

Mr Niloy Karia

# Karia Dental – Woolwich

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 12 November 2015 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**

Karia Dental – Woolwich is located in the London Borough of Greenwich. The premises are situated in a

purpose-built building with a single floor on a high-street location. There are four treatment rooms, a dedicated decontamination room, a waiting room with reception area, a staff room, administrative office, and a patient toilet.

The practice provides NHS and private services to adults and children. The practice offers a range of dental services including routine examinations and treatment, veneers, crowns and bridges, and oral hygiene. The practice offers intravenous conscious sedation for some treatments. The practice carries out domiciliary care visits to some elderly patients in care homes.

The staff structure of the practice comprises of a principal dentist (who is also the owner), six associate dentists, one trainee dentist, two dental nurses, three trainee dental nurses, a hygienist, a practice manager, an administrator and two receptionists. The practice is a training practice for the Dental Foundation Training (DFT) scheme. DFT provides postgraduate dental education for newly qualified dentists in their first (foundation) year of practice; usually within general dental practices. The principal dentist is a trainer for the DFT scheme and provides clinical and educational supervision.

The practice opening hours are on Monday and Tuesday from 9.15am to 8.00pm, Wednesday from 9.10am to 6.00pm, Thursday from 8.45am to 5.00pm, Friday from 9.15am to 5.00pm, and Saturday from 9.15am to 1.30pm. The practice is closed for lunch between 1.20pm and 2.20pm each week day.

# Summary of findings

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.

The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

Twenty-four people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

## **Our key findings were:**

- Patients' needs were assessed and care was planned in line with current guidance such as from the National Institute for Health and Care Excellence (NICE).
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults and children living in vulnerable circumstances.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- Patients indicated that they felt they were listened to and that they received good care from a helpful and caring practice team.
- The practice ensured staff maintained the necessary skills and competence to support the needs of patients.
- The practice had implemented clear procedures for managing comments, concerns or complaints.
- The principal dentist had a clear vision for the practice and staff told us they were well supported by the management team.
- Governance arrangements and audits were effective in improving the quality and safety of the services.

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

- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Review the list of products identified under Control of Substances Hazardous to Health (COSHH) 2002 Regulations to ensure they are current and that appropriate risk management strategies are in place.
- Review the system of stock checks to ensure that out-of-date products are disposed of in a timely manner.
- Establish a system for reviewing the suitability and cleanliness of the equipment used in domiciliary care visits.

# 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.

There was a safeguarding lead and staff understood their responsibilities in terms of identifying and reporting any potential abuse. The practice had policies and protocols, which staff were following, for the management of infection control and medical emergencies. There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

The practice had systems in place to minimise the risks associated with providing dental services. However, improvements could be made in better identifying and mitigating the various risks associated with the running of the practice, such as undertaking regular stock checks and reviewing the suitability and cleanliness of the domiciliary care bag, Control of Substances Hazardous to Health (COSHH) 2002 Regulations products, and sharps handling.

### **Are services effective?**

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

The practice provided evidence-based care in accordance with relevant, published guidance, for example, from the General Dental Council (GDC). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained treatment options to ensure that patients could make informed decisions about any treatment. The practice worked well with other providers and followed up on the outcomes of referrals made to other providers.

Staff had engaged in continuous professional development (CPD) and were meeting all of the other training requirements of the General Dental Council (GDC). Staff had received appraisals within the past year to discuss their role and identify additional training needs.

### **Are services caring?**

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

We received positive feedback from patients through comment cards and by checking the results of the practice's own patient satisfaction survey. Patients felt that the staff were kind and caring; they told us that they were treated with dignity and respect at all times. We found that dental care records were stored securely and patient confidentiality was well maintained.

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

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

The practice had translated key information into four different languages, which reflected the needs of the local population. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment rooms on the ground floor. Patients were invited to provide feedback via a satisfaction survey.

Patients generally had good access to appointments, including emergency appointments, which were available on the same day.

# Summary of findings

There was a complaints policy in place and we saw that complaints received in the past year had been acted on in line with this policy. The practice manager had carried out relevant investigations and recorded the outcome of these. The practice disseminated the outcomes of these investigations at staff meetings with a view to preventing a recurrence of any problems.

## **Are services well-led?**

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

The practice had clinical governance and risk management structures in place. A system of audits was used to monitor and improve performance. On the day of the inspection, we found that further action was needed to assess and minimise some risks. For example, systems for identifying out of date stock needed to be improved. We discussed these issues with the management team at the time of the inspection and saw that they took immediate action to address our concerns.

