Dr Helen Christie

St James Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 10 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

St James Dental Centre has one dentist who works part time, a part time dental hygienist, three qualified dental nurses who are registered with the General Dental Council (GDC), a practice manager and a receptionist. The practice's opening hours are 8.30am to 6pm on Monday 8.30am to 1pm on Wednesday and 8.30am to 5.30pm on Friday.

St James Dental Centre provides private dental treatment for adults and children. The practice has two dental treatment rooms on the ground floor. Sterilisation and packing of dental instruments takes place in the treatment room. There is a reception with separate waiting area.

Before the inspection we sent Care Quality Commission comments cards to the practice for patients to complete to tell us about their experience of the practice. During the inspection we spoke with three patients. Overall we received feedback from 35 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good and staff were friendly and caring.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.

Summary of findings

- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Staff had been trained to deal with medical emergencies.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The governance systems were effective.
- The practice was well-led and there were clearly defined leadership roles within the practice. Staff told us they felt supported, involved and they all worked as a team.

There were areas where the provider could make improvements and should

- Review the practice's RIDDOR policy to ensure correct information regarding reporting information under RIDDOR regulations is recorded.
- Review the practice's procedures regarding medicines and equipment to be used in a medical emergency to ensure that the frequency of checks completed is in line with the Resuscitation Council (UK) guidance.
- Review the systems in place for managing first aid and provide evidence that those staff identified as the designated first aider has completed relevant training.
- Review the practice's protocols for completion of dental records and ensure that the dental hygienist gives due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the systems in place to ensure firefighting equipment at the practice is serviced, maintained and checked on a regular basis.

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.

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

Emergency medical equipment and medicines were available on the premises in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. Staff had received training in responding to a medical emergency.

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

Decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use. Infection control audits were being undertaken on a six monthly basis. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

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. There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

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

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

Are services caring?

No action

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

We observed the staff to be welcoming and caring towards the patients. Staff treated patients with kindness and respect and they were aware of the importance of confidentiality Patient's privacy and confidentiality was maintained on the day of the inspection. Feedback from patients was overwhelmingly positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful.

Summary of findings

Are services responsive to people's needs?

No action

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

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

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

Are services well-led?

No action

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

There were good governance arrangements and an effective management structure in place.

Systems were in place to share information with staff by means of monthly practice meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us that the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

St James Dental Centre

Detailed findings

Background to this inspection

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

This inspection took place on 10 October 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

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

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

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

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

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Systems were in place to enable staff to report incidents and accidents. An accident book was available in the staff kitchen and significant event reporting forms were available in a file along with accident, treatment and investigation record forms. Staff spoken with were aware of the location of accident and incident records and confirmed that once completed these were to be forwarded to the principal dentist or practice manager.

Reporting forms were comprehensive and included details of the accident, witness statements, details of the cause of the injury, actions taken to reduce or eliminate reoccurrence and whether or not a risk assessment had been completed or updated, staff training requirements, workplace adjustments and follow up information. No accidents had been reported within the last 12 months; the date of the last accident recorded was 6 March 2015.

We were told that accidents and incidents were discussed at practice meetings on an annual basis. This involved review of policies and procedures, however discussions would be held regarding any accidents or incidents at the practice as they occurred.

The practice had reported one event within the last 12 months. Records were comprehensive and evidence was available to demonstrate that appropriate follow up action was taken. We were told that any learning points identified from these events were discussed with staff during practice meetings.

We saw that there was an accident reporting policy and a policy regarding managing events. Policies were reviewed on at least an annual basis. Information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) was also detailed in this policy. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice's policy had not been updated to include this information. We were told that there had been no events at the practice that required reporting under RIDDOR.

A poster on display in the reception area made staff made aware of when to contact the Care Quality Commission regarding any incidents that occurred at the practice. Staff said that they would reference this document or speak with the principal dentist if they needed any advice.

Systems were in place to ensure that all staff members were kept up to date with any national patient safety and medicines alerts. The practice received these alerts via email and any that were relevant were printed off and kept in a medical alerts log and where relevant were discussed with staff at a practice meeting.

The practice had developed a Duty of Candour policy. This informed patients that they would be told when things went wrong, when there was an incident or accident and would be given an apology.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. Various other pieces of information such as a flowchart for safeguarding action for a child or vulnerable adult and details of how to report suspected abuse to the local organisations responsible for investigation were available. For example details of how to make a referral to the Birmingham safeguarding adult's and children's board were kept on file.

