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Parkside Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 May 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

Parkside Dental Practice has four dentists who work part time, three part time dental hygienists, five qualified

dental nurses who are registered with the General Dental Council (GDC), one trainee dental nurse, a practice manager, assistant practice manager, business development manager and two receptionists. The business development manager works between two dental practices and spends some time at each location. The practice's opening hours are 9am to 6pm on Monday to Thursday and 9am to 5pm on a Friday and the practice was closed between 1pm to 2pm each day during lunch time. The practice opened at 8am on a Monday and Tuesday and from 9am to 1pm every other Saturday for orthodontic patients only. This helped to ensure that those patients with work commitments were still able to receive an appointment.

Parkside Dental Practice provides NHS orthodontic treatment and private general dental treatment for adults and children. The practice has five dental treatment rooms; two of which are on the ground floor. There is a separate decontamination room for cleaning, sterilising and packing dental instruments on the first floor which serves the treatment rooms on this floor. Sterilisation of dental equipment used on the ground floor is completed within the treatment room. There is also a reception desk and departure desk and two waiting areas; one on each floor of the practice.

The practice manager has applied to become the 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

Summary of findings

'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 practice manager was in attendance at this inspection.

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

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Staff had been trained to deal with medical emergencies.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice was well-led and staff felt involved and worked as a team.
- Governance arrangements were in place for the smooth running of the practice and there was a structured plan in place to audit quality and safety.

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

- Review the fire safety checklist and ensure that checks are completed in line with the frequency required on the checklist.
- Review the systems for recording batch numbers and expiry dates of local anaesthetics used.
- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

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.

Systems were in place for recording significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). Emergency medical equipment was also available and documentation was available to demonstrate that checks were being made to ensure equipment was in good working order and medicines were within their expiry date. Staff had received training in responding to a medical emergency. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. The practice followed procedures for the safe recruitment of staff, this included carrying out disclosure and barring service (DBS) checks, and obtaining references.

Infection control audits were being undertaken on a six monthly basis which is in line with the recommendations of Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05)'. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Are services effective?

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

The practice used oral screening tools to identify oral disease. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. Patients' dental care records confirmed this and it was evident that staff were following recognised professional guidelines. Referrals were made in a timely way to ensure patients' oral health did not suffer.

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

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. Feedback from patients was overwhelmingly positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful

Are services responsive to people's needs?

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

Summary of findings

Patients had good access to treatment and urgent care when required. Patients in dental pain or who were in need of urgent treatment were able to get an appointment within 24 hours of their phone call. Staff told us that routine appointments were available within a few days of the request. Patients we spoke with confirmed this. The practice had ground floor treatment rooms and ramped access was provided into the rear of the building for patients with mobility difficulties and families with prams and pushchairs.

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

Are services well-led?

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

There were good governance arrangements and an effective management structure in place. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

Regular staff meetings were held and staff said that they felt well supported and could raise any issues or concerns with the registered manager.

The practice was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

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

Parkside Dental Practice

Detailed findings

Background to this inspection

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

This inspection took place on 11 May 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with seven members of staff, including the registered manager. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records and patient dental health education programme.

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

Systems were in place to enable staff to report incidents and accidents. We were told that there had been two accidents within the last twelve months. The practice kept an accident book which recorded details of these accidents. Staff told us that accidents were discussed at informal meetings but said that there were no minutes of these meetings. We spoke with two dental nurses who were able to recall recent accidents and discussed actions taken. These staff members confirmed that all accidents were discussed with staff at informal meetings.

All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR). An accident policy had been developed which included information regarding RIDDOR and forms were available to enable staff to report incidents under RIDDOR regulations if necessary. The policy had been reviewed in 2016 to ensure information was up to date. We were told that there had been no events at the practice that required reporting under RIDDOR.

We were told that there had been no significant events at the practice. We saw that significant event reporting forms were available on the computer desktop. Learning outcomes and an action plan would be recorded on this form. The practice manager told us that significant events would be discussed at staff meetings when they occurred. Staff spoken with said that they would report any significant events to the practice manager or the business manager. We saw that there was a significant events policy which had been reviewed on an annual basis.