Staff described an open and transparent culture where they were comfortable raising and discussing concerns with the principal dentist. They were confident in the abilities of the management team to address any issues as they arose.

# Karia Dental - Woolwich

## Detailed findings

### Background to this inspection

We carried out an announced, comprehensive inspection on 12 November 2015. The inspection took place over one day and was carried out by a CQC inspector and a dentist specialist advisor.

We reviewed information received from the provider prior to the inspection. During our inspection we reviewed policy documents and spoke with seven members of staff, including the principal dentist. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We also checked the arrangements in place for the provision of conscious sedation at the practice and the provision of domiciliary care visits outside of the practice premises. The head nurse demonstrated how they carried out decontamination procedures of dental instruments.

Twenty-four people provided feedback about the service. Patients were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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

There was an effective system in place for reporting and learning from incidents. Three incidents and two accidents had been recorded in the past year. There was a practice policy for staff to follow for the reporting of incidents or accidents, which had been followed in these cases. Staff told us they understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). None of the accidents or incidents had required notification under the RIDDOR guidance.

Incidents had been appropriately recorded and investigated. Actions taken at the time and any lessons that could be learned to prevent a recurrence were noted and discussed with individual members of staff. Learning points were also shared at staff meetings. For example, there had been an incident in the reception area involving an aggressive patient. This had led to an immediate discussion with reception staff about how best to work with patients presenting in this manner. The incident had also been raised at a staff meeting where the practice's 'zero tolerance' policy was reviewed.

We noted that it was the practice policy to offer an apology when things went wrong.

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

The practice manager was the named practice lead for child and adult safeguarding. They were able to describe the types of behaviour a child might display that would alert them to possible signs of abuse or neglect. They also had a good awareness of the issues around vulnerable elderly patients who presented with dementia.

The practice had a well-designed safeguarding policy which referred to national guidance and included local authority telephone numbers for escalating concerns that might need to be investigated. This information was displayed in the reception area, administrative office and each of the treatment rooms. There was evidence in staff files showing that staff had been trained in safeguarding adults and children to an appropriate level.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to

keeping staff and patients safe. For example, we asked staff about the prevention of needle stick injuries. The practice used a safe system to minimise needle stick injuries whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A rubber needle guard was used during the recapping stage at all times and the responsibility for this process rested with each dentist. The staff we spoke with demonstrated a clear understanding of the practice policy and protocol with respect to needle stick injuries. This protocol had been accurately followed by a member of staff following a needle stick injury which had occurred in the past month. However, the practice did not have a written risk assessment and associate risk-reduction protocol describing the rationale behind the reasons why dental local anaesthetic syringes were to be recapped during patient treatment in accordance with EU Directive on safer sharps (2013).

The practice followed national guidelines on patient safety. For example, we checked how the practice treated the use of instruments which were used during root canal treatment. One of the dentists explained that these instruments were single use only. She explained that root canal treatment was carried out using a rubber dam in line with guidance supplied by the British Endodontic Society. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth.]

### Medical emergencies

The practice had arrangements in place to deal with medical emergencies. The practice had an automated external defibrillator (AED), oxygen and other related items, such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). The practice held emergency medicines in line with guidance issued by the British National Formulary for dealing with common medical emergencies in a dental practice. The emergency medicines were all in date and stored securely with emergency oxygen in a location known to all staff. Staff received annual training in using the emergency equipment. The staff we spoke with were all aware of the location of the emergency equipment.

### Staff recruitment

# Are services safe?

The staff structure of the practice comprises of a principal dentist, six associate dentists, one trainee dentist, two dental nurses, three trainee dental nurses, a hygienist, a practice manager, an administrator, and two receptionists.

There were effective recruitment and selection procedures in place. There was a recruitment policy which had last been reviewed in May 2014. The practice held a staff file for each person. We checked five of these files. This showed that pre-employment checks of staff had been carried out in line with the relevant regulations. This included the use of application forms, a review of employment history, evidence of relevant qualifications, the checking of references and a check of registration with the General Dental Council (where required). The practice manager told us that it was their policy to carry out a Disclosure and Barring Service (DBS) check for all staff members prior to employment and periodically thereafter. Information about the outcome of the DBS check was held in each staff member's file.