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

We saw evidence that all staff had completed the appropriate level of safeguarding training. On-line training was available to all staff. We were told that as part of the routine review of policies and procedures safeguarding, child protection and the Mental Capacity Act would be discussed at a practice meeting on an annual basis. Further discussions would be held as necessary in the event of any suspected abuse being reported by the practice.

Leaflets and posters regarding child protection and adult safeguarding were on display in the waiting room. These included information and contact details for Child line, Action on Elder Abuse and the National Society for Prevention of Cruelty to Children (NSPCC).

No action

Are services safe?

The practice had conducted a needle stick injury assessment; this was an internal audit on the potential causes for needle stick injuries. Any issues identified had been recorded, addressed and ways for prevention were highlighted. The practice had changed to a safer sharps system and implemented the use of disposable matrix bands. A matrix band is a thin metal strip that is positioned around the tooth during placement of certain fillings, they can be very sharp and so the use of disposable bands mitigates the risk involved in changing the bands. Needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist.

Needle stick policies were on display in each treatment room. Contact details for the local occupational health department were recorded on these policies. Sharps bins were stored in appropriate locations which were out of the reach of children. Forms were available to be completed following a sharps injury regarding virus risk. We were told that there had been one sharps injuries at the practice.

We asked about the instruments which were used during root canal treatment. The registered manager explained that these instruments were single use only. We were told that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work).

Medical emergencies

There were systems in place to manage medical emergencies at the practice. A folder was available which listed all medical emergencies and how to deal with them. Staff had all received annual training in basic life support on 8 March 2016.

Emergency equipment including oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored in a clearly marked cupboard. Records confirmed that emergency medical equipment and medicines were checked monthly by staff. The date of the last check was recorded as 3 October 2016. This is not in line with the guidance produced by the Resuscitation Council UK which records that emergency equipment and medicines should be checked on at least a weekly basis.

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

One of the dental nurses was the designated first aider and we were told that this staff member had completed first aid training. However there was no documentary evidence available on the day of inspection to demonstrate when this training was completed.

Staff recruitment

The practice had a robust recruitment policy that described the process to follow when employing new staff. This policy included details of the pre-employment information to obtain, interview processes and equal opportunities policy to follow. The policy had been reviewed and updated on 25 May 2016.

We discussed the recruitment of staff, we were told that one member of staff had been employed in January 2016 and all other staff had worked at the practice for over eight years. We looked at the recruitment file of the newly employed staff member in order to check that recruitment procedures had been followed. We saw that this file contained pre-employment information such as proof of identity, written references details of qualifications and registration with the professional body. Staff had also completed a pre-employment medical questionnaire.

Recruitment files contained other information such as contracts of employment, job descriptions and copies of grievance and disciplinary policies.

We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. 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.

No action

Are services safe?

The practice planned for staff absences to ensure the service was uninterrupted. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave. There was enough staff to support the dentist and the dental hygienist during patient treatment. We were told that these staff always worked with a dental nurse. The practice had developed a policy and action plan regarding working without chairside support. This included a poster regarding the "action to take in case of a medical emergency" which was on display in the treatment room and a risk assessment for working without chairside support. We saw that this had not been completed. We were told that this was not needed as the dentist and hygienist worked with chairside support.

A weekly duty rota; which was on display in the staff kitchen, detailed where dental nursing staff would be working. For example on reception or it recorded whether the staff member would be working with the dentist or the hygienist.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that the practice had developed a health and safety policy which had been reviewed on an annual basis. The principal dentist or the practice manager was the named leads regarding health and safety. All staff spoken with said that they could speak with either of these people for health and safety advice if required. A health and safety poster was on display in the staff kitchen. Health and safety including a review of policies was discussed at the practice meeting of 29 July 2016.

Numerous risk assessments had been completed such as a practice risk assessment, radiation, sharps and a fire risk assessment. Risk assessments were reviewed on an annual basis. The date of last review for the practice risk assessment was 10 June 2016.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire risk assessment was completed on 7 November 2015 and we were told that this would be reviewed on an annual basis thereafter. We saw that a low risk had been identified throughout the practice. Issues for action had been identified and acted upon. The risk assessment had been signed and dated when issues were addressed. We saw that a standardised form had been used to complete this risk assessment which had not been adapted to meet the needs of the practice.

Records seen confirmed that fire extinguishers were subject to routine maintenance by external professionals on 21 December 2015. There were no records to demonstrate that emergency lighting had been serviced or was being regularly tested. The principal dentist confirmed that this had not taken place. We were told that a weekly fire safety check was completed. This included checks of fire doors and exit pathways. There was no documentary evidence to demonstrate that these checks had been undertaken. We saw that a fire precautions test form had been completed. This recorded that the practice would undertake monthly tests of escape lighting, escape routes, emergency exits and fire doors.

