Mr. Neil Thomas Appleby

# Appleby and Associates Dental Practice

## Inspection Report

**227 Lincoln Road**
**North Hykeham**
**Lincoln LN6 8NH**
Tel:**01522 687000**
Website: no website

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **No action** ✓ |
| Are services safe? | **No action** ✓ |
| Are services effective? | **No action** ✓ |
| Are services caring? | **No action** ✓ |
| Are services responsive? | **No action** ✓ |
| Are services well-led? | **No action** ✓ |

## Overall summary

We carried out an announced comprehensive inspection on 23 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

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

**Are services effective?**

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

**Are services caring?**

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

**Are services responsive?**

# Summary of findings

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**

Appleby and Associates Dental Practice is a dental practice providing private care for adults and private and NHS care for children. Some treatment is provided under a fee per item basis and some under a dental insurance plan. The practice is situated in a converted single storey property; therefore all patient facilities are on the ground floor.

The practice has two dental treatment rooms and a separate decontamination room where cleaning, sterilising and packing of dental instruments takes place. There is also a reception and waiting area and other rooms used by the practice for office facilities and storage. The practice is open from 8.00am to 7.30pm on Mondays, from 8.00am to 5.00pm Tuesday to Thursdays and from 8.00am to 4.30pm on Fridays. The practice shuts for lunch between 12.30pm and 1.30pm each day.

The practice has two dentists and is able to provide general dental services including endodontic (root canal) treatment. They both work four days per week. They are supported by a part time hygienist and six part time dental nurses who also carry out reception duties.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We also spoke with patients on the day of our inspection. We received feedback from 35 patients. These provided an overwhelmingly positive view of the services the practice provides. Patients commented on the high standard of care, the friendliness and professionalism of staff, the cleanliness of the practice and the efficiency of all staff.

**Our key findings were:**

- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect; and they were involved in discussions about treatment options.
- Patients said they had no problem getting appointments whether routine or more urgent.
- The practice was visibly clean and well maintained and infection control standards were in line with national guidance.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD). However they had not received appraisals of their performance.
- The practice had suitable facilities and was well equipped to treat patients and meet their needs. However the practice did not have access to a translation service for patients who did not speak English, or a hearing loop to support patients with a hearing impairment.
- The practice had medicines and equipment for use in a medical emergency which were in accordance with national guidelines. However the frequency these were checked was not in line with national guidance. Some equipment was out of date on the day of our inspection but replaced immediately.
- There was a system to identify, investigate and learn from significant events. However there were inconsistencies in how incidents were reported and recorded.
- Some governance arrangements were in place for the smooth running of the service. However we found that risks in respect of fire had not been assessed and policies relating to key areas were not available.

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

- Review the practice's system for the recording, investigating and reviewing incidents or significant events to ensure events are recorded and investigated appropriately.
- Review the availability of a hearing loop for patients with hearing difficulties and translation services for patients whose first language is not English.

# Summary of findings

- Review stocks of medicines and equipment and the system for identifying and disposing of out-of-date stock.
- Review governance arrangements, including acting on recommendations of the fire risk assessment, making appropriate policies available and implementing staff performance appraisals.
- Review the security of prescription pads in the practice to ensure there are systems to monitor and track their use with reference to the NHS guidance on security of prescription forms August 2013.

# 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?**

No action

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

The practice had a system to identify, investigate and learn from significant events, although there were inconsistencies in the processes.

There were sufficient numbers of suitably qualified staff working at the practice.

Staff had received safeguarding training and were aware of their responsibilities regarding the protection of children and vulnerable adults.

X-ray equipment was regularly serviced to make sure it was safe for use.

Infection control procedures were in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health. Infection control procedures were audited to ensure they remained effective.

Most risks to staff and patients had been assessed and control measures or identified actions been implemented. However the risks relating to fire had not been assessed but the provider took steps to address this both during and after our visit.

**Are services effective?**

No action

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. The clinicians used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

The staff received on-going professional training and development appropriate to their roles and learning needs. Dental nurses had received training to enable them to carry out extended duties such as fluoride varnish application and taking X rays.

Clinical staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

The practice had a process in place to make referrals to other dental professionals when appropriate to do so.

