

Stella Maris Practice Limited

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Inspection Report

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Date of inspection visit: 13 September 2016
Date of publication: 15/11/2016

Overall summary

We carried out an announced comprehensive inspection on 13 September 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

Stella Maris Dental Practice Limited is a dental practice providing general dental services on a private basis. Additional services include implant dentistry and orthodontics. The service is provided by three dentists, three dental hygienists and one dental therapist. They are supported by six dental nurses (three of whom are trainees), a practice manager and a receptionist. All of the dental nurses also carry out reception duties. A clinical dental technician also visits the practice on a weekly basis to provide prosthetic dentistry. Another dentist visits the practice on an ad hoc basis to provide complex oral surgery.

The practice is located on a main road near local amenities and bus routes. There is wheelchair access to the practice and car parking facilities. The premises consist of a waiting room, a reception area, an office, staff room/kitchen two treatment rooms and accessible toilet facilities on the ground floor. The first floor comprises of a decontamination room, three treatment rooms and a waiting area. There is also a designated area for taking X-rays. There is also a basement which is used as a storage area. The practice opening hours are from 9am to 5:45pm on Monday to Thursday and from 9am to 1pm on Fridays.

The provider 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

Summary of findings

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.

Twenty-eight patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients. The information from patients was all complimentary. Patients were positive about their experience and they commented that staff were friendly, professional and welcoming.

Our key findings were:

- The practice appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patients told us they found the staff polite and friendly. Patients were able to make routine and emergency appointments when needed.
- 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. We identified some areas of improvement.
- Dental professionals provided treatment in accordance with current professional guidelines.
- 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.
- The practice demonstrated that they undertook audits in infection control, radiography and dental care record keeping.

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 availability of medicines and equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK) and the General Dental Council (GDC) standards for the dental team.
- Review staff training in safeguarding ensuring it covers both children and adults and all staff are trained to an appropriate level for their role and aware of their responsibilities. The practice should also review the training, learning and development needs of individual staff members and have an effective process established for the ongoing assessment and supervision of all staff.
- Review the practice's recruitment policy and procedures to ensure character references, DBS (Disclosure and Barring Service) checks and the assessment of related risks for new staff are requested and recorded suitably.
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development.

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.

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. We identified areas where improvements were required and staff responded promptly to feedback.

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.

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'.

Staff told us they felt confident about reporting accidents but no incidents had been documented. Staff were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

No action



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. 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. 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.

No action



Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was completely positive about the care they received from the practice. Patients described staff as friendly and polite. 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 supportive and understanding.

No action



Are services responsive to people's needs?

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

No action



Summary of findings

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?

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.

The practice carried out audits such as radiography, dental care record keeping and infection control to help improve the quality of service.

No action



Stella Maris Practice Limited

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 Stella Maris Dental Practice Limited on 13 September 2016. 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 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 (we were told that the practice had not received any written complaints during this period).

During the inspection we toured the premises, spoke with the provider, the practice manager, one other dentist, one hygienist, two dental nurses and the receptionist. We also reviewed CQC comment cards which patients had completed and spoke with patients. 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 2015 and was documented with sufficient details about what happened and any actions subsequently taken. The practice had a policy for recording significant events 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 at the practice agreed and told us they would begin implementing this with immediate effect to share learning.

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 with the Central Alerting System; however, they had not received some relevant alerts that had been sent from another organisation (Medicines and Healthcare products Regulatory Agency). Within 48 hours, the practice manager emailed us evidence that they had now registered with the additional organisation too. The practice manager was responsible for obtaining information from relevant emails and forwarding this information to the rest of the team in the daily staff meetings. The practice manager was not aware of the practice's arrangements for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult 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 practice manager 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. Some of the staff members needed to attend refresher training as some of their certificates had expired in 2015.

This included the safeguarding lead at the practice but they booked training online almost immediately. We also found that one of the trainee dental nurses had not received any formal training on safeguarding. Within 48 hours, the provider contacted us to inform us that a formal staff meeting had been arranged for October and training will be provided on this date. In the meantime, we were told that staff had read all of the relevant policies to update their knowledge.

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, operating field and airway. We saw a rubber dam kit at the practice and were told that all dentists used them when carrying out root canal treatment whenever practically possible.

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.

Staff we spoke with were aware of the duty of candour regulation but had limited knowledge. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment. There was a policy present which had recently been implemented but the information was brief. Within 48 hours, the provider informed us that this will be discussed during a formal staff meeting in October 2016.