The practice had not made arrangements to receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These are sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Following the inspection the practice informed the Care Quality Commission (CQC) that they had signed up to receive MHRA alerts.

We saw that an overview of Duty of Candour was available for staff. This informed staff that the practice would inform patients when things went wrong, when there was an

incident or accident and patients would be given an apology. Staff we spoke with confirmed that an apology would always be given to patients both verbally and in writing as necessary.

Reliable safety systems and processes (including safeguarding)

The practice had a child protection and a separate safeguarding vulnerable adults policy in place. We were told that these policies had been updated recently following change of contact details for local organisations responsible for investigation. Staff had been sent an email informing them that the policy and contact details had been amended. Updated contact details for the appropriate external organisations including out of hours contacts were on display throughout the practice. The business manager had been identified as the safeguarding lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. Staff also said that the practice manager was always available to provide advice and guidance. We were told that there had been no safeguarding issues to report. We saw evidence that all staff had completed the appropriate level of safeguarding training. On-line training was available to all staff. A poster regarding how to access help for domestic violence was on display in the patient toilet.

We were told that although safeguarding was not a standard agenda item for practice meetings, this topic was regularly discussed in informal meetings held between the management team. Where issues for discussion were identified these would be included in practice meetings.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. This policy was on display in treatment rooms and other locations where sharps bins were located. The policy gave staff advice on the action to take if they sustained a needle stick injury. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. Practice policy was that only dentists handled sharp instruments. The accident book recorded one sharps injuries at the practice within the last 12 months

We asked about the instruments which were used during root canal treatment. We were told that root canal

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treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support and emergency equipment was available and checked regularly to ensure it was in good working order. Emergency equipment including oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available. However child face masks to fit a self-inflating bag were not available. The practice manager told us that this piece of equipment would be ordered immediately. Records confirmed that emergency medical equipment was checked regularly by staff.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored and were regularly checked to ensure they were within date for safe use. We saw that the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF).

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. Records were available to demonstrate that equipment in the first aid box was checked on a weekly basis to ensure it was available and within its expiry date. All of the staff were booked on a first aid course on 12 May 2016. We were told that all staff undertook this training on an annual basis.

Staff recruitment

We discussed the recruitment of staff and looked at four recruitment files in order to check that recruitment procedures had been followed. We saw that these files contained pre-employment information such as proof of identity, details of qualifications and registration with

professional bodies. However, we could not see evidence of written references on each occasion. We were told that occasionally verbal references were sought. There was no evidence on file of the verbal references obtained. Recruitment files also contained other information such as contracts of employment, and a health and safety checklist which was discussed during induction and on a regular basis as refresher training.

We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice planned for staff absences to ensure the service was uninterrupted. We saw that there was a log of annual leave requests. Staff said that wherever possible they were required to request annual leave at least two weeks in advance. However the management always tried to accommodate requests at shorter notice. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave. The practice manager and business manager were both qualified dental nurses and would be able to cover times of annual or unexpected leave. Dentists covered each other with some appointments having to be re-scheduled. We were told that emergency patients would always be seen. The practice manager said that there was always a sufficient number of staff so that the practice did not need to use agency staff.

We were told that dental nurses always worked with the same dentist or hygienist and there was therefore no requirement to produce a duty rota. There were enough staff to support dentists and hygienists during patient treatment. This helped to ensure that all dentists and hygienists worked with a dental nurse.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. A health and safety policy and environmental risk assessments were available. Risk assessments had been reviewed in April 2015 and we were told that there had been no changes since that date, although a review date had not been recorded.

Are services safe?

We saw that staff had completed a health and safety checklist upon employment at the practice. This helped staff to identify risks and to ensure all staff were aware of emergency exit routes, gas, electricity and water cut off points and other health and safety related matters. Staff told us that they completed this health and safety checklist on a regular basis as part of refresher training. Staff told us that they would speak with the practice or business manager for any health and safety advice.