**Are services caring?**

No action

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

We received feedback from 35 patients and these provided an extremely positive view of the service the practice provided. Comments reflected that patients were very pleased with the care they received and commented on the welcoming, warm and friendly nature of the staff. Patients told us treatment options were explained to them and they were involved in decisions about their treatment.

# Summary of findings

We observed that patients were treated with dignity and respect and the confidentiality of patients' private information was maintained.

**Are services responsive to people's needs?**

**No action** 

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

The practice had good facilities and was well equipped to treat patients and meet their needs.

Routine dental appointments were readily available, as were on the day appointments for urgent cases. Patients told us they never had a problem getting an appointment with the practice. Information was readily available for patients in the practice.

The premises were adapted to meet the needs of disabled patients and all patient services were on the ground floor. Treatment rooms were fully wheelchair accessible and there was a disabled toilet.

Information about how to complain was available to patients. The practice had responded appropriately to complaints received.

The practice did not have access to a translation service for patients who did not speak English or have a hearing loop to support patients with a hearing impairment.

**Are services well-led?**

**No action** 

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

There were some policies and protocols in place to assist in the smooth running of the practice but other key policies were not available.

There was an open culture and staff were well supported and able to raise any concerns. However staff had not received appraisals of their performance.

There were regular staff meetings.

Feedback was obtained from patients and we saw evidence that this was discussed and acted upon to make improvements to the service provided.

# Appleby and Associates 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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

We carried out an announced, comprehensive inspection on 23 November 2016. The inspection was led by a CQC inspector who was supported by a specialist dental adviser and a second CQC inspector.

We reviewed information we held about the practice prior to our inspection.

During the inspection we spoke with the principal dentist, the associate dentist, the hygienist and dental nurses.

To assess the quality of care provided we looked at practice policies and 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**
We spoke with the principal dentist about the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR) and found that guidance was provided for staff. Accident forms were available which aided staff to consider when a report was necessary. The last accident reported was in July 2014.

We found that there was a system for reporting, recording and investigation of significant events but it was not consistent. We saw there were significant event reporting forms available in the practice. Our review of practice meeting minutes showed that significant events were a standing item on the agenda and events had been discussed and learning from them implemented. However there were no forms completed in respect of incidents discussed and there was no formal significant events policy document. We discussed this with the principal dentist who told us that going forward events would be recorded on the appropriate forms.

We asked the principal dentist about national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession. They were able to tell us about and show us recent alerts and records of the actions they had taken in response to them.

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 with showed an awareness of this and told us they were encouraged to be open and honest if anything was to go wrong.

**Reliable safety systems and processes (including safeguarding)**
The practice had a comprehensive policy available for safeguarding children which had been reviewed in February 2016. The principal dentist was named as the safeguarding lead for the practice and both dentists had received safeguarding children training to the higher level 3. Other staff had been trained appropriately to level 2. The policy contained up to date contact numbers for the relevant agency for raising a concern and this information was readily available to all staff as it was also displayed on the staff notice board. The practice did not have a formal safeguarding adults' policy but relevant contact details were available.

The practice had an up to date employers' liability insurance certificate which was displayed in the reception area. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969. This was due for renewal in February 2017.

We spoke with both dentists who told us they used rubber dams when providing root canal treatment to patients, although one of the dentists did not use them in every case. We pointed out the need to record the alternative method of isolation used and the rationale for this in line with guidance from the British Endodontic Society. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided.

We spoke with staff about the procedures to reduce the risk of sharps injury in the practice. Most staff were using 'safer sharps' in line with the requirements of the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation. We spoke with the principal dentist who told us they were moving towards all clinical staff using them.

**Medical emergencies**
The practice had medicines and equipment available to manage medical emergencies. These were stored together securely and staff we spoke with were aware how to access them. Emergency medicines were available in line with the recommendations of the British National Formulary.

Equipment for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

There was a system to ensure that all medicines and equipment were checked on a regular basis to confirm they were in date and safe to use. Records we saw showed that the emergency medicines and oxygen were checked on a six monthly basis and the AED on a weekly basis. This was

# Are services safe?

not in line with national guidance from the Resuscitation Council UK. Medicines we checked were in date for safe use. However we found that plastic syringes were out of date. New syringes were ordered immediately.

Staff had completed practical training in emergency resuscitation and basic life support on an annual basis with the last training being undertaken in December 2015. However, staff did not regularly rehearse emergency medical simulations to enable them to practice what to do in the event of an incident.