Fire drills took place on a six monthly basis with the date of the last fire drill being 29 July 2016.

A well organised COSHH file was available. Details of all substances used at the practice which may pose a risk to health were recorded in a COSHH file. In May 2016 staff had signed documentation to demonstrate that they had read and understood the information in the COSHH file.

Infection control

Infection prevention and control policies and procedures had been developed to keep patients safe. These were kept in an infection control folder; all of the contents of this folder were reviewed on an annual basis with the last review taking place on 11 May 2016. This folder contained various infection prevention and control related policies, for example decontamination processes, infection prevention and control and a sharps and blood spillage policy. Standardised policies and procedures had been purchased which did not record a date of implementation and some of the information had not been adapted to meet the needs of the practice. However we saw that infection prevention and control was discussed at the practice meeting of 24 August 2016.

We saw that laboratory staff who undertook work for the practice had completed infection prevention questionnaires and the practice had obtained information to demonstrate that these staff were registered with the General Dental Council, their professional body.

No action

Are services safe?

A general infection prevention and control policy statement was on display in the decontamination and treatment rooms. This recorded the name of the dental nurse who was the infection control lead. We were told that the principal dentist and decontamination lead were responsible for ensuring infection prevention and control measures were followed.

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

Infection prevention and control audits were completed on a six monthly basis. The last audit was undertaken in May 2016 and we saw evidence of previous audits completed on a six monthly basis. We looked at some of the recent audits and saw that outcomes, improvements and action plans were recorded. Infection prevention and control was discussed at staff meetings and we saw that the results of the recent audit were discussed at the practice meeting held on 24 August 2016.

Records demonstrated that all staff had undertaken training on 18 May 2016 regarding the principles of infection control. All staff completed annual training and we saw evidence of online training and external courses attended.

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and toilet were visibly clean, tidy and uncluttered. Patient feedback also reported that the practice was always clean and tidy. Dental nurses who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

We looked at the procedures in place for the decontamination of used dental instruments. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05).

Decontamination of used dental instruments took place in the treatment room. The treatment room had clearly identified zones in operation to reduce the risk of cross contamination.

The dental nurse showed us the procedures involved in manual cleaning, rinsing, inspecting and decontaminating dirty instruments. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty zone to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. Packaged instruments were appropriately stored in cupboards and rotated to ensure appropriate usage.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria legionella is a term for particular bacteria which can contaminate water systems in buildings)

they described the method they used which was in line with current HTM 01 05 guidelines.

A risk assessment regarding Legionella had been carried out by an external agency in 2010. As there had been no changes at the practice and a low risk was identified during the initial risk assessment, staff at the practice had completed annual risk assessments thereafter. We saw records to confirm that routine temperature monitoring checks were being completed.

We discussed clinical waste and looked at waste transfer notices. We saw that the practice had a contract in place regarding the disposal of clinical and municipal waste. Evidence seen demonstrated that clinical waste was collected every few weeks. Clinical waste was securely stored in a locked bin. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

The practice had maintenance contracts for essential equipment and records seen demonstrated the dates on which the equipment had recently been serviced. For example compressors had been serviced in June 2016, the autoclave serviced in December 2015. All the equipment

used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in February 2016 with an additional visual check being completed in October 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that one of the emergency medicines (Glucagon) was stored in the emergency medicines kit. Glucagon is used to treat diabetics with low blood sugar. Although staff spoken with were aware that if this medicine was stored at room temperature the expiry date should be adjusted, this had not been done. We were told that this would be addressed immediately.

Dental treatment records 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.

Prescription pads were securely stored and a log of each prescription issued was kept. This recorded details of the date, prescription number and patient code. A log of the number of prescriptions used was also recorded at the end of each working day.

We were told that this practice dispensed medicine. These medicines were stored safely for the protection of patients. A log book recorded which medicines were dispensed, patient details and the batch number and expiry date.

Radiography (X-rays)

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

Local rules were available in each of the treatment rooms were X-ray machines were located for all staff to reference if needed.

The procedure for action in case of malfunction was displayed on the wall by the emergency cut of switches. Clear signage was available identifying that X-ray machinery was located in the room.

We saw that the practice had notified the Health and Safety Executive on the 22 April 2010 that they were planning to carry out work with ionising radiation.

Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the current recommended interval of three years.