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

There were arrangements in place to deal with foreseeable emergencies. We saw that there was a health and safety policy in place. The practice had been assessed for risk of fire and there were documents showing that fire extinguishers had been recently serviced.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products. However, we noted that a review of COSHH substances in use at the practice had not been carried out for over a year.

The practice had a system in place to respond promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the principal dentist via email. These were disseminated to staff, where appropriate.

There was a business continuity plan in place. The practice was one of three sites owned by the principal dentist. There was an arrangement in place with one of the owner's other

practices to provide continuity of care in the event that the practice's premises could not be used. Key contacts, for example, for the servicing of electrics or plumbing, were kept up to date in the plan.

## **Infection control**

There were effective systems in place to reduce the risk and spread of infection within the practice. The practice manager, who had also trained as a dental nurse, was the infection control lead. There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. The practice had carried out practice-wide infection control audits every six months, with the last audit having been completed in October 2015.

We observed that the premises appeared clean, tidy and clutter free. Clear zoning demarked clean from dirty areas in all of the treatment rooms. Hand washing facilities were available, including wall-mounted liquid soap, hand gels and paper towels in each of the treatment rooms, decontamination room and toilet. Hand-washing protocols were also displayed appropriately in various areas of the practice.

We asked the head dental nurse to describe to us the end-to-end process of infection control procedures at the practice. The protocols described demonstrated that the practice had followed the guidance on decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (HTM 01-05)'.

The dental nurse explained the decontamination of the general treatment room environment following the treatment of a patient. We saw that there was a checklist system for ensuring that the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines.

We checked the contents of the drawers in one of the treatment rooms. These were well stocked, clean, ordered and free from clutter. All of the instruments were pouched. It was obvious which items were for single use and these items were clearly new. Each treatment room had the appropriate personal protective equipment, such as gloves and aprons, available for staff and patient use.



# Are services safe?

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). The practice manager described the method they used which was in line with current HTM 01-05 guidelines. A Legionella risk assessment had been carried out by an external contractor in November 2010. A number of recommendations were detailed in the report; this included regular testing of the water temperatures of the taps in several rooms in the building. We saw evidence that these checks were being carried out. A record had been kept of the outcome of these checks on a monthly basis.

The practice used a decontamination room for instrument processing. In accordance with HTM 01-05 guidance, an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination room which ensured the risk of infection spread was minimised. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean.

Instruments were manually scrubbed in temperature-controlled water in a bowl in the treatment room. Items were then rinsed in the dirty-zone sink and inspected under a light and magnification before being transported in a lockable, lidded box to the decontamination room. Items were then placed in an autoclave (steriliser). When instruments had been sterilized, they were pouched and stored appropriately, until required. All pouches were dated with a date of sterilisation and an expiry date. We found that pouched items in the treatment rooms were all within their expiry date. However, some items which had been pouched and stored in a stock room were now out of date. These items were clearly not in current use and were removed by the practice manager at the time of the inspection.

We also checked the content of a dentist's bag which was taken outside the premises for treating patients who required domiciliary care in the local area. For example, this equipment was used on a weekly basis by the trainee dentist when they visited local care homes for the practice's elderly patients. Items were either pouched or in lidded boxes. However, the inside of the bag appeared visibly unclean. For example, there was melted wax on one of the lidded boxes. We noted that there was a lack of a system in place for monitoring the cleanliness of this bag. We

discussed our concerns with the practice manager. We noted that they took immediate action by removing and reviewing items stored in the bag; they told us they would implement a log book system for weekly checks on the contents and cleanliness of the bag, in line with the effective infection control practices seen in all of the treatment rooms.

We saw that there were systems in place to ensure that the autoclaves were working effectively. These included the automatic control test and steam penetration test. It was observed that the data sheets used to record the essential daily validation checks of the sterilisation cycles were always complete and up to date.

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and municipal waste were properly maintained. The practice used a contractor to remove dental waste from the practice. Waste was stored in a separate, locked location within the practice prior to collection by the contractor. Waste consignment notices were available for inspection. Environmental cleaning was carried out in accordance with the national colour coding scheme

Staff files showed that staff regularly attended training courses in infection control. Clinical staff were also required to produce evidence to show that they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients.

## Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the autoclave had been serviced and calibrated in June 2015. The pressure vessels had been checked and serviced in May 2015. Certificates for this equipment had been issued in accordance with the Pressure Systems Safety Regulations 2000. Portable appliance testing (PAT) for all electrical appliances had also been carried out in December 2014.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely.