We saw certificates demonstrating four members of staff had completed a first aid at work course.

**Staff recruitment**

The practice did not have a formal recruitment policy document. We reviewed four staff recruitment files which contained evidence that some of the appropriate recruitment checks had been undertaken, such as qualifications and registration with the appropriate professional body. There was evidence of checks through the Disclosure and Barring Service (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). A DBS check had not been undertaken for two members of staff. However they were long standing members of staff and a risk assessment had been carried out. There was no evidence of references having been sought or photographic identification. The principal dentist told us that they had gained verbal references and seen proof of identification at the time of employment.

**Monitoring health & safety and responding to risks**

The practice had some systems to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had a health and safety policy dated January 2015. A health and safety risk assessment had been carried out and was last reviewed in January 2016. We saw that this included risk assessments relating to blood and saliva, the autoclave, radiation, the use of sharps, and slips, trips and falls in the premises.

The practice did not have suitable arrangements in respect of fire safety in accordance with the Regulatory Reform (Fire Safety) Order 2005.

A fire risk assessment had not been undertaken, there was no written fire policy and although the fire extinguishers had been serviced regularly there were no arrangements for regular maintenance or checks of the fire alarm or emergency lighting. A fire drill had not been carried out in the last three years. We were told that staff had received informal fire training in January 2016. We raised this with the principal dentist who immediately booked a fire risk assessment with an external company for the following week. They provided us with a copy of the report and told us that in line with the recommendations they had made arrangements for staff fire training and maintenance of the equipment.

There were some arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There were risk assessments pertaining to the hazardous substances used in the practice. Safety data sheets were available for dental materials which gave details of actions required to minimise risk but these were not available for non-dental materials such as the products used by the cleaning company.

There was a business continuity policy dated February 2012 which had been recently updated. This outlined the arrangements in case of a major incident such as fire, power failure, loss of the telephone system or incapacity of staff. This gave details of alternative premises to be used if necessary. The plan contained details of contractors who might be required in these instances and staff contact details in order to inform them in an emergency. A copy of the plan was kept away from the practice by the principal dentist and associate dentist.

**Infection control**

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We discussed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had an infection control policy which was dated January 2015 and which had been reviewed in January 2016. This gave guidance on areas which included the decontamination of instruments and equipment, personal protective equipment, waste disposal and environmental cleaning of the premises.

# Are services safe?

The decontamination process was performed in a dedicated decontamination room and we discussed the process with one of the dental nurses.

The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a defined system of zoning from dirty through to clean. Instruments were first cleaned in an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. Instruments were then inspected under an illuminated magnifier before being sterilised in an autoclave (a device used to sterilise medical and dental instruments). After this the instruments were transferred to a sterile area for packaging. The dental nurse demonstrated that systems were in place to ensure that the ultrasonic baths and autoclaves used in the decontamination process were working effectively. We saw that the required personal protective equipment was available to be worn by staff throughout the decontamination process.

The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and general waste were used and stored in accordance with current guidelines. The practice used an appropriate contractor to remove clinical waste from the practice. We saw the relevant waste consignment notices. (When hazardous waste is moved it must be accompanied by correctly completed paperwork called a consignment note.)

Practice staff told us how 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. We saw a Legionella risk assessment which had been carried out at the practice by an external company in July 2015. Control measures had been implemented to reduce the risk of legionella in line with the risk assessment which included the monthly monitoring of water temperatures.

We saw evidence that all clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact).

We saw that the two dental treatment rooms, waiting area, reception and toilets were clean and tidy. In the treatment rooms we found there were some loose and uncovered items in drawers which could become contaminated over time. We also saw there were a large number of burs together in a stand on the work surface creating a possible risk of contamination. A bur is a dental instrument used for cutting hard tissues. We discussed this with the principal dentist who told us loose items would be boxed going forward and they would review storage in the treatment rooms in order to reduce clutter.

Hand washing facilities were available including liquid soap and paper towel dispensers in each of the treatment rooms, the decontamination room and toilet. Each treatment room had the appropriate routine personal protective equipment available for staff use, this included protective gloves and visors.

The practice contracted a cleaning company to carry out environmental cleaning tasks and the nationally recognised colour coding system for cleaning equipment was followed in the practice.

