zones in operation to reduce the risk of cross contamination.

The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. The practice manager confirmed that it had been identified that a visual inspection was not always undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. Staff had been made aware that this procedure should always be completed. There was a clear flow of instruments through the dirty zone to the clean area. Staff wore PPE during the process to protect themselves from injury which included gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. Packaged instruments were appropriately stored in cupboards and rotated to ensure appropriate usage.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines.

A risk assessment regarding Legionella had been carried out by an external agency in November 2016. The only issue for action relating to taking photographs of dip slide test results which was now being completed. We saw records to confirm that quarterly water sampling was being undertaken by an external organisation.

We looked at waste transfer notices for 2016. We saw that the practice had a contract in place regarding the disposal of clinical and municipal waste. Evidence seen demonstrated that clinical waste was collected on a monthly basis. Clinical waste was securely stored in an area that was not accessible to patients. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

The practice had maintenance contracts for essential equipment and records seen demonstrated the dates on which the equipment had recently been serviced. For example compressors had been serviced on 15 April 2016 and the autoclaves serviced in September 2016. All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) on 4 January 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test. Other records demonstrated that fixed wiring had been checked on a five yearly basis with the next check due in June 2018, we also saw documentation to confirm that the practice completed an in-house electrical check.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. There were no records to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. The practice manager confirmed that they would purchase a thermometer for the fridge during and monitor and record the fridge temperature on a daily basis. The day following our inspection we received confirmation that a thermometer had been purchased and daily fridge temperatures were now being taken and recorded.



Are services safe?

Prescription pads were securely stored and a log of each prescription issued was kept. This recorded details of the date, prescription number and patient code.

Radiography (X-rays)

The registered manager told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure equipment was operated safely and by qualified staff only. We saw evidence that the dentists were up to date with the required radiography continuing professional development.

Local rules were available in one of the treatment rooms where X-ray machines were located. These should be available for all staff to reference if needed.

There was no signage in place identifying that X-ray machinery was located in the room.

We saw that the practice had notified the Health and Safety Executive on the 10 May 2012 that they were planning to carry out work with ionising radiation.

Copies of the maintenance logs for each of the X-ray sets were available for review. The maintenance logs were within the current recommended interval of three years. Critical examination packs for each of the X-ray sets were not available for review.

Dental care records where X-rays had been taken showed that dental X-rays were justified,

and reported on every time. The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines.

We saw a recent X-ray audit completed in November 2016. Audits were available for each dentist who had taken an X-ray on a monthly basis. Audits help to ensure that best practice is being followed and highlight 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

We discussed patient care with the dentist and checked dental care records to confirm the findings. The practice kept up to date detailed electronic dental care records.

We were told that following discussions and update of medical history records, an examination of the patient's teeth, gums and soft tissues was completed. Detailed records were kept which included details of the condition of the teeth and the gums using the basic periodontal examination (BPE) scores. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). A proforma was available on the practice's computer system to enable details of the assessment of the soft tissues lining the mouth to be recorded.

Risk factors such as oral cancer, dental decay, gum disease and patient motivation to maintain oral health were taken into consideration to determine the likelihood of patients experiencing dental disease. Smoking and alcohol intake were recorded as part of the oral cancer assessment.

The Dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. Oral hygiene assessments were recorded.

Following the clinical assessment patients were made aware of the condition of their oral health; the diagnosis was then discussed and treatment options explained in detail.

Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE), particularly in respect of lower wisdom teeth removal and antibiotic prescribing. NICE guidance was also used to determine recall intervals for patients.

Patient dental care records that we were shown demonstrated that the dentist was following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. The dentist applied fluoride varnish to the teeth of children aged three to 18 where appropriate and to adults with a high dental caries risk. High concentration fluoride was prescribed for adults as required and advice and guidance was given about dental hygiene including explaining tooth brushing and interdental cleaning techniques.

Medical history forms completed by patients included questions about smoking and alcohol consumption. The practice manager and a dental nurse explained that new patients initially completed and signed a paper copy record regarding their medical history. Following this the dentist discussed patient's medical history with them at each visit to the practice and their computer records were updated. Reception then asked patients to sign an electronic signature pad to confirm that their medical history had been discussed and records were correct. Patients we spoke with told us that they were asked regularly to update their medical history.

Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice. Oral health promotion leaflets and information about dental treatments were on display in the waiting room. A large display in the waiting area explained the dangers of hidden sugars in drinks. The practice participated in national smile month and provided advice and information to patients. Details of discussions regarding improving oral health were recorded in patient dental care records.