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

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

We saw a recent X-ray audit completed in May 2016. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. X-ray audits were completed on a six monthly basis, these were reported and actions identified. A safe use of X-ray audit was completed in September 2016.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic and paper dental care records. They contained information about the patient's current dental needs and past treatment. Wediscussed patient care with the dentist and checked dental care records to confirm the findings. Patient dental care records that we were shown demonstrated that the dentist was following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping. Records were comprehensive and included details of the condition of the teeth, soft tissues lining the mouth and the gums 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). During this assessment dentists looked for any signs of mouth cancer.

The Dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. Patients were referred to the dental hygienist if they had more advanced gum disease. The dental hygienist kept paper notes and those shown to us were not sufficiently detailed on all occasions.

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

Risk factors such as diet, oral cancer, tooth wear, dental decay, gum disease and patient motivation to maintain oral health were taken into consideration to determine the likelihood of patients experiencing dental disease. Patient care records demonstrated that risk factors had been documented and discussed with patients.

We were told that medical history records were completed or updated every time the patient attended for treatment.

Health promotion & prevention

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

Medical history forms completed by patients included questions about smoking and alcohol consumption. A reminder notice in the reception area asked patients to inform reception if anything had changed regarding their health or medication. Patients we spoke with told us that they were asked regularly to update their medical history.

Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice. Information regarding oral cancer and health promotion leaflets and posters were on display in the waiting room to support patients to look after their teeth. The practice participated in oral cancer awareness month and provided advice and information to patients. Details of discussions regarding improving oral health were recorded in patient dental care records.

The dentist gave oral health advice and where necessary patients were referred to the dental hygienist who explained tooth brushing and interdental cleaning techniques.

Staffing

Practice staff included a principal dentist, a part time dental hygienist, three part time dental nurses, a practice manager and a part time receptionist. One member of staff had recently been employed. Records seen demonstrated that this staff member had completed a period of induction to familiarise themselves with the systems and policies at the practice. This included ongoing training and a one and three month probationary review meeting. Induction records were comprehensive and included familiarising the staff member with emergency procedures including fire and emergency medicines and equipment, safeguarding and confidentiality.

Appraisal systems were in place. We saw that personal development plans were available for staff. We were told that discussions were held with staff about continuing professional development (CPD) and training during appraisal meetings. CPD is a compulsory requirement of registration as a general dental professional. Staff confirmed that they were encouraged to attend training courses. We looked at two staff CPD files and saw training certificates which demonstrated that staff had completed a

No action

Are services effective?

(for example, treatment is effective)

variety of training such as infection prevention and control, environmental maintenance and cleaning and hand hygiene. Training was provided to staff via attendance at courses, in-house and on-line training.

We saw evidence to demonstrate that staff had undertaken core CPD training such as safeguarding, mental capacity, fire safety, infection control and basic life support training. We also saw that some staff had received training in other specific dental topics such as patient focussed care, decontamination and dental radiography.

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

Working with other services

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

oral surgery, oral medicines and orthodontics.

A written referral log was set up for each patient, a copy of the referral letter was kept and patients could have a copy of this letter if requested. The referral log remained 'open' until the dentist had confirmed that the referral had been received and treatment completed.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. The dentist followed Federation of General Dental Practice (FGDP) guidelines when making notes for these referrals.

Consent to care and treatment

A consent policy had been implemented and reference was made to the Mental Capacity Act 2005 (MCA) in this policy. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Discussions were held with the dentist who demonstrated an understanding of the principles of the MCA and best interest decisions. We saw that MCA assessment forms were available for use if required. We were told that support would be obtained when patients were unable to give consent.

There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. We saw that consent was reviewed as part of a recent record card audit in May 2016.

We were told that patients were given verbal and written information to support them to make decisions about treatment. Information leaflets were available to assist with the decision making process. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment.

Staff confirmed individual treatment options were discussed with each patient and during the course of our inspection we were shown entries in dental care records where treatment options were discussed to confirm this. Any risks involved in treatment were also recorded. There was evidence in records that consent was obtained.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy.

Music was played in the reception, waiting area and treatment rooms, this helped to distract anxious patients and also aided confidentiality as people in the waiting room would be less likely to hear conversations held at the reception desk. Staff said that they would ask patients to write down personal sensitive information or they could speak with them in an unused treatment room if a confidential discussion was requested.

Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times. The door to the practice was locked and patients had to press an intercom to gain entry. This helped to maintain confidential information at reception.

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

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Staff told us that they took their time to fully explain treatment, options, risks and fees. Patients confirmed they felt involved in their treatment and it was fully explained to them. We saw that clear treatment plans were given to patients which detailed possible treatment and costs.