**Equipment and medicines**

We found there was enough suitable equipment for staff to carry out their jobs and there were adequate numbers of instruments available for each clinical session to take account of decontamination procedures. We saw evidence that equipment checks had been regularly carried out in line with the manufacturer's recommendations. The practice's X-ray machines had been serviced and calibrated as specified under current national regulations in July 2016. Portable appliance testing had been carried out in November 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in

February 2015 and a safety certificate issued. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the two autoclaves had been serviced in April 2016.

The dentists used the British National Formulary and were aware of the 'yellow card' system to report any adverse patient reactions to medicines to them.

# Are services safe?

There was not a system to monitor and track the use of prescriptions within the practice in line with the NHS guidance on security of prescription forms August 2013. The principal dentist told us they would implement a prescription logging system.

**Radiography (X-rays)**

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice had an intra-oral X-ray machine in each of the two treatment rooms; these can take an image of one or a few teeth at a time. The practice displayed the 'local rules' of the X-ray machine in the room where each X-ray machine was located. Both X-ray machines were fitted with a rectangular collimator which reduces the radiation dose to the patient.

The practice used exclusively digital X-rays, which were available to view almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

The practice kept a radiation protection file which contained the names of the Radiation

Protection Advisor and the Radiation Protection Supervisor, this being the principal dentist. We found that the X-ray machines had undergone testing and servicing in line with current regulations.

The dentist and dental nurses were trained in radiography and we found that they were all up to date with their radiation training as specified by the General Dental Council.

The justification for taking an X-ray as well as the quality grade, and a report on the findings of that X-ray were documented in the dental care record for patients as recommended by the Faculty of General Dental Practice.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

We spoke with the dentists and found they were following guidelines from the National Institute for Health and Clinical Excellence (NICE) and General Dental Council (GDC) guidelines in relation to lower wisdom tooth removal and dental recall intervals. The GDC is the statutory body responsible for regulating dental professionals.

The dentist carried out consultations, assessments and treatment in line with recognised general professional guidelines. The dentist described to us and we looked at records which confirmed how they carried out their assessment of patients for routine care. The assessment began with the patient completing a medical history questionnaire and their medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer.

Dental care records that we were shown demonstrated that a risk assessment for caries (dental decay) and periodontal (gum) disease was routinely recorded in patient notes. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums).

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive. A justification, grade of quality and report of the X-ray taken was documented in the dental care record.

**Health promotion & prevention**

The practice had one waiting room for patients. A wide range of health promotion leaflets and information was available in the waiting area which included advice on oral health and hygiene, and smoking cessation.

The practice sold a range of dental hygiene products to maintain healthy teeth and gums such as toothbrushes, dental floss and mouthwashes. These were available in the reception area.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. Fluoride varnish is a material that is painted on teeth to prevent cavities or help stop cavities that have already started. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with the dentists showed they had a good knowledge and understanding of 'delivering better oral health' toolkit. Leaflets in the waiting room explained the importance of fluoride and the benefits for patients' teeth. One of the dental nurses was also trained to carry out fluoride varnish applications.

One of the dental nurses was trained as an Oral Health Educator. Staff told us they regularly provided smoking and alcohol cessation advice to patients. Staff were aware of local smoking cessation services in order to refer patients. Appointments were available with a hygienist in the practice on two days of the week to support the dentist in delivering preventative dental care.

One of the dentists had visited local community groups to deliver presentations on good oral health.

**Staffing**

The practice was staffed by the principal dentist and an associate dentist who both worked in the practice four days a week. They were supported by a dental hygienist on two days and six part- time qualified dental nurses who also carried out reception duties. Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). We asked to see evidence of indemnity cover for relevant staff (insurance professionals are required to have in place to cover their working practice) and saw that all staff were covered.

There was a low turnover of staff and patients commented that the continuity of staff was important to them. They described staff as professional and friendly. We found that staff had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the GDC. We found clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding.

Dental nurses were encouraged and supported to undertake extended duties. For example one had been trained in fluoride application and another in oral health education.

# Are services effective?

## (for example, treatment is effective)

We found that the practice did not have a system for induction or staff appraisals and none had been undertaken. Training needs were identified informally. We discussed this with the principal dentist who told us they would introduce a system for appraisals and induction for any new members of staff.