A health and safety law poster was on display in the practice manager's office. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment. The fire risk assessment was completed in May 2014. Issues for action had been identified. The practice had been recommended to complete six monthly fire drills with staff and install emergency lighting. We saw evidence that these actions had been completed. We were told that some of the other issues for action had not been addressed. The practice had not developed an action plan to record when the necessary action would be taken. We were told that an action plan would be developed; issues identified would be prioritised and addressed in the very near future.

Records seen confirmed that fire safety equipment such as fire extinguishers; fire alarms and smoke alarms were subject to routine maintenance by external professionals. A weekly fire safety checklist was completed. This included checks of fire extinguishers and smoke alarms. We saw that fire doors were checked on an annual basis. The fire safety checklist requested that fire doors were checked on a monthly basis. The practice manager confirmed that monthly checks would be completed going forward. Staff spoken with were aware of the muster point for staff and visitors.

A file was available which recorded details of all substances used at the practice which may pose a risk to health. This file contained information for example regarding the chemical, handling, storage and firefighting measures.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and toilet were visibly clean, tidy and

uncluttered. Patient feedback also reported that the practice was always clean and tidy. Dental nurses who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. Cleaning schedules and cleaning logs were available to demonstrate who had completed the cleaning task. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and we saw that when mops were not in use they were appropriately stored.

The practice had developed an infection prevention and control policy which was available to all staff. The policy had been reviewed in 2016. The practice manager was named as the infection control lead. Staff spoken with were aware who held this role and confirmed that the practice manager was always available to give advice and support. Records we saw demonstrated that all staff had undertaken infection prevention and control training in October 2015. Infection prevention and control audits were undertaken on a six monthly basis with the last audit being completed on 2 May 2016.

We looked at the procedures in place for the decontamination of used dental instruments. A separate decontamination room was available for processing of the instruments used in the treatment rooms located on the first floor. Decontamination of instruments used in the treatment rooms on the ground floor took place in the room in which they were used. Both the treatment and the decontamination rooms had dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified. Designated hand washing sinks were available with hand gel and liquid soap. Systems were in place to ensure that instruments were safely transported between treatment rooms and the decontamination room.

A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves,

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aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with the latest HTM 01-05 guidelines. All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). A written waterline management scheme was in place. Staff described the method they used which included the use of a concentrated chemical for the continuous decontamination of dental unit water lines to reduce the risk of bacteria developing. A risk assessment regarding Legionella had been carried out by an external agency in November 2014. An action plan had been developed to record actions taken following this risk assessment. We saw records to confirm that monthly temperature monitoring checks were being completed.

We discussed clinical waste with the practice manager. The practice had a contract with a company to collect waste matter on a regular basis. Clinical waste was stored securely away from patient areas. Waste transfer consignment notes were available which demonstrated the frequency of waste collection.

The practice had a spillage kit for blood and bodily fluids and a separate kit for mercury. This helped to ensure that any spillages were hygienically and safely cleaned.

Equipment and medicines

The practice kept an equipment file with details of equipment held at the practice and records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines. We saw that maintenance contracts were in place for fire equipment, autoclaves, X-ray sets and compressor units. Records seen demonstrated the dates on which the equipment had most recently been serviced. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in April 2014. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test. The practice manager had been advised that PAT testing should be completed every three years, although stickers on equipment requested an annual check. We were told that a further PAT test would be undertaken.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine could be stored at room temperature with a shortened expiry date. However, the practice's preference was to store this medicine in the fridge. We saw that records were kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. Staff completed and signed records every day and these were available for review.

Prescription pads were securely stored and a log of each prescription issued was kept. We saw that there was an audit trail regarding prescriptions which helped to identify any missing prescriptions.

Dental treatment records for one dentist did not record the batch numbers and expiry dates for local anaesthetics when these medicines were administered. We were not shown evidence to demonstrate that this information was recorded elsewhere.

