Dr. Graham Brown

Dr Browns Dental Surgery

Inspection Report

3 Dog Kennel Lane
Oldbury
West Midlands
B68 9LU
Tel: 0121 552 1070

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Overall summary

We carried out an announced comprehensive inspection on 14 February 2017 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

Dr Browns Dental Surgery is a dental practice providing general dental services on a NHS and private basis. The service is provided by one dentist (who is the provider). They are supported by two dental nurses and a receptionist.

The practice is located on a main road near local amenities and bus routes. There is wheelchair access to the practice (via a side entrance) and on-street car parking.

The premises consist of a waiting room, a reception area, one treatment room, a decontamination room and a disused laboratory on the ground floor. Toilet facilities are available for patients on the ground floor but these are not wheelchair-accessible. The first floor is for staff use only and comprises of a storage room, staff room, kitchen and toilet facilities. The practice opens between 9:30am and 5:30pm from Monday to Friday.

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

Twenty-three patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection. Only two patients were booked on the day of our visit and we were unable to speak with them. Patients were unanimous in their praise

Summary of findings

of the practice and its staff. Patients were positive about their experience and they commented that staff were caring, warm and professional. Those that commented on cleanliness confirmed that the practice was always clean and hygienic. A number of patients commented that they had been patients at the practice for many years and would not want to go anywhere else.

Our key findings were:

- The practice was organised and appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patients were able to make routine and emergency appointments when needed and gave us positive feedback about the service they received.
- An infection prevention and control policy was in place. We saw the decontamination procedures followed recommended guidance.
- The practice had systems to assess and manage risks to patients, including health and safety, safeguarding, safe staff recruitment and the management of medical emergencies.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had a complaints system in place.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Practice meetings were used for shared learning.
- The practice demonstrated that they undertook audits in infection control, radiography and dental care record keeping; however, one of these was overdue.

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

- Review the practice's system for the recording, investigating and reviewing incidents or significant events with a view to preventing further occurrences and ensuring that improvements are made as a result.
- Review stocks of medicines and equipment and the system for identifying and disposing of expired stock.
- Review the practice's recruitment policy and procedures to ensure proof of identification are requested and recorded suitably.
- Review its audit protocols to ensure infection control audits are undertaken at regular intervals and where applicable learning points are documented and shared with all relevant staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

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

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff although no recruitment policy was present.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. However, one emergency medicine had expired and had not been disposed of in a timely manner.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit which centred around future refurbishment plans to update the ceiling lining and the upholstery on the dental chair in the treatment room. The provider responded promptly to deal with any issues.

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

Are services effective?

No action

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. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

No action

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

Summary of findings

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was overwhelmingly positive about the care they received from the practice. Patients described staff as caring, considerate and knowledgeable. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were warm, friendly and professional.

Are services responsive to people's needs?

No action 

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

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Patients were able to contact staff when the practice was closed and arrangements were subsequently made for these patients requiring emergency dental care.

The practice had a complaints process.

The practice offered access for patients with limited mobility.

Are services well-led?

No action 

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

There was a clearly defined management structure in place and staff we spoke with felt supported in their own particular roles.

There were systems in place to monitor the quality of the service including various audits. The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. However, one audit was overdue.

Dr Browns Dental Surgery

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 Dr Browns Dental Surgery on 14 February 2017. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the provider, the dental nurse and the receptionist. We also reviewed CQC comment cards which patients had completed. 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 systems in place for staff to report accidents and incidents. The last accident was recorded in 2012. We reviewed records of accidents and these were completed with sufficient details about what happened and any actions subsequently taken. There was a policy for recording incidents but none had been recorded. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reportable incidents had taken place at the practice in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We saw that the practice had registered one organisation for receiving alerts but not with the Medicines and Healthcare products Regulatory Agency (MHRA). There was not a robust process for obtaining information from relevant emails and forwarding this information to the rest of the team. Within 48 hours, the provider informed us they had subscribed to the MHRA and provided details about how any relevant information would be disseminated to staff at the practice.