Single-use items were clearly identified and disposed of appropriately. We noted one exception. This was in relation to the use of hand files for root canal treatments. The



# Are services safe?

practice was currently reusing these items throughout a course of treatment for the same individual. The practice used their sterilisation processes in between treatment sessions. We noted that this adequately addressed infection control issues. However, the hand files were not designed for re-use and therefore there was an increased risk of fracture when they were re-used. The principal dentist told us they would now only use these items on one occasion prior to disposal.

We checked a sample of dental care records which showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients. We also noted that the medicines used in intravenous conscious sedation, (e.g. Midazolam and the reversal agent Flumazenil) were stored appropriately and were in date. The batch number and expiry dates of Midazolam along with the amounts used were recorded during each episode of conscious sedation. [Conscious sedation - these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation].

We checked the equipment and medicines stored in a dentist's bag which was taken outside the premises for treating patients who required domiciliary care in the local area. For example, this equipment was used on a weekly basis by the trainee dentist when they visited local care homes for the practice's elderly patients. We found that the materials stored in this bag had not been reviewed. A number of items used in the treatment of fillings were out of date; there was also one item used for the making of dental impressions which was out of date. The practice manager disposed of these items immediately.

The principal dentist told us that the majority of the domiciliary care carried out involved impression taking for the making of dentures. Therefore the materials used for managing fillings had not been in use. We reviewed the dental care records for some of the patients receiving domiciliary care and saw that this was the case. Therefore, we found that the majority of out of date stock had not been in use and the issue was resolved on the day of the inspection. The practice manager also assured us that a system for regularly checking the contents of the domiciliary care bag would be put in place.

## **Radiography (X-rays)**

There was a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor as well as the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three-yearly maintenance logs and a copy of the local rules. We also saw evidence that staff had completed radiation training.

A copy of the most recent radiological audit was available for inspection. We also checked the dental care records to confirm the findings. The audits and records showed that dental X-rays were justified, reported on and quality assured every time. X-rays and CT scans were taken in line with current guidelines by the Faculty of General Dental Practice of the Royal College of Surgeons of England and National Radiological guidelines.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The staff working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The principal dentist and one of the associate dentists described to us how they carried out their assessment. The assessment began with the patient completing a medical history questionnaire covering any health conditions, medicines being taken and any allergies suffered. We saw evidence that the 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. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment.

The patient's dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this included the cost involved. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

We checked a sample of dental care records to confirm the findings. These showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums were noted using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (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). These were carried out where appropriate during a dental health assessment.

We checked the dental care records for one patient who had undergone intra-venous sedation on the day of the inspection. We found that patients had important checks prior to sedation; this included a medical history, height, weight and blood pressure. During the sedation procedure, checks were also carried out at regular intervals and a record of these checks was kept. These checks included pulse, blood pressure and the oxygen saturation of the blood. The processes carried out were in line with current good practice guidelines demonstrating that sedation was carried out in a safe and effective way.

### Health promotion & prevention

The practice promoted the maintenance of good oral health through the use of health promotion and disease prevention strategies. Staff told us they discussed oral health with their patients, for example, effective tooth brushing or dietary advice. The dentists were aware of the need to discuss a general preventive agenda with their patients. This included discussions around smoking cessation, sensible alcohol use and weight management. The dentists also carried out examinations to check for the early signs of oral cancer.

There was a hygienist working at the practice one day a week. The dentists could refer patients to the hygienist to further address oral hygiene concerns.

We observed that there were some health promotion materials displayed in the waiting area; including information aimed at engaging children in good dental hygiene practices. These could be used to support patient's understanding of how to prevent gum disease and how to maintain their teeth in good condition.

### Staffing

Staff told us they received appropriate professional development and training. We checked five staff files and saw that this was the case. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies, safeguarding and X-ray training. Staff involved in providing sedation services had attended, or were booked to attend, the required training courses.

There was an induction programme for new staff to follow to ensure that they understood the protocols and systems in place at the practice.

Staff told us they had recently been engaged in an appraisal process which reviewed their performance and identified their training and development needs. We reviewed some of the notes kept from these meetings and saw that each member of staff had the opportunity to put a development plan in place.

### Working with other services

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals were made to other dental specialists when required.