Radiography (X-rays)

The practice had three intraoral X-ray machines, two located in the ground floor treatment rooms and one in a dedicated X-ray room (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw. Appropriate signage was in place on doors where X-ray machines were located.

We saw records to confirm that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed. This helps to ensure equipment was operated safely and by qualified staff only. We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety. The practice held radiation protection information on the computer for all staff to access as required.

Local rules were available in each of the treatment rooms where X-ray machines were located for all staff to reference if needed. Cut-off switches were also located outside of the treatment rooms.

We saw that the practice had notified the Health and Safety Executive that they were planning to carry out work with

Are services safe?

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

Not all of the dental care records where X-rays had been taken showed that dental X-rays were justified, and

reported on every time. We saw that X-ray audits were completed on a six monthly basis. Audits help to ensure 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

We spoke with dentists about oral health assessments. We saw that patients completed a medical history form, or updated their details at every appointment for an examination. The dentist then checked the medical history with the patient before treatment began. Oral health assessments included an examination of the patient's teeth, gums and soft tissues. Dentists also looked for any signs of mouth cancer. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). All patients with high BPE scores such as 3 or 4 were referred to the hygienist for further periodontal treatment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Patient dental care records that we saw demonstrated that all of the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping. Patient's dental care records showed a thorough examination had been completed, and identified risk factors such as smoking and diet for each patient. Information was recorded about the assessment, diagnosis, and treatment and also discussions held and advice given to patients by the dentist. All patients were given written treatment plans.

Dentists we spoke with told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. High concentration fluoride was prescribed for adults as required and advice and guidance was given about dental hygiene procedures.

Health promotion & prevention

The dentist explained that they saw very few children at the practice apart from orthodontic work. The practice used the government document: 'Delivering better oral health: an evidence based toolkit for prevention' to guide their practice. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). The practice placed a high

emphasis on preventative care. We were told that this was top priority. High concentration fluoride toothpastes were prescribed when required. Patients that we spoke with told us that oral health information was given to them by dentists.

We saw entries in dental care records that detailed patients' oral health, discussions that had taken place with patients regarding improving oral health. Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption when needed.

We saw that there was a folder available in the waiting area which contained detailed information regarding oral health and hygiene. We were told that leaflets could be printed off and given to patients to take home if this was felt necessary. Information was also available regarding smoking cessation and the effects of smoking on the healing process. Free samples of toothpaste were available in the reception area for patients, also other oral hygiene products were available for patients to purchase. Televisions were available in the waiting area which were showing dental health messages and information about the practice.

The business manager told us that they had completed a dental health talk with children from a local school this included giving guidance on tooth brushing techniques.

Staffing

Practice staff included a business manager (who worked between two dental practices), a practice manager, deputy practice manager, four part time dentists, three part time dental hygienists, five qualified dental nurses, a trainee dental nurse and two receptionists.

We discussed staff training with the practice manager and with staff. Staff told us that they were encouraged to attend training courses and supported to develop their skills. The business manager told us that career progression was encouraged. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. We saw evidence in staff recruitment files that staff had undertaken safeguarding, medical emergencies and infection control training. We also saw that some staff had received training in other specific dental topics such as impression taking and dental radiography.

Are services effective?

(for example, treatment is effective)

We were told that dental nursing staff were responsible for ensuring that they met their continuing professional development (CPD) requirements. CPD is a compulsory requirement of registration as a general dental professional. Support would be given to staff who were falling behind their CPD requirements. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Records showed professional registration with the GDC was up to date for all relevant staff. Systems were in place to monitor professional registration to ensure that staff were up to date.

Appraisal systems were in place. Staff had received an annual appraisal and notes made on the day of their appraisal were read and signed by the appraiser. Personal development plans were in place for staff. We were told that staff had contact details including out of hours for the business manager so that they could contact her at any time to discuss issues or concerns.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required sedation or community services. Standard referral form templates were available on the practice computer. We saw that prescriptions and referral forms were on file where a patient was referred to the hygienist located at the practice. In-house referrals were made to the orthodontic services located at the practice and the practice received orthodontic referrals from other local practices.