Not all staff we spoke with were aware of the Duty of Candour regulation. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Within 48 hours, the provider sent us evidence of a policy which staff had signed to confirm their acceptance and understanding.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and protection of vulnerable adult policies and procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local 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 refer concerns. Training records showed staff had completed training in 2016 in safeguarding vulnerable adults but this did not include child protection. Within 48 hours, the provider sent us evidence that all staff had completed the relevant training.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We saw a rubber dam kit at the practice and were told that the dentist used them when carrying out root canal treatment whenever practically possible. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

All staff members we spoke with were aware of the whistleblowing process within the practice and there was a policy present. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues. The policy had not been reviewed since 2009 and some information was outdated. Within 48 hours, the provider sent us an amended policy which contained all necessary details.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were not aware of 'never events' and the practice did not have written processes to follow to prevent these happening. For example, there was no written process to make sure they did not extract the wrong tooth. However, staff described to us the methods they used to prevent such incidents from occurring.

The practice had processes in place for the safe use of needles and other sharp instruments.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies in the practice were in line with the Resuscitation Council UK guidelines and the British

Are services safe?

National Formulary (BNF). However, we identified some necessary improvements. 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 and delivers an electrical shock to attempt to restore a normal heart rhythm. This arrived at the practice two days before our visit.

Staff received annual training in the management of medical emergencies. The practice took responsibility for ensuring that all of their staff received annual training in this area. All equipment and medicines were stored in a secure but accessible area.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and AED and monthly checks of the emergency medicines. The emergency medicines were in date and stored securely, however, we found one medicine (glucagon) stored in the fridge that had expired and had not been disposed of. There was an additional glucagon injection kit and this was well within its expiry date. A glucagon injection kit is used to treat episodes of severe hypoglycemia which is defined as having low blood glucose levels. The provider informed us the expired glucagon had been disposed of.

We noted that the practice did not have any buccal midazolam; this is an emergency medicine used to treat a number of conditions including seizures. The practice did have some midazolam in the correct dose but it was not available in the buccal form (it was for other routes such as intravenous, intramuscular and rectal). This was discussed with the provider and they emailed us with evidence they had placed an order for the appropriate midazolam the day after our visit.

All staff we spoke with were aware of the location of this equipment and equipment.

Bodily fluid spillage, eyewash and mercury spillage kits were available to deal with any incidents.

Staff recruitment

We looked at the recruitment records for two members of the practice team. The records we saw contained evidence of employment contracts, curricula vitae and written references. there was no staff identity verification for one staff member. Where relevant, the files contained copies of General Dental Council (GDC) registration certificates.

There were also Disclosure and Barring Service (DBS) checks present for staff members. 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 a system in place to monitor the professional registration and dental indemnity of its clinical staff members.

The practice did not have a written recruitment policy for the safe recruitment of staff. Within two working days, the provider sent us a policy and this contained all relevant details.

Monitoring health & safety and responding to risks

The practice had systems to identify and mitigate risks to staff, patients and visitors to the practice. A health and safety risk assessment had been carried out and we were told this was reviewed annually.

We saw evidence that the fire extinguishers had been serviced ad this was valid until April 2017. Fire safety instructions were displayed clearly throughout the building for staff and patients. Fire drills took place annually to ensure staff were rehearsed in evacuation procedures. Smoke detectors were present but they were not tested regularly. The provider replaced the batteries every January but they were not tested in between. There were two fire exits on the ground floor and these had clear signage to show where the evacuation point was. A fire risk assessment had been carried out in 2010 by an external contractor and we saw that it had been reviewed in January 2017 by the provider. The risk assessment had details of recommended actions – most actions had been completed although had not been documented to reflect this.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to contain risk assessments for most relevant substances. Risk assessments for blood and saliva were not contained within the COSHH file although this information was

available in the practice's infection control policy. The COSHH file had not been reviewed since 2013. Within 48 hours, the provider informed us that blood and saliva now had their own entries in the practice's COSHH file. They also told us that the entire file was being reviewed systematically and that this process was due to be completed soon.

Infection control

There was an infection control policy and procedures to keep patients and staff safe and it was dedicated to the practice. The practice 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. A booster dose is usually recommended five years after the initial course of immunisation. One staff member told us they had not received a booster because their physician advised them it was not necessary due to their response to the initial dose.

We observed the treatment room and the decontamination room to be visually clean. Many patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition; however, we observed minor defects in the upholstery and the ceiling lining in the treatment room. Within 48 hours, the provider informed us that they had arranged for the chair to be re-upholstered and we saw evidence of this. They also informed us they had arranged for a decorator to assess the ceiling lining within the week with a view to full smooth surface replacement.

There were handwashing facilities in the treatment room and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Hand washing protocols were displayed appropriately in various areas of the practice.