# Are services effective?

(for example, treatment is effective)

The principal dentist and practice manager explained how they worked with other services, when required. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. For example, the practice carried out some implant treatments. However, they did not possess a computed tomography (CT) scanner used for the diagnosis and treatment planning in dental implant cases. The practice used a specialist medical imaging company to provide this service. We were shown the referral form for how the system operated.

We also reviewed the systems for referring patients to specialist consultants in secondary care. A referral letter was prepared and sent to the hospital with full details of the dentist's findings and a copy was stored on the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was then monitored after being referred back to the practice to ensure patients had received a satisfactory outcome and all necessary post-procedure care. A copy of the referral letter was always available to the patient if they wanted this for their records.

## **Consent to care and treatment**

The practice ensured valid consent was obtained for all care and treatment. We spoke to the principal dentist and an associate dentist about their understanding of consent issues. They explained that individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. They stressed the importance of communication skills when explaining care and treatment to patients to help ensure they had an understanding of their treatment options. Patients were asked to sign to indicate they had understood their treatment plans and formal written consent forms were completed for specific treatments.

Staff were aware of the Mental Capacity Act 2005. They could explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities. 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.

# Are services caring?

## Our findings

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

We collected feedback from twenty four patients. They described a positive view of the service. The practice had also carried a patient survey every three months throughout 2015. The results of the survey indicated a high level of satisfaction with care. During the inspection we observed staff in the reception area. They were polite and helpful towards patients and the general atmosphere was welcoming and friendly.

All the staff we spoke with were mindful about treating patients in a respectful and caring way. There was a good awareness of the need to support people with mental health problems to access the service in a caring and supportive manner following some issues in this area. The practice had actively recruited an additional associated dentist with expertise on this topic who would be able to provide in house training and support to all members of staff.

Staff were aware of the importance of protecting patients' privacy and dignity. Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were having treatment. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy.

Staff understood the importance of data protection and confidentiality and had received training in information governance. Patients' dental care records were stored electronically and in a paper format. Computers were

password protected and regularly backed up to secure storage; screens at reception were not overlooked which ensured patients' confidential information could not be viewed.

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

The practice displayed information in the waiting area and on its website which gave details of the private and NHS dental charges or fees. There were a range of information leaflets in the waiting area which described the different types of dental treatments available.

We spoke with the principal dentist, one of the associate dentists and one of the dental nurses, on the day of our visit. All of the staff told us they worked towards providing clear explanations about treatment and prevention strategies. We saw evidence in the records that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The patient feedback we received via comments cards, together with the data gathered by the practice's own survey, confirmed that patients felt appropriately involved in the planning of their treatment and were satisfied with the descriptions given by staff. The practice could show that they had responded to feedback about the quality of communications as a result of the satisfaction survey and following an audit of dental care records. For example, the practice manager had held a meeting to discuss improving explanations and communication with patients with one of the clinicians. This had led to an improved performance in the survey results for the three months after this meeting had been held.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice had a system in place to schedule enough time to assess and meet patients' needs. Each dentist could decide on the length of time needed for their patient's consultation and treatment. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient. The feedback we received via comments cards and from the practice's satisfaction survey indicated that patients felt they had enough time with clinicians and were not rushed.

During our inspection we looked at examples of information available to people. We saw that the practice waiting area displayed a variety of information including opening hours, emergency 'out of hours' contact details and practice policy documents. This information was also explained in the patient information leaflet and policy folder which was available in the waiting area. The practice had a website which reinforced this information. New patients were given a practice brochure which included advice about payment, appointments, and complaints.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. We noted that it was part of the staff induction to discuss issues around equality and diversity with reference to the practice's policy on this topic.

The practice manager told us the service was situated in a diverse area with a range of languages spoken. They showed us that key information had been translated into four different languages to support patients when they accessed this service. This information was clearly displayed in the waiting area. They were also able to provide large print, written information for people who were hard of hearing or visually impaired.

The majority of the practice was wheelchair accessible with all of the treatment rooms on the ground floor with level access from the street. There was also a disabled toilet. The practice had carried out a Disability Discrimination Act

audit in June 2015. This had led to some changes with a view to keeping patients safe. For example, a mat in the reception area had been replaced and an emergency cord in the toilet was now being checked on a monthly basis.

### Access to the service

The practice opening hours were on Monday and Tuesday from 9.15am to 8.00pm, Wednesday from 9.10am to 6.00pm, Thursday from 8.45am to 5.00pm, Friday from 9.15am to 5.00pm, and Saturday from 9.15am to 1.30pm. The practice was closed for lunch between 1.20pm and 2.20pm each week day.