Consent to care and treatment

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. A consent policy had been developed which had been reviewed in February 2016. Reference was made in the policy to Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. However, the policy did not clearly identify all of the issues involved in the consent process such as the Mental Capacity Act. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Following this inspection we were sent email confirmation that the consent policy had been amended to include relevant MCA information. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

Staff confirmed individual treatment options were discussed with each patient. We were told that patients were given verbal and written information to support them to make decisions about treatment. We were shown entries in dental care records where treatment options were discussed with patients. Any risks involved in treatment were also recorded. There was evidence in records that consent was obtained. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment. We saw that leaflets were available in the waiting area explaining some treatments.

We saw records to confirm that a consent audit was completed on a six monthly basis.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed staff greeting patients when they entered the practice. Staff were friendly, helpful, discreet and respectful to patients when interacting with them. Patients were given a warm welcome and treatment options were confirmed with patients at the departures desk. Patients commented that staff were professional, friendly, helpful and caring.

We saw that patient confidentiality was maintained at the practice. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. We asked how patient confidentiality was maintained within reception. We were told that patients' clinical records were stored electronically and that computers were password protected and regularly backed up to secure storage. Staff said and we saw that computer screens could not be overlooked at the reception desk. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times.

Discussions of a private nature could be held in the manager's office or in any treatment room that was not being used at the time.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Clear treatment plans were given to patients which detailed possible treatment and costs. We saw evidence on the patient care records of how the treatment options and costs were explained and recorded before treatment started. Where necessary the dentist and dental hygienist gave patients information about preventing dental decay and gum disease. Patients were given advice leaflets and dentists highlighted the risks associated with smoking and diet. Patients commented they felt involved in their treatment and it was fully explained to them.

We spoke with the practice manager and a dentist about the Gillick competency. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions about their care and treatment. Staff spoken with demonstrated a good understanding of Gillick principles. The practice's consent policy refers to Gillick and provided useful information for staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS and private orthodontics and private general dentistry. The practice's described the range of private treatments offered to patients such as dental implants, tooth whitening, general dentistry and aesthetic dentistry. Information about finance options or dental payment plans was available on the website as well as details of the staff team. We were told that the website was under construction due to some changes that were taking place at the practice. Details of fees payable were recorded in the practice folder which was available in the waiting area.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. Staff told us that patients were usually able to get an appointment within a few days of their request and were always able to get a same day appointment if they were in dental pain. Staff said that patients were generally seen on time. Feedback from patients confirmed that they were rarely kept waiting beyond their appointment time and were able to get an appointment at a time that suited them.

Tackling inequity and promoting equality

We were told that none of the patients at the practice required the use of sign language. However arrangements could be made with an external company to provide assistance with communication via the use of British sign language if required.

We asked about communication with patients for whom English was not a first language. We were told that the vast majority of patients had English as a first or second language and communication was not an issue. However the practice had the contact details for an interpretation service which could be used if required.

A car park was available to the rear of the practice and double doors at the rear of the practice enabled those patients who required the use of a wheelchair access to the

ground floor. There were two ground floor treatment rooms and one patient toilet. However, the toilet had not been adapted to meet the needs of patients with restricted mobility.

Access to the service

The practice was open from 9am to 6pm on Monday to Thursday, 9am to 5pm on a Friday and was closed between 1pm to 2pm each day during lunch time. The practice opened at 8am on a Monday and Tuesday and from 9am to 1pm every other Saturday for orthodontic patients only. This helped to ensure that those patients with work commitments were still able to receive an appointment.

A telephone answering machine informed patients that the practice was closed between 1pm to 2pm each day. A separate answer machine message informed patients to contact the practice manager when the dental practice was closed during the evenings, weekends and bank holidays. We were told that private patients were given the practice manager's telephone number so that they could make contact out of normal opening hours if necessary. These details were also on the practice website.