**Working with other services**

The principal dentist explained how they worked with other services. The dentists referred patients to a range of specialists in primary and secondary services when the treatment required was not available in the practice, such as orthodontics some complex endodontic treatment and minor oral surgery. Urgent referrals were made by telephone and then followed up with a fax message. Referrals were also made electronically.

We were told that patients were referred to another dental practice for Orthopantomograms (OPG). These are panoramic scanning dental X-rays of the upper and lower jaw. However there was no service level agreement in place for this.

**Consent to care and treatment**

The Mental Capacity Act 2005 (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. Most staff had undertaken training in the MCA and those we spoke with about it demonstrated knowledge of the act and its relevance when dealing with patients who might not have capacity to make decisions for themselves and where a best interest decision might be required. They also demonstrated their understanding regarding Gillick competence which relates to children under the age of 16 being able to consent to treatment if they are deemed competent.

We spoke with the dentists and found they were able to give examples which demonstrated their understanding of consent issues. They told us how they explained different treatment options and gave patients the opportunity to ask questions before gaining consent. Patients were given a written treatment plan detailing their options, choices and costs involved. Leaflets were also available relating to certain treatments which patients could take away to aid their decision making.

We viewed a sample of patients' dental care records which recorded that the process had been followed and valid consent had been obtained.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Before our inspection, Care Quality Commission (CQC) comment cards were left at the practice to enable patients to tell us about their experience of the practice. We also spoke with patients on the day of our inspection. We received feedback from 35 patients which provided an extremely positive view of the service the practice provided. Patients told us how happy they were with the quality of care they had received and commented that they were always treated with the utmost dignity and respect. Staff were described as having a positive attitude, cheerful and nothing being too much trouble for them. This was reflected during the course of our inspection in the interactions between staff and patients we observed. We saw that staff quickly put patients at their ease with their friendly and welcoming approach.

The confidentiality of patients' private information was maintained as patient care records were computerised and we saw that practice computer screens were not visible at reception which ensured patients' confidential information could not be seen.

Confidentiality was maintained during consultations as treatment room doors were closed when patients were with dentists and conversations between patients and dentists could not be overheard from outside the rooms. Staff told us that if a patient wanted to talk privately they would make use of the staff room.

**Involvement in decisions about care and treatment**

From our discussions with dentists, extracts of dental care records we were shown and feedback from patients it was apparent that patients were given clear treatment plans which contained details of treatment options and the associated costs.

A price guide for treatments was displayed in the waiting rooms and available in a leaflet to take home. Information on monthly payment plans was also available.

Patients commented that they were listened to by staff, good explanations were given and that they had the information they needed to make decisions about their treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

During our inspection we found that the practice had good facilities and was well equipped to treat patients and meet their needs.

In the reception area and waiting room we saw there was a range of information available to patients. This included the practice's patient information leaflet, leaflets about the services offered by the practice, health promotion, complaints information and the cost of treatments. The patient information leaflet included opening hours and emergency arrangements for both when the practice was open and when it was closed.

Patients commented that they were able to get appointments easily and did not feel rushed as they were given sufficient time for their appointments.

Staff said that when patients were in pain or where treatment was urgent the practice saw patients on the same day. To facilitate this, the practice made specific appointment slots available for patients who were in pain. Comments from patients confirmed they had been accommodated in situations where their needs were considered more urgent.

**Tackling inequity and promoting equality**

Some staff had completed equality and diversity training and staff told us they treated all patients equally. The practice had made reasonable adjustments to help prevent inequity for patients that experienced limited mobility or other issues that might have hampered them from accessing services. There was ramped access to the front door and treatment rooms were on the ground floor which made them accessible for patients with limited mobility, as well as parents and carers using prams and pushchairs. There was also a disabled friendly toilet.

The practice did not have access to an interpreting service to support patients whose first language was not English, should this be required. They told us this facility had never been needed or requested to date. The practice did not have a hearing induction loop to assist patients with a hearing impairment. The Equality Act (2010) requires where 'reasonably possible' hearing loops are installed in public spaces, such as dental practices.

**Access to the service**

The practice was open from 8.00am to 7.30pm on Mondays, from 8.00am to 5.00pm Tuesday to Thursdays and from 8.00am to 4.30pm on Fridays. The practice shut for lunch between 12.30pm and 1.30pm each day.

There was car parking to the front of the practice or on street parking nearby.

