

Dr. Joo & Associates Ltd

The Academy of Birmingham Cosmetic Dentistry

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 February 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

The Academy of Birmingham Cosmetic Dentistry provides private dental care and treatment. The principal dentist operates the practice as a limited company and is the sole director and registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The principal dentist is supported by a practice manager, one dental nurse and one receptionist. The receptionist had been on long term leave and was due to return to work the week after our visit. Another two dentists also visit the practice to provide additional dental services. One dentist visits on a fortnightly basis to provide dental implants and cosmetic orthodontic treatment. The other visits every six weeks and provides orthodontic treatment only.

The practice is located in the heart of the city centre. There is wheelchair access to the premises and the main treatment room is on the ground floor. The premises consist of a reception area, waiting room, one treatment room, a storage room and a decontamination room on the ground floor. There is a second treatment room, a

Summary of findings

storage room, a disused X-ray room and toilet facilities on the lower ground floor. Opening hours are 8.30am Monday – Wednesday, 9.30am to 6.30pm on Thursdays, 8.30am to 4pm on Fridays and 9am to 2.30pm on Saturdays.

Thirteen patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that the practice provided a professional service that was of a high standard.

Our key findings were:

- Emergency equipment for dealing with medical emergencies mostly reflected published guidelines. We highlighted areas for improvement and these were all dealt with on the day of our visit.
- An infection control policy was in place and procedures followed mainly reflected published guidance. We highlighted areas for improvement and these were all dealt with promptly.
- The practice had systems to assess and manage risks to patients, including infection prevention and control, safeguarding and the management of medical emergencies.
- Patient feedback was positive and they found the staff friendly and professional.
- Patients commented that the practice was clean and safe.
- The appointment system met the needs of the patients and waiting times were kept to a minimum.
- The practice had a complaints process in place. No written complaints had been received by the practice in the last 12 months.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.
- We identified some shortfalls in areas such as radiation protection and staff recruitment and most of these were promptly resolved.

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

- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Establish whether the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes ensuring recruitment checks, including references, are suitably obtained and recorded.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Staff told us they felt confident about reporting incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The practice had some arrangements in place to assess and manage risks to patients, such as whistleblowing, complaints and safeguarding. It had a recruitment policy to help ensure the safe recruitment of staff; however, the practice did not always follow their own recruitment policy with regard to references.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medication issues which could affect the planning of treatment. Not all staff had received training in medical emergencies within the last 12 months although the provider arranged for all staff to attend training soon after our visit. Emergency medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines; however, the defibrillator pads had expired.

The practice was not fully compliant with radiation (X-ray) regulations. Following inspection, these concerns were promptly addressed and rectified.

Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained.

The dentist followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE).

Are services caring?

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

Patient feedback was positive about the care they received from the practice. They commented that staff were polite and treatment was of a high standard. They said that staff were friendly and accommodating and it was easy to book an appointment. Staff members we spoke with were aware of the importance of providing patients with privacy.

Are services responsive to people's needs?

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

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours.

The practice offered access for patients with mobility difficulties and visual impairments. Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. The practice could open beyond its opening hours to accommodate patients with urgent dental needs, if required.

No written complaints had been received by the practice in the last 12 months.

Summary of findings

Are services well-led?

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

Staff told us the dentist was supportive and the culture within the practice was open and transparent. Staff were aware of the practice ethos and philosophy and told us they felt well supported and able to raise any concerns where necessary.

We identified some shortfalls in the practice's governance and leadership but most of these were promptly resolved. For example, some safety related matters including some aspects of infection control, equipment for medical emergencies and compliance with radiation protection (safe exposure of X-rays).

The Academy of Birmingham Cosmetic Dentistry

Detailed findings

Background to this inspection

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

We inspected the The Academy of Birmingham Cosmetic Dentistry on 11 February 2016. The inspection team consisted of one CQC inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed Healthwatch that we were inspecting the practice and we did not receive any information of concern from them. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives.

During the inspection we toured the premises, spoke with the practice manager, the principal dentist and the dental nurse. We reviewed CQC comment cards which patients had completed. We were unable to speak with patients on the day because the dentist had rescheduled all dental appointments to provide staff with ample time to speak with the inspection team. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had arrangements for staff to report accidents and incidents (adverse events). There was an incident reporting policy but no entries had been made. The most recent accident was recorded in June 2014. There was no evidence that incidents/accidents were discussed with staff members during practice meetings. We were told they were discussed informally with staff members at the earliest opportunity. This was corroborated when we spoke with staff members.

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

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with the MHRA (Medicines and Healthcare products Regulatory Agency). The provider and the practice manager were both responsible for obtaining information from relevant emails and disseminating the information to staff members.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for both child protection and adult safeguarding teams. The provider was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to do so.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. The provider told us that rubber dam kits were available in the treatment rooms but they did not always

use them during endodontic treatment. The dentist described what alternative precautions were taken to protect the patient's airway during the treatment when a rubber dam was not used.