Staffing

Practice staff included four dentists, two who work full time and two who work part time (this includes the two owners of the practice), five qualified dental nurses who are registered with the General Dental Council (GDC), two trainee dental nurses, a practice manager and a receptionist.

Detailed induction records were available for all staff including those who had recently been employed. More in-depth induction training was provided to trainee dental nurses which ran alongside training provided at college. A



Are services effective?

(for example, treatment is effective)

six month probationary review meeting was held to ensure all staff were confident in their roles, probationary periods would be extended when it was identified that further training was required.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave. There was enough staff to support the dentist during patient treatment. We were told that these staff always worked with a dental nurse.

Appraisal systems were in place. We saw that personal development plans were available for staff. We were told that discussions were held with staff about continuing professional development (CPD) and training during appraisal meetings. CPD is a compulsory requirement of registration as a general dental professional. We saw evidence to demonstrate that staff had undertaken core CPD training such as safeguarding (including mental capacity), infection control and basic life support. Some staff had also completed training in other specific dental topics such as decontamination, information governance and dental radiography.

Records seen confirmed that professional registration with the GDC was up to date for all relevant staff and monitoring systems were in place to ensure staff maintained this registration.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required

Sedation, oral medicines and orthodontics.

We saw a template that was used in the treatment room to refer patients a copy of this was scanned onto patient records and reception staff tracked progress to ensure patients received their referral appointment.

Consent to care and treatment

The practice had developed and implemented a consent policy although this did not reference 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.

Not all staff spoken with were fully aware of the MCA and best interest decisions. However, we were told that support would be obtained where patients were unable to give consent. There were no examples of patients where a mental capacity assessment or best interest decision had been needed.

Not all of the staff spoken with demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. We were told that patients were given verbal and written information to support them to make decisions about treatment. Any risks involved in treatment were not always recorded. Elements of the consent process were recorded in patient care records that we were shown.

Information leaflets were available to assist with the decision making process. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment.

We saw that consent was reviewed as part of a recent record card audit. This had been completed by all four of the dentists at the practice in June 2016 and three of the dentists in December 2016.



Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Music was played in treatment rooms; this helped to distract anxious patients. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. Staff said that they could speak to patients in the room behind reception or in an unused treatment room if a confidential discussion was requested.

The practice did not keep paper records, reducing the opportunity for confidential information to be overseen. Computers were password protected and regularly backed up to secure storage. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. Patients provided overwhelmingly positive feedback about the practice on comment cards which were completed prior to our inspection. Patients we spoke with during the inspection said that they were always treated with respect; we were told that staff were caring, helpful and professional.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. We were told that staff took their time to fully explain treatment, options, risks and fees. We saw that clear treatment plans were given to patients which detailed treatment and costs. We saw evidence in the records that we were shown that the dentists often recorded "patient discussion" without recording further information regarding the options discussed. However patients commented they felt involved in their treatment and it was fully explained to them.

Information about NHS and private costs were available in the waiting area for patients to review.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

At the time of our inspection the practice were taking on new NHS patients and a new patient appointment could be secured within a week of the initial contact. Patient comments indicated that the practice made every effort to secure an appointment at a time and day that was convenient.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. There were vacant appointment slots to accommodate urgent appointments. We were told that 'emergency appointment' slots were kept free each morning for each dentist. Once these appointments were filled patients were asked to visit the practice and were told that they would have to sit and wait to see the dentist.

Patients were reminded of their appointment by an agreed method; for example letter, text or telephone call.

Feedback confirmed that patients were rarely kept waiting beyond their appointment time. The receptionist told us that if there was ever a delay, which was rare, they would speak with the patient, inform them of the delay and offer an alternative appointment if this was preferable.

Tackling inequity and promoting equality

The practice did not have a hearing induction loop for use by people who were hard of hearing and no contact details for an external company to provide assistance with communication via the use of British sign language. Staff spoken with told us that they did not have difficulty communicating with patients who were hard of hearing as these patients were able to lip read. However, the practice manager confirmed that they would obtain contact details for British sign language interpreters and ensure all staff were made aware of this information.

We asked about communication with patients for whom English was not a first language. We were told that currently all patients were able to communicate using English language. We saw that contact details for a translation service were available for use if required.

This practice was suitable for wheelchair users, having a ground floor treatment room with a portable ramp used to access the front of the building and the single internal step to access the ground floor treatment room; however the practice did not have an adapted toilet to meet the needs of patients with a disability. We were told about the planned changes to the practice which would address these areas.