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 an 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. There appeared to be sufficient instruments available and staff confirmed this with us. Staff we spoke with were aware of disposable items that were intended for single use only.

Staff used a washer-disinfector to clean the used instruments. They are used to carry out the processes of cleaning and disinfection consecutively in an automated cycle. HTM 01-05 identifies the use of washer-disinfectors as best practice. The instruments 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 disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment on a regular basis. We saw records which confirmed these had taken place.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument – this included all the necessary information and was easily accessible. Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

Are services safe?

All clinical and non-clinical areas were cleaned daily by practice staff. The practice had a dedicated area for the storage of their cleaning equipment.

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 in line with current guidance; however, the next audit was overdue as it had been over six months since the previous audit. Due to unforeseeable circumstances, the infection control lead had been away from the practice for several months. Within 48 hours, the provider sent us evidence that staff had almost completed a new infection control audit. We reviewed the audit from April 2016 and this was satisfactory.

Staff members were following the guidelines on managing the water lines in the treatment room to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We reviewed the Legionella risk assessment and this was carried out by an external contractor in June 2015. The practice recorded water temperature on a weekly basis to check that the temperature remained within the recommended range. The practice also carried out and documented quarterly checks of the water quality. We reviewed these and found that the results demonstrated that the water quality was satisfactory.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves.

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in March 2016.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The prescription number was not recorded in the patients' dental care records. The practice did not keep a log of prescriptions given so they could not ensure that all prescriptions were tracked. Within 48 hours, the provider emailed us a copy of a newly devised log. They also informed us that prescription numbers would be recorded in the clinical records for individual patients.

There was a separate fridge for the storage of medicines and dental materials. The temperature was monitored and recorded daily.

Stock rotation of all dental materials was carried out on a regular basis by the dental nurse and all materials we viewed were within their expiry date. A system was also in place for ensuring that all processed packaged instruments were within their expiry date.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used non-digital X-rays.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed.

We saw 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 X-ray equipment in the treatment room was not fitted with a part called a rectangular collimator. Using rectangular collimation is good practice as it reduces the radiation dose to the patient. The provider told us that the dental practice held a collimator and they intermittently used it. They could not locate this at the time and informed us they would purchase a new part if they were unable to find it within five days.

We saw evidence that the dentist was up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

We saw evidence that the practice carried out an X-ray audit in 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.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date, written dental care records. They contained information about the patient's current dental needs and past treatment. The dentist carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP) although they did not record the patients' risk assessment to oral disease.

We spoke with the dentist about the oral health assessments, treatment and advice given to patients and they showed us a selection of patient dental care records to corroborate this. Dental care 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 documented in the records we viewed. This should be updated and recorded for each patient every time they attend.

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 all adults and children aged 7 and above (as per guidelines). We saw evidence that patients diagnosed with gum disease were appropriately treated.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentists 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.

Staff told us that treatment options and costs (where applicable) were discussed with the patient.

Health promotion & prevention

The dentists we spoke with told us 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 in looking after their health. Examples included information on oral cancer and oral health.

The practice was aware of the provision of preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive oral hygiene advice. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This included areas such as fire safety, infection control and obtaining consent. There was no official induction programme for one staff member but we saw an additional form that all staff were required to sign. This included information about confidentiality, information handling and reporting incidents.

Staff told us they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC.

The provider monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. All of the employed staff were part-time and had the flexibility to work additional hours, if required. In the absence of one staff member, the others described how they had increased their hours to support the provider.

Dental nurses were supervised by the dentist. Staff told us that senior staff was readily available to speak with at all times for support and advice.

A dental nurse always worked with the dentist. The General Dental Council (GDC) recommends that dental staff are supported by an appropriately trained member of the dental team at all times when treating patients.

Working with other services

Are services effective?

(for example, treatment is effective)

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 specialist dental services for complex oral surgery. We viewed three referral letters and noted that they were comprehensive to ensure the specialist services had all the relevant information required.

Staff understood the procedure for urgent referrals, for example, patients with suspected oral cancer. However, there was no referral log to track the status of referrals.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began and all patients were given written treatment plans.

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). 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.