Reception staff told us that there were generally appointments available within a reasonable time frame. The feedback we received from patients confirmed that they could generally get an appointment when they needed one. The administrator had actively monitored access to the service by auditing the appointments system. This identified a higher than usual number of patients failing to attend for appointments and some issues with booking courses of treatment in good time. This had led to a change in the booking system and a system of issuing text reminders to patients who failed to attend regarding the practice's policy on this issue.

The practice manager told us that the dentists always planned some spare time in their schedule on any given day. This ensured that patients, who needed to be seen urgently, for example, because they were experiencing dental pain, could be accommodated. We reviewed the appointments book and saw that this was the case. The appointment schedules showed that patients were given adequate time slots for appointments of varying complexity of treatment.

### Concerns & complaints

Information about how to make a complaint was displayed in the reception area in a patient information folder. There was a complaints policy which described how the practice handled formal and informal complaints from patients. There had been five complaints recorded in the past year. These complaints had been responded to in line with the practice policy. A record was kept of what had occurred and actions taken at the time to address the problem. Patients had received a written or verbal response following the investigation of any complaint. We noted some examples where the records showed that an apology had been offered.

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

We asked the practice manager how staff were informed about the outcomes of complaints with a view to sharing learning points and preventing a recurrence. They told us

the complaints were discussed on a one-to-one basis with individual members of staff and were also reviewed at staff meetings. We reviewed the minutes from staff meetings over the past three months and saw that this was the case.



# Are services well-led?

## Our findings

### Governance arrangements

The practice had governance arrangements with an effective management structure. There were relevant policies and procedures in place. These were all frequently reviewed and updated. Staff were aware of the policies and procedures and acted in line with them.

There were arrangements for identifying, recording and managing risks through the use of risk assessment processes. However, improvements could be made to ensure all of the potential risks associated with the running of the practice were identified and well managed. We discussed these issues with the principal dentist and practice manager on the day of the inspection; they assured us they would take action to resolve these issues in response to our feedback.

There were monthly staff meetings to discuss key governance issues. For example, we saw minutes from meetings where issues such as infection control, X-ray equipment, referral processes and the outcomes of patient surveys had been discussed. This facilitated an environment where improvement and continuous learning were supported. We also noted that the outcomes of incidents and complaints were discussed at staff meetings with a view to preventing a recurrence of any problems.

### Leadership, openness and transparency

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said that they felt comfortable about raising concerns with the principal dentist. They felt they were listened to and responded to when they did so.

We found staff to be hard working, caring towards the patients and committed to the work they did. We found the principal dentist provided effective clinical leadership to the whole dental team. They were supported by a practice manager and head nurse who took the lead in key areas such as safeguarding and infection control.

Staff told us they enjoyed their work and were supported by the principal dentist. They received regular appraisals which commented on their own performance and elicited their goals for the future.

### Learning and improvement

The principal dentist had a clear vision for the practice and discussed plans for developing the practice in the coming year. This included improvements to the fabric of the premises. For example, there were plans to replace one of the dentist's chairs and to replace some floor coverings.

All staff were supported to pursue development opportunities. We saw evidence that staff were working towards completing the required number of CPD hours to maintain their professional development in line with requirements set by the General Dental Council (GDC).

The practice had a programme of clinical audit that was used as part of the process for learning and improvement. These included audits for infection control, clinical record keeping, and X-ray quality. The audits showed a generally high standard of work. Areas for improvement were identified through the auditing programme. For example, an audit of the appointments system had identified higher than typical numbers of patients who had failed to attend for appointments which subsequently impacted on the practice's ability to offer appointments in a timely manner. This led to a review of the policy on missed appointments. Actions were taken to make patients aware of the impact of missed appointments on the running of the practice by putting up posters in the surgery and sending text message updates to patients who had not attended.

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

The practice gathered feedback from patients through the use of a suggestions box in the waiting area, patient satisfaction survey and through the 'Friends and Family Test'. The majority of feedback was positive about the quality of care received. The practice manager had carried out an analysis of the feedback received and acted on the results. For example, a water vending machine had been installed in the waiting area in response to feedback.

Staff told us that the principal dentist and practice manager were open to feedback regarding the quality of the care. The appraisal system and staff meetings also provided appropriate forums for staff to give their feedback.