Patients were able to make appointments over the telephone or in person. Appointment slots were not kept to accommodate urgent appointments, patients requiring emergency treatment were told that they would have to sit and wait. These patients were usually given the first appointment of the day and the first appointment after lunch but would be seen within 24 hours of their initial phone call. Patients commented that they were able to see a dentist easily in an emergency. Patients received a telephone call or written reminder of their appointment a few days before their appointment date. This helped to reduce the number of patients who did not attend their appointments. Patients could access care and treatment in a timely way and the appointment system met their needs.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. Staff spoken with were knowledgeable about how to handle a complaint. We were told that any complaints received would be sent to the practice manager or the business manager.

Patients were given information on how to make a complaint. The practice folder in the waiting room

Are services responsive to people's needs?

(for example, to feedback?)

contained a copy of the complaints policy. From information received before the inspection we saw that there had been one formal complaint received in the 12 months prior to our inspection. We looked at the practice's complaint folder and saw that the complaint had been responded to in accordance with the practice's complaint policy. We were told that a meeting was always offered to patients who were unhappy with an aspect of the service provided.

We saw that complaints were discussed at practice meetings and evidence was available to demonstrate that lessons had been learnt from complaints to try and avoid re-occurrence.

Are services well-led?

Our findings

Governance arrangements

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference on the computer desktop; these had been reviewed and where relevant updated on an annual basis. Staff had signed a document to confirm that they had read and were happy with the practice's policies. Staff were provided with a portable storage device which contained a copy of all policies and procedures. This enabled staff to read information in their own time if they wished.

The practice had clear lines of responsibility and accountability. The management team consisted of the practice manager who had applied to become the registered manager for the practice and a business manager. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice.

Systems were in place for monitoring and improving the quality of services provided for patients. Comprehensive risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, health and safety and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

We saw a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment.

Staff told us that they were emailed by the business manager to inform them of any changes, updates or relevant information about the practice. This was done to ensure staff received information in a timely manner.

Leadership, openness and transparency

We spoke with staff who told us that they worked well together, enjoyed their job and felt valued and supported by the management. There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff were aware of who held lead roles within

the practice such as complaints management, safeguarding and infection control. Staff told us that the management team and dentists were always available to discuss concerns, clinical issues or to provide advice.

We saw that formal staff meetings took place on a regular basis throughout the year. We looked at the minutes of meetings held during 2016. The minutes from these meetings were available to staff on the computer desktop. This ensured that all staff, even those who were unable to attend the meeting were aware of issues discussed. We saw that the minutes from recent meetings did not contain the level of detailed information recorded in the minutes from meetings held earlier in the year. We were told that informal meetings were also held on at least a weekly basis. These were discussions about the day to day events at the practice, any changes and issues that occurred. Staff told us that the management team were approachable and helpful. They said that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately.

A whistleblowing policy was available to staff on the practice computer. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that both clinical and non-clinical areas were audited. We looked at some completed audits regarding infection control, radiography, record card, consent, health and safety, medical history and waiting times. There was a designated lead for clinical audit at the practice and clinical staff spoken with were aware who held this lead role.

Clinical staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Training records demonstrated that staff were up to date with their CPD requirements. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period. Annual appraisal meetings were held and personal development plans were available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

Are services well-led?

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. Patients had various avenues available to them to provide feedback, for example; a visitors book (used to record both positive and negative comments) and the friends and family test (FFT) box in the waiting room. The friends and family test is a national programme to allow patients to provide feedback on the services provided. Satisfaction surveys were given to patients on an annual basis; the results were reviewed and we were told that they were discussed with staff at a staff meeting. We saw that a

suggestion made by a patient in the satisfaction survey had been actioned at the practice. The patient had requested seating in the porch. This provided a seated waiting area for those patients who arrived early for their appointment before the practice opened.

Staff we spoke with told us that they felt supported and involved at the practice. Staff said that they would speak with the practice manager or another member of the management team if they had any issues they wanted to discuss. We were told that the management team were open and approachable and always available to provide advice and guidance. A staff satisfaction survey was completed in March 2016.