The practice used the NHS 111 service to give advice in case of a dental emergency when the practice was closed. This information was publicised in the practice information leaflet and through the telephone answering service when the practice was closed.

The practice operated a reminder service for patients for their appointments. Patients received a phone call or text two days before their appointment.

**Concerns & complaints**

The practice had a complaints policy which had been reviewed in November 2016. The policy explained how to raise a complaint and identified time scales for complaints to be made and responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the policy.

Information about how to complain was displayed in the waiting room and complaints procedure information was available for patients. The principal dentist was the person designated as responsible for managing complaints about the practice.

There had been two complaints received in the last 12 months which we found had been responded to in a timely and appropriate manner. We saw that complaints had been discussed in practice meetings and learning from them identified.

# Are services well-led?

## Our findings

**Governance arrangements**

There was a governance framework in place which provided a staffing structure whereby staff were clear about their own roles and responsibilities.

The practice had some arrangements for monitoring and improving the services provided for patients. There were some practice specific policies which had been updated and were available to staff to provide guidance. These included those which covered infection control, health and safety, complaints and safeguarding children. However we found there were no formal policies available relating to staff recruitment, significant events, safeguarding adults or legionella.

There were some systems and processes for identifying, recording and managing risks, issues and implementing mitigating actions. Risks associated with infection control and legionella were assessed and actions taken to make improvements where these were identified. However no risk assessment had been undertaken in respect of fire arrangements. During our inspection the principal dentist made the arrangements for a fire risk assessment to be carried out and following our inspection provided us with a copy of the report. They told us they would act on the recommendations made.

**Leadership, openness and transparency**

The team within the practice was led by the principal dentist. Staff told us they felt able to raise concerns and were listened to and supported if they did so. The staff worked closely together and they were able to express their views both in team meetings and informally. Staff said the principal dentist was approachable and responsive to discussing any issues. Our discussions with different members of staff showed there was a good understanding of how the practice worked, and knowledge of existing procedures.

The principal dentist was responsive to issues we raised with them and acted promptly, for example in respect of fire arrangements to implement appropriate procedures.

The practice had a whistleblowing policy dated June 2016. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice.

This was both internally and with identified external agencies. We saw there was also information displayed in the staff room giving guidance for staff on how to raise concerns.

The principal dentist demonstrated they understood and discharged their responsibilities to

comply with the duty of candour. They told us if there was an incident or accident that affected a patient the practice would act appropriately and offer an apology and an explanation.

We saw evidence of staff meetings being held every two to three months. The meetings were minuted and were available for staff unable to attend. The minutes we looked at showed that complaints or incidents had been discussed at the meetings as well as being used as an opportunity to share any learning.

**Learning and improvement**

In the last year, the practice had undertaken audits in order to monitor quality and to make improvements. There were action plans documented as a result of the audits and we saw that the actions had either been completed or were in the process of being completed. We saw that infection control audits had been completed regularly, the last one being in September 2016. One of the areas identified for improvement was the need to keep instruments moist if cleaning was not immediate. The practice now used a spray designed to keep instruments moist prior to cleaning when necessary.

We saw that a comprehensive X-ray audit had been completed in October 2016 which documented the analysis of the results and discussions. The previous X-ray audit had been carried out two years prior to this. This was not in line with national guidance and the principal dentist told us that going forward, they planned to complete the audits annually. An audit of clinical record keeping had also been undertaken in September 2016. We saw that the areas identified for improvement had been acted upon.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals are

# Are services well-led?

required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

The practice ensured that all staff underwent regular training in cardio pulmonary resuscitation (CPR), infection control, safeguarding of children and vulnerable adults and dental radiography (X-rays). Staff development was by means of internal training, staff meetings, completion of online courses or attendance at external courses.

We found that staff had not received appraisals in order to review their performance and training needs, discuss objectives and document a personal development plan. The principal dentist told us they would implement a system to address this.

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

The practice had carried out patient surveys and we looked at the results from the last two which had taken place in April and October 2016. Meeting minutes demonstrated that the latest survey had been discussed at a staff meeting. A summary of the results and actions taken were displayed in the waiting room. We saw that areas that had been identified for action as a result of patient feedback were redecoration of the practice and to provide a bike rack outside the practice. The practice had been redecorated and a bike rack had been purchased although this yet had to be installed. Staff told us they were also able to make suggestions and these were acted upon by the principal dentist.