Staff members we spoke with were familiar with the concept of Gillick competence regarding 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 members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Staff told us that written treatment plans were provided. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Twenty-three patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection. Only two patients were booked on the day of our visit and we were unable to speak with them. Patients were unanimous in their praise of the practice and its staff. Patients were positive about their experience and they commented that staff were caring, warm and professional. Those that commented on cleanliness confirmed that the practice was always clean and hygienic. A number of patients commented that they had been patients at the practice for many years and would not want to go anywhere else.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the door to the treatment room was closed during appointments 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. The reception area was not left unattended and confidential patient information was stored in a secure area. There was a room available for patients to have private discussions with staff. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit. There was a policy about the importance of confidentiality and staff had signed this to demonstrate understanding and awareness.

We were told that the practice appropriately supported children and anxious patients using various methods. Longer appointments were arranged to allow additional time for discussions. Patients could also request a referral for dental treatment under sedation.

We saw that patients were very complimentary and grateful to the practice for the dental care they received. We saw several cards addressed to the practice which thanked staff for their kindness and support.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Comments made by patients stated they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available.

Examination and treatment fees were displayed in the waiting room.

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 via a side entrance that had level access to the building. The treatment room, waiting room, toilet facilities and reception area were all situated on the ground floor. Car parking was available for patients with physical disabilities near the main entrance to the practice.

There were toilet facilities available on the ground floor but these were not wheelchair-accessible.

The practice had an appointment system in place to respond to patients' needs. Feedback from patients confirmed that it was easy to book a convenient appointment and that reception staff were friendly and accommodating.

Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred. There was also a sign in reception encouraging patients to contact the receptionist if they were waiting beyond their allocated appointment time.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We reviewed the appointment system and saw that dedicated emergency slots were available on a daily basis to accommodate patients requiring urgent treatment. If these slots became unavailable, the practice was able to accommodate patients by utilising a 'sit and wait' policy.

Staff shared examples with us where they had made adjustments so that vulnerable patients could access the service.

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 recognised the needs of different groups in the planning of its services. The practice had an audio loop system for patients who might have hearing impairments. Also, the practice had access to sign language interpreters, if required.

The practice welcomed patients with visual and hearing impairments and described the processes used to ensure they remained sensitive to the patients' needs.

The practice had access to an interpreting service for patients that were unable to speak fluent English.

Access to the service

Feedback from patients confirmed they 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. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment via the telephone answering service. There were also details for patients in the waiting room.

We reviewed the appointment book and found that patients were allocated enough time for their appointments. We did not see any evidence of double-booking.

The practice opened between 9:30am and 5:30pm from Monday to Friday.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and accessible to patients. This included details of external organisations in the event that patients were dissatisfied with the practice's response. This policy required an update as some of the external organisations had been superseded since. Within 48 hours, we received an amended policy with the updated contact details.

No written complaints had been received by the practice in the 12 months prior to our visit. There was a designated complaints lead.

Are services well-led?

Our findings

Governance arrangements

The senior dental nurse was also in charge of the management aspects. However, they had been on long-term leave for the past few months. In their absence, the existing team had continued with the governance and the provider was very grateful to the remaining staff members for all of their effort. They were described as focused and reliable.

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. One example was their risk assessment of injuries from sharp instruments. We were told that the dentist 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. The practice also had risk assessments for areas such as the autoclaves, clinical waste and gas boiler.

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, complaints lead and infection control lead.

The provider had systems in place to support communication about the quality and safety of services. Staff told us they were aware of the need to be open, honest and apologetic to patients if mistakes in their care were made. This was in line with the Duty of Candour regulation.

Learning and improvement

The provider monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The GDC requires all registrants to undertake CPD to maintain their professional registration.

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

Staff meetings took place on a monthly basis. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as fire safety, infection control and the management of anxious patients had been discussed in 2016.

Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed. We saw evidence that the appraisals had started very recently for two staff members. Staff had not previously received appraisals but the provider planned to do these on an annual basis for all staff.

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

Staff we spoke with told us that they felt engaged and involved at the practice. They described the team as a small family and told us they thoroughly enjoyed working together.

The practice had systems in place to involve, seek and act upon feedback from people using the service. An example of this included the introduction of new systems to minimise the likelihood of patients waiting beyond their allocated appointment time. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. There was a suggestions box in the waiting room for patients. Patients were also selected randomly to complete satisfaction surveys.

The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. We reviewed some of the responses and the vast majority of patients were 'extremely likely' to recommend this practice to their family and friends.

Are services well-led?

Patients had made comments on the NHS Choices website and these were predominantly positive. The practice had not yet responded to the entries on the website.

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