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

Staff members were unaware of the duty of candour regulation. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment. However, staff told us the practice had an open culture. The practice manager emailed us a few hours after the inspection with evidence of a duty of candour policy.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an Automated External Defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Emergency drugs and equipment was stored in a secure area and all staff we spoke with were aware of its location.

Medical emergency training previously took place at the practice in January 2014. This should be on an annual basis. Staff members had completed online training in 2016 but had not participated in hands-on training. The provider contacted us after our visit and sent us evidence that all staff members were due to attend hands-on training in May 2016.

The practice undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. The emergency medicines were all in date and stored securely. There was a checklist and this was updated monthly. Glucagon (one type of emergency medicine) was stored in the fridge and the temperature was monitored.

Are services safe?

The defibrillator pads for the AED had expired in June 2013. The practice manager emailed us a few hours after the inspection with an invoice showing that an order had been placed for new pads.

Staff recruitment

The practice had a policy for the safe recruitment of staff. We looked at the recruitment records for two members of the practice team. The records we saw contained evidence of immunisation status (where relevant), curricula vitae, employment contracts and an induction plan. One of the staff member's identity verification was not present. Their recruitment policy stated that two references for each prospective employee must be sought; however, not all staff members had two references. This meant that they could not fully assure themselves that they had satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health care. There were Disclosure and Barring Service (DBS) checks present for both of the staff files we viewed but one was more than three years old. The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults. The practice had also registered with an organisation (in December 2015) which included new DBS checks for any prospective employees prior to their recruitment. The practice manager told us they planned to seek new DBS checks as the existing ones had not been updated for a few years.

The practice manager emailed us a few hours after the inspection with an amended recruitment policy. This was more detailed and specific with regard to the recruitment process.

The practice manager monitored the professional registration of its clinical staff members and we were told that one of the clinical staff members was not registered with the GDC. She was newly qualified and had applied but had encountered some delays with the application. The practice manager was aware of this and said she would continue to monitor this. All other clinical staff members were registered with the GDC.

Monitoring health & safety and responding to risks

A business continuity plan describes situations which might interfere with the day to day running of the practice. These include extreme situations such as loss of the

premises due to fire. This plan was unavailable on the day of our visit. However, the provider contacted us a few hours later and sent us evidence of this. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. The practice manager carried out a fire risk assessment every six months. Fire alarms were tested and documented weekly. The most recent fire drill took place in June 2015 and we reviewed a fire evacuation drill report. Fire extinguishers were present on both floors and had been serviced in May 2015. Fire evacuation procedures were clearly displayed in the practice. There was no fire exit in the basement and this issue had been raised with the landlord.

Comprehensive information on COSHH (Control of Substances Hazardous to Health 2002) was not available. There was a file of materials but the details were very limited and only contained data sheets from the manufacturer. This was discussed with the provider and they contacted us after the inspection with evidence that they had revised their COSHH file and this included more detailed information.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice mostly followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be visually clean and hygienic. Patients commented that the practice was clean and tidy. Work surfaces and drawers were clean and free from clutter. The floors were adequately sealed in all clinical areas.

Are services safe?

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. The practice used computers and the keyboards in the treatment rooms did not have water-proof covers.

The treatment rooms had portable fans and these have the potential to spread contamination due to the rapid uncontrolled air circulation. The provider contacted us after the inspection and told us they had been removed from clinical areas.

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

Sharps bins were appropriately located and out of the reach of children. We observed waste was separated into safe and lockable containers for monthly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in a secure area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. We were told there was a system for checking the expiry dates of processed and packaged and the infection control lead was responsible for this.

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

The practice had some systems in place for daily and weekly quality testing the decontamination equipment and we saw records which confirmed these had taken place. The practice did not undertake regular tests on the

ultrasonic cleaning bath. These testing kits were ordered on the same day as our visit and the provider sent us evidence after the inspection that they were regularly carrying out the recommended tests.

There appeared to be sufficient instruments available to ensure the services provided to patients were uninterrupted. Staff also confirmed this with us. Staff we spoke with were aware of instruments that were designed for single use.