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. Within 48 hours, the provider informed us that a formal staff meeting had been arranged for October 2016 where training on this will be provided to staff.

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 mostly in line

Are services safe?

with the Resuscitation Council UK guidelines and the British 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 including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

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 oromucosal form (it was for other routes such as intravenous and intramuscular). The practice did not have a paediatric self-inflating bag. The practice carried a self-inflating bag for adults but did not have the clear face masks that are required to attach to the self-inflating bag. Within 48 hours, the provider sent us evidence that a paediatric self-inflating bag with a paediatric face mask had been delivered to the practice. The provider emailed us to explain they had difficulties obtaining the face masks in all of the recommended sizes. The practice manager emailed us several weeks after our visit with evidence that these had been purchased and delivered.

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 checks of the equipment and emergency medicines to ensure they were safe to use but this process was not consistent. We noticed that no safety checks had been documented in March 2016 or at various points between April 2016 and August 2016. The practice manager told us this could be due to certain staff members taking annual leave during these periods. Where present, we found that staff were documented weekly checks of the emergency oxygen, AED and emergency medicines. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge but the temperature was not monitored to ensure it remained within the recommended parameters. Within 48 hours, the provider contacted us with an updated policy which assigned a deputy lead for the weekly checks

in the absence of the lead person. They also sent us evidence that a thermometer was now attached to the fridge and they told us the results were now monitored and recorded.

All staff we spoke with were aware of the location of this equipment and equipment and medicines were stored in purposely designed storage containers.

Staff recruitment

The practice had a recruitment policy for the safe recruitment of staff. We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of employment contracts, curricula vitae, staff identity verification and induction plans. Where relevant, the files contained copies of staff's dental indemnity and General dental Council (GDC) registration certificates.

Only one of the files we reviewed contained a written reference. The practice's recruitment policy stated that the practice would seek two written references for each staff member. There were also Disclosure and Barring Service (DBS) checks present for two 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 provider had only recently applied for DBS checks for the third staff member although they were recruited in 2015. The practice's own policy stated that all new staff members should have a 'recent' DBS check. The practice manager clarified that they would accept DBS checks that had been carried out within the last five years. Within 48 hours, the provider sent us evidence that they were in receipt of the third DBS check. They also told us that all staff members at the practice now held a DBS check. The practice also emailed us a copy of a risk assessment that they used when accepting DBS checks from previous employers.

The practice had a system in place to monitor the professional registration and dental indemnity of its clinical staff members.

Monitoring health & safety and responding to risks

We saw evidence of a business continuity plan which described situations which might interfere with the day to

Are services safe?

day running of the practice. This included extreme situations such as loss of the premises due to fire. 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. Fire safety training was carried out by an external contractor in October 2013. We saw evidence that the fire extinguishers had been serviced in December 2015 and they were visually checked and documented every month by staff at the practice. We were told that fire drills would be carried out every six months to ensure staff were rehearsed in evacuation procedures. We reviewed the records and found that a fire drill took place in June 2016 and one in 2014. Staff carried out and recorded weekly fire alarm tests. An internal fire risk assessment had been carried out by the practice's fire marshal in August 2016. There were two fire exits on the ground floor and these had clear signage to show where the evacuation point was.

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 be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. 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. However, the practice manager had recently identified that one staff member needed to repeat the course as the initial course had not been completed. The practice manager had risk assessed the situation and ensured that this person did not carry out clinical duties until the course had been repeated. This information had not been documented in the staff member's personal file. Within 48 hours, the provider

emailed us to inform us that there was a misunderstanding between the staff member and their GP. We were told that the staff member did not have to repeat the whole course but had completed it since our visit. To avoid a situation like this from reoccurring, the practice manager told us they would be devising a spreadsheet of all immunisations.

We observed the treatment rooms 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. Dental chairs were covered in non-porous material which aided effective cleaning. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

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 weekly 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 manual scrubbing techniques to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. The decontamination room had clearly

Are services safe?

defined clean and dirty zones to reduce the risk of cross contamination. 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 daily. We saw records which confirmed these had taken place during the week of our visit.

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.

Staff told us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All clinical and non-clinical areas were cleaned daily by an external cleaner. 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. We reviewed the audit from May 2016.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in February 2016. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range. The practice also carried out quarterly tests to check the water quality.

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 May 2016.