Access to the service

The practice was open from 9am to 5pm on Monday to Thursday and 8.30am to 1pm on Friday (closed between 1pm to 2pm). The opening hours were displayed in the entrance to the practice and on the practice leaflet.

A telephone answering machine informed patients that the practice was closed at lunchtime and also gave emergency contact details for patients with dental pain when the practice was closed including during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone or in person. Emergency appointments were set aside for the dentist every day that the practice was open; this ensured that patients in pain could be seen in a timely manner. Patients commented that they were able to see a dentist easily in an emergency.

Concerns & complaints

A member of staff we spoke with was able to describe the complaints process. We were told that the complaint policy was available to all staff and a copy was on display in the waiting area. Patients who wished to make a complaint were given a copy of the policy if requested. Staff said that they aimed to resolve all complaints immediately whether verbal or written. Patients would be offered an apology and a meeting with the practice manager or one of the providers. All complaints, whether verbal or written were recorded on a complaint log sheet along with details of the complaint. Complainants would receive a letter of acknowledgement within the timescale recorded on the complaint procedure.

The practice's complaints policy set out how complaints would be addressed, who by and the timeframes for responding. The policy also recorded contact details such



Are services responsive to people's needs? (for example, to feedback?)

as NHS England and the General Dental Council. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice.

As part of induction training all staff read the practice's complaints policy and received in-house training regarding this. We were told that trainee dental nurses were not able to handle any complaints until they had received further training.

We saw that two complaints had been received during 2016.

Information regarding 'Duty of Candour' was available on file for staff to review. This recorded that patients would be informed of any incident that affected them; they would be given feedback and an apology. Staff spoken with felt that by being open and honest, offering an initial apology and immediate assistance to sort out any problems mitigated the risk of receiving complaints.



Are services well-led?

Our findings

Governance arrangements

The practice manager and providers were in charge of the day to day running of the service. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice such as complaints management, safeguarding and infection control.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. All policies were available to staff on the practice's computers and in a practice handbook. A separate folder was available in each treatment room which helped staff gain access to important information that may be required in an emergency situation. For example child protection and adult safeguarding policies and contact details and other emergency procedures.

Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, sharps, infection prevention and control, radiography and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately. The practice manager informed us that these risk assessments were overdue for their annual review. However following attendance at a health and safety training update the practice manager intended to amend all risk assessments to record more detailed information.

As well as regular scheduled risk assessments, the practice undertook clinical audits. These included six monthly infection prevention and control audits, audits regarding clinical record keeping and radiography. We saw evidence to demonstrate that all audits and risk assessments were reported on and action plans completed.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us that they worked well as a team and provided support for each other. We were told about social events organised for staff by way

of thanks for a job well done and other team bonding events organised throughout the year. Staff we spoke with told us that they felt supported and involved at the practice.

We saw that practice meetings took place on a monthly basis. Staff said that if they were unable to attend the meeting they were sent a copy of the meeting minutes and could have a discussion with the practice manager to obtain an update. The minutes of practice meetings were available to staff on the computer desktop.

We spoke with staff about communication within the practice. We were told that the practice manager was always available, either on the telephone or in the practice, to provide assistance and advice. Staff said that they were able to speak out about issues or concerns at any time including appraisal meetings and practice meetings. We were told that there was a blank agenda on the reception and staff were able to record any issues that they wished to discuss during the practice meeting.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a six monthly basis. Walsall Health Care Trust completed an infection control audit on an annual basis and the practice completed an in-house infection control audit on an annual basis. We saw that reports and action plans were available. The last audit completed by Walsall Health Care Trust was dated January 2016 and the practice's in house audit was 4 December 2016. Other audits included radiography and record card. We saw that record card audits had been completed in June and December 2016 and a radiography audit in November 2016. Action plans were recorded as required and reported upon.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The practice manager had introduced a system of monitoring to ensure staff were up to date with their CPD requirements and staff said that support was provided to enable them to complete training required. Annual appraisal meetings were held and personal development plans available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

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



Are services well-led?

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. There was a comment book and suggestions box in the waiting area and satisfaction surveys were given to patients twice per year. A member of staff had the responsibility for reviewing and correlating the results. Staff spoken with told us that any patient feedback was always

discussed during practice meetings. This included any comments made in the suggestions box, comments book, friends and family test (FFT) and the practice's satisfaction survey results

The practice participated in the FFT which is a national programme to allow patients to provide feedback on the services provided. At the time of this inspection 100% of patients who responded to the FFT (8 patients) would recommend the practice.