The practice manager informed us that all general cleaning (such as the treatment room floors and other rooms in the building) was carried out daily by staff at the practice. Colour coded cleaning equipment was supplied and was stored in accordance with HTM 01-05 guidance.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument. There were no contact details on it for the practice's designated Occupational Health department. However, we were told that all staff members had been given the contact details. In addition to this, the practice manager emailed us a few hours after the inspection and sent us an updated protocol which included contact details.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every six months in line with current guidance. Results of the most recent audit (January 2016) showed that action plans were documented subsequent to the analysis of the results. By following the action plan, the practice could subsequently assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on running the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. A risk assessment process for Legionella was carried out in October 2014 by an external agency. We viewed a written management scheme and its implementation. The practice was recording water temperature on a monthly basis to check that the temperature remained within the

Are services safe?

recommended range. This was for all water outlets as identified in the risk assessment. They were not carrying out tests of the water quality but told us that the contractor advised them this was not necessary until the next risk assessment (due in October 2016). The risk assessment also advised a boiler service – this had not been carried out since the risk assessment. The provider contacted us after the inspection and told us that they had consulted several experts who all advised that a service was not required.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as the X-ray sets, pressure vessels and autoclaves. The autoclave was last serviced in October 2014 but the provider sent us evidence that an autoclave service had been carried out after our visit.

Regular Portable Appliance Testing (PAT) is required to confirm that portable electric items used at the practice are safe to use. We saw a PAT certificate which was valid until April 2016.

The practice kept a log of all dispensed medicines so they could ensure that all prescriptions were tracked and safely given.

There was a separate fridge for the storage of medicines and dental materials. We saw evidence that the temperature was being monitored on a daily basis.

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded and corroborated this by reviewing patient care records. All dental materials we viewed were within their expiry date and we were told that the practice manager carried out monthly checks to ensure any expired materials were disposed of in a timely manner. This was not logged but the provider sent us evidence after the inspection that they were now documented this on a monthly basis.

Radiography (X-rays)

The practice used digital X-rays. The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. A machine was present which previously enabled the taking of orthopantomograms (OPG). An OPG is a rotational

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

A Radiation Protection Supervisor (RPS) had been appointed but we did not see evidence that a Radiation Protection Advisor (RPA) was available. Both are required to ensure that the equipment was operated safely and by qualified staff only. The practice manager contacted us within two working days to inform us that they had contacted an external organisation for the appointment of a RPA and this would be completed on the next working day. Subsequently, we saw evidence that this process had been completed.

Local rules were available in the practice for all staff to reference if needed. These were displayed in both treatment rooms.

We did not see evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this. The practice manager emailed us a few hours after the inspection with evidence that the HSE had been notified on the same day.

We viewed current maintenance logs for all X-ray equipment. We did not see any evidence that an Acceptance Test had been carried out for the X-ray equipment. This is a report provided on installation of X-ray equipment stating that the equipment is safe to use and fit for purpose.

An X-ray audit had been carried out at the practice in January 2016. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. This audit was not available to view during our visit but it was emailed to us a few hours after.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP). The practice carried out a record keeping audit in January 2016.

The dentists consistently documented the recall intervals, as directed by NICE (National Institute for Health and Care Excellence). NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines. This takes into account the likelihood of the patient experiencing dental disease.

We talked to the dentist about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient care records. Clinical records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were updated by each patient every six months. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE for adults and children. Treatment was then provided according to the results of the BPE.

The practice used other guidelines and research to improve their system of clinical risk management. For example, following clinical assessment, the dentist told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records. The dentist was grading the quality of their own X-rays but not using the universal grading system.

Staff told us that treatment options and costs were discussed with the patient.

Health promotion & prevention

The medical history form patients completed included questions about their smoking and alcohol consumption. The dentist and the patient records showed that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

There were oral health promotion leaflets available in the practice to support patients look after their health. Examples included information on tooth decay, gum disease and oral hygiene instructions. There was a television in the waiting area which displayed information on dental education for patients.

We were told that the practice carried out preventative care and supported patients to ensure better oral health. We were told that the practice mostly followed guidance from The Delivering Better Oral Health Toolkit (DBOH). This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran.

We saw evidence that the provider maintained the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. The dental nurse had recently qualified and had applied for GDC registration at the time of our visit.

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that the dentist and dental nurse took planned leave at the same time. The practice would remain open during these periods as there would be a staff member to cover reception duties. The practice occasionally utilised the services of a locum agency if staff members were absent due to sickness.

At the time of inspection, two staff members were on long-term leave (practice manager and receptionist). However, the practice manager was flexible and was able to work remotely. Also, she was able to visit the practice whenever required as she lived locally and she was also registered as a dental nurse. We were told the receptionist

Are services effective?

(for example, treatment is effective)

was due to return to work the week after the inspection. In their absence, we were told that the dental nurse would always cover reception duties. We were told that the dental nurse and dentist were always present in the treatment room when patients were present. This meant that the reception area was not always supervised – we were told that the main door was locked whenever this situation arose. We were told that patients were instructed to leave a message on the answer phone if the reception desk was unsupervised. Staff would return these calls as soon as possible.

We were told that staff were supported on a day to day basis by the dentist and practice manager. Staff told us the practice manager was readily available to speak to at all times for support and advice – staff could call her at any time if required.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. We viewed one referral letter and noted that it was comprehensive to ensure the specialist services had all the relevant information required.