All prescriptions were written only at the time of issue. The practice dispensed antibiotics and these were stored securely. The practice maintained a log of all medicines that had been dispensed; however, this did not include the quantity of remaining medicines. Within two working days, the provider emailed us a copy of an amended log sheet that included this information.

There was a separate fridge for the storage of medicines and dental materials. The temperature was not monitored 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 digital X-rays. Equipment was present to enable 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 2-dimensional representation of these.

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 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 provider told us they notified the HSE many years ago when they first bought the premises (over thirty years ago).

Are services safe?

The X-ray equipment in the treatment rooms was fitted with a part called a rectangular collimator which is good practice as it reduces the radiation dose to the patient.

We saw evidence that two of the dentists were up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The practice did not have evidence of training for the third dentist. The provider emailed us after our visit with copies of the third dentist's training certificates in this area.

We saw evidence that the practice had recently carried out an X-ray audit in September 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. We saw evidence that the results were analysed and reported on.

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).

We spoke with two dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. 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. 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 were discussed with the patient and this was corroborated when we spoke with patients.

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 was information available on diet and decay. Oral cancer screening was available at the practice.

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, COSHH and accident reporting.

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 (apart from the trainee dental nurses as only qualified staff can register).

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that some of the employed dental nurses were part-time and had the flexibility to work additional hours, if required. Occasionally, the practice utilised a locum dental nurse agency.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us that senior staff were readily available to speak with at all times for support and advice.

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 specialist dental services for complex oral surgery. We viewed two

Are services effective?

(for example, treatment is effective)

referral letters and noted that they were comprehensive to ensure the specialist services had all the relevant information required. Patients were given the option of receiving a copy of their referral letter.

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

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 this was recorded in the dental care records.

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 and patients 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-eight patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was highly positive about the care they received from the practice. They described staff as friendly, welcoming and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here as the staff were caring. Several patients commented that they had attended this practice for many years, even decades. We were told that some of the patients had moved abroad but still attended this practice.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were 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. Staff told us they had individual

passwords for the computers where confidential patient information was stored. There was a room available for patients to have private discussions with staff and information about this was displayed in the reception area. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

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. They also had the choice of seeing different dentists at the practice. Patients could also request a referral for dental treatment under sedation.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available. Patients commented that the cost of treatment (where applicable) was discussed with them and this information was also provided to them in the form of a customised written treatment plan.

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 as two treatment rooms were on the ground floor. There was a car parking bay for patients with physical disabilities near the main entrance to the practice. There were accessible toilet facilities on the ground floor.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were usually seen on time and that it was easy to make an appointment. Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred.

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 opening up appointment slots during the lunch hour.

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 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. The practice also used various methods so that patients

with hearing impairments could still access the services, such as providing information in a written format. The practice had access to sign language interpreters, if required.

The practice had access to an interpreting service for patients that were unable to speak fluent English. Some of the staff at the practice spoke additional languages, such as Punjabi and Arabic.

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. The dentist had an arrangement with another local dental practice whereby patients could be seen for emergency dental treatment. Details were provided on the practice telephone's answering machine and they were also displayed at the main entrance to the practice.

Opening hours were from 9am to 5:45pm on Monday to Thursday and from 9am to 1pm on Fridays.

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.

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

Are services well-led?

Our findings

Governance arrangements

The practice manager 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 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. The practice also had risk assessments for areas such as the autoclaves, fire safety and display screen equipment.

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.

Learning and improvement

Staff audited areas of their practice as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. The practice had only just commenced audits in X-rays and told us they planned to regularly carry these out for all dentists.

Staff meetings took place every morning for 15-20 minutes. This was an opportunity for staff to discuss all aspects of clinical and non-clinical practice. 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. We saw evidence that patients' feedback was discussed regularly. Topics such as infection control and housekeeping had been discussed but there were no detailed minutes regarding audits, training or health and safety.

The practice manager, dental nurses and receptionists all received annual appraisals and we reviewed ten of these. The practice manager told us they would consider appraising dentists in the near future. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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. An example of this included providing a particular magazine for the waiting room in response to suggestions made by patients. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. Patients were invited to complete satisfaction surveys and these were carried out twice a year. There was a dedicated book in the waiting area for patients' testimonials.

Staff we spoke with told us their views were sought and listened to but there were currently no dedicated staff satisfaction questionnaires. The practice manager told us they were planning to introduce these for all staff in the near future.