We saw evidence in the records that we were shown that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had recently changed to only provide private treatment and a letter detailing treatment costs was clearly displayed in the waiting area and on reception. Patients were able to take a copy of this information to review at their leisure. Information about private fees was also available on the practice's website.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. Patients we spoke with told us that the dentist took their time to explain treatments to them and they were always able to ask questions and never felt rushed. There were vacant appointment slots to accommodate urgent appointments. We were told that 'emergency appointment' slots were kept free before the practice closed each day for lunch. Once these appointments were filled patients were asked to visit the practice and were told that they would have to sit and wait to see the dentist.

Staff told us that patients were usually able to get an appointment within a few days of their telephone call and were always able to get an appointment within 24 hours if they were in dental pain.

Feedback confirmed that patients were rarely kept waiting beyond their appointment time. However we saw that the practice had completed a waiting time audit in 2015 which identified an issue with waiting times. Four out of six of the practice's recent feedback forms identified that patients were occasionally kept waiting to see the dentist. The principal dentist confirmed that they were aware of this and were constantly striving to ensure people were not kept waiting but this was occasionally out of their control.

Tackling inequity and promoting equality

The practice had policies on equality and diversity and equal opportunities to support staff in understanding and meeting the needs of patients. Records seen demonstrated that staff had undertaken equality and diversity training and a disability access audit had been completed in September 2016

The practice had a hearing induction loop for use by people who were hard of hearing. We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

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

This practice was suitable for wheelchair users, having ground floor treatment rooms with ramp access to the front of the building; however the practice did not have an adapted toilet to meet the needs of patients with a disability.

Access to the service

The practice was open from 8.30am to 6pm on Monday 8.30am to 1pm Wednesday and 8.30am to 5.30pm on Friday (closed between 1pm to 2pm). The opening hours were displayed in the entrance to the practice and on the practice's website, however we were told that these details were incorrect and required updating.

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

Patients were able to make appointments over the telephone or in person. The website also recorded the practice's email address and we were told that patients had requested an appointment via email. Emergency appointments were set aside for the dentist every day that the practice was open; this ensured that patients in pain could be seen in a timely manner. Patients commented that they were able to see a dentist easily in an emergency. One patient told us that they were pleased that they were seen quickly in an emergency. This involved visiting another practice owned by the principal dentist when St James's dental centre was closed.

Patients could access care and treatment in a timely way and the appointment system met their needs.

Concerns & complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a complaints policy which provided guidance about how to handle a complaint and the timeframes for responding to complaints. This included acknowledging the complaint within three working days and providing a formal response within 10 working days. Details of how patients could make a complaint were on display in the waiting area and in the reception. Patients were also able to complain through the practice website if they preferred. Staff spoken with were knowledgeable about how to handle a complaint. Staff told us that any complaints received would be sent to the practice manager and principal dentist.

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

We were told that no complaints had been received at the practice.

We saw that information regarding 'Duty of Candour' was available on file for staff to review. This recorded that patients would be informed of any incident that affected them; they would be given feedback and an apology.

No action

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service. Staff were aware of

their roles and responsibilities and were also aware who held lead roles within the practice such as complaints management, safeguarding and infection control.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints,

safeguarding, and infection control policies. Systems were in place to review these policies on at least an annual basis and these were discussed with staff during practice meetings. Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, sharps, infection prevention and control, radiography and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

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

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff told us that they worked well as a team, provided support for each other and were praised by the management team for a job well done. Staff we spoke with told us that they felt supported and involved at the practice.

We saw that practice meetings took place on a monthly basis. Staff said that if they were unable to attend the meeting they were aware of the location of the meeting minutes and could review them at any time. Staff signed a register to confirm that they had attended the meeting.

Staff told us there was an open culture within the practice and they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately.

Staff said that they would speak with the principal dentist if they had any issues they wanted to discuss. We were told that the principal dentist was open and approachable and always available to provide advice and guidance.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a six monthly basis. Other audits included radiography, record card, disability access audit, environmental cleaning audit. Action plans were recorded as required and we saw evidence to demonstrate that the findings of audits were discussed with staff at monthly meetings.

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

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. Patients were able to contact the practice via their website to leave comments or ask questions. Satisfaction surveys were given to patients on a continual basis; the results were reviewed and correlated. An analysis of the May to August 2016 survey results was on display in the waiting room.

A suggestions box was available in the waiting area and feedback was reviewed on a regular basis. The principal dentist told us that as they were a small team ongoing feedback was given to staff regarding the results of satisfaction surveys. A more formal discussion would also be held at a staff meeting.