The practice understood the procedure for urgent referrals, for example, patients with suspected oral cancer.

Consent to care and treatment

Patients were given appropriate verbal information to support them to make decisions about the treatment they

received. Staff ensured patients gave their consent before treatment began. Patients were asked to sign a statement if they declined recommended procedures to state they understood the consequences of no treatment.

Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) and how it was relevant to ensuring patients had the capacity to consent to dental treatment. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. 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. The provider had completed MCA training in February 2016.

Staff we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. All staff members we spoke with who were directly involved in providing dental care and obtaining consent were familiar with the concept of Gillick competence. This relates to the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff confirmed individual treatment options, risks, benefits and costs were discussed with each patient and these were documented in the dental care records. Patients were given time to consider and make informed decisions about which option they preferred. We were told that all patients were given customised treatment plans in writing.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Thirteen patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that the treatment received was of a very high standard. They said that staff were friendly and accommodating and it was easy to book an appointment.

We were told that privacy was always maintained and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. Staff said if a patient wished to speak in private they would find an available room to hold any confidential discussions. Confidential patient information was stored in a secure area.

We were told that the practice appropriately supported anxious patients using various methods. The practice

booked longer appointments so that patients had ample time to discuss their concerns with the dentist. Patients were given the opportunity to discuss any dental concerns with staff at reception and patients could choose which music they played in the treatment room. The dentist and staff would talk to the patients in a calming manner to help to alleviate any concerns. The dentist would refer any patients for sedation if the above methods proved to be unsuccessful or at the patient's request.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. We were told that patients were informed of the range of treatments available. Information was provided to them in the form of a customised written treatment plan.

Examination and treatment fees were displayed in the waiting room. We were told that the receptionist always discussed the private fees with any new patients so they were fully informed before they booked an appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as there was a treatment room on the ground floor. The practice did not have toilet facilities on the ground floor. However, the practice had an agreement with a public house (on the same street) so that dental patients with mobility difficulties could use their toilet facilities.

The practice had an appointment system in place to respond to patients' needs. We saw that staff blocked gaps in the appointment book to allow the dentist to catch up in between patients. We were told this was a successful method of preventing the dentist from running late so that patients would almost always be seen at their allocated time.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. The practice could open beyond its opening hours to accommodate patients with urgent dental needs, if required. Patient feedback confirmed that the practice was providing a good service that met their needs.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients.

The practice appeared to recognise the needs of different groups in the planning of its services. The practice had a list of fees available in Braille for patients with visual impairments. The practice did not have an audio loop system for patients with hearing impairments; however, the practice accommodated these patients using alternative methods.

Access to the service

The practice displayed its opening hours on the premises. Patients could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. The practice had an arrangement with local dentists whereby patients could be seen for emergency dental treatment.

Opening hours are 8.30am Monday – Wednesday, 9.30am to 6.30pm on Thursdays, 8.30am to 4pm on Fridays and 9am to 2.30pm on Saturdays.

Concerns & complaints

No complaints had been received at the practice within the past 12 months.

The practice had a complaints process and staff were knowledgeable about how to handle a complaint. The complaints policy had the contact details for external organisations such as the GDC if patients were dissatisfied with the response from the practice.

Are services well-led?

Our findings

Governance arrangements

The provider was in charge of the day to day running of the service. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service.

The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately; however, we identified some areas that required improvement. The practice promptly resolved most of these shortfalls. Areas included some aspects of infection control and radiation protection.

Risk assessments were in place and one example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead and infection control lead.

Learning and improvement

We reviewed the provider's training records and saw that they had completed CPD in areas such as consent, radiography, infection control, safeguarding and equality and diversity within the past 12 months.

Staff audited areas of their practice as part of a system of continuous improvement and learning. These included audits of X-rays, dental care record keeping and infection control.

The practice manager told us that formal staff meetings had not been regularly held over the past year. This was because it was a small practice and discussions took place on an informal and daily basis. We were told that they would begin to hold formal staff meetings once the receptionist returned to the practice and they would record minutes of staff meetings. This would allow staff members to update themselves if they were unable to attend. The practice manager subsequently contacted us within two working days with minutes from staff meetings held every month between September 2015 and March 2016 inclusive. Topics covered included safeguarding and infection control.

We were told that the practice manager planned to carry out regular staff appraisals where learning needs, concerns and aspirations could be discussed. They had planned to do this every 6-12 months for the dental nurse and receptionist. There were no appraisals to view during our visit as both staff members had been in continuous post for less than 12 months at the practice. We saw examples of the identification of poor performance and improvements made.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. The practice undertook patient satisfaction surveys and the feedback was generally positive. The practice manager told us they had implemented changes as a direct result of patient feedback. One example of this was they started to book longer appointments after a patient commented they had to wait beyond their allocated time. A suggestions box for patients was available at the practice.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires.