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Acocks Green Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 February 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Acocks Green Dental Practice has three dentists, who work fulltime and a trainee dentist who works part time, six qualified dental nurses who are registered with the General Dental Council (GDC) and a dental hygienist. The practice's opening hours are 9am to 5pm Monday to Thursday and 9am to 3pm on Friday. The practice is also open for pre-booked appointments only between the hours of 5pm to 7pm on a Monday evening and also on some Saturday mornings.

Acocks Green Dental Practice provides NHS and private treatment for adults and children. The practice is situated in a converted property. The practice has five dental treatment rooms; one on the ground floor and four on the first floor and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area.

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

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We

Summary of findings

collected 20 completed cards and spoke to eight patients. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

We carried out an announced comprehensive inspection on 8 February 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

Our key findings were:

- Systems were in place for recording accidents and adverse incidents at the practice.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice was visibly clean and well maintained
- The practice met the essential standards in infection control as set out in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained
- Emergency medicines were available in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Patients were treated with dignity and respect.
- The dentist provided dentistry in accordance with current guidance.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- Staff were observed to be friendly, caring and professional
- The appointment system met the needs of the patients and waiting times were kept to a minimum.
- Staff we spoke with felt well supported by the management team and were committed to providing a quality service to their patients.

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

- Review accident reporting procedures to ensure information is recorded including details of advice given or follow up action taken.
- Review the practice's procedures for training in cardiopulmonary resuscitation to ensure staff receive simulation training as detailed in the quality standards for cardiopulmonary resuscitation practice and training produced by the resuscitation council (UK).
- Review the protocols and procedures to ensure staff are up to date with their mandatory training and their Continuing Professional Development.
- Review the practice's audit protocols of various aspects of the service, such as infection prevention and control, radiography and dental care records at regular intervals to help improve the quality of service. Review its audit protocols to document learning points that are shared with all relevant staff and ensure that the resulting improvements can be demonstrated as part of the audit process.
- Review the procedure for completion of soil and protein tests on the ultra-sonic cleaner to ensure they are completed in line with HTM 01-05 recommendations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Staff had received training in safeguarding vulnerable adults and children and were aware of the external reporting process and who was the safeguarding lead for the practice.

Infection control standards met the essential guidance described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' Published by the Department of Health. Apart from the soil and protein tests on the ultrasonic cleaner identified above.

Standards for taking X-rays met the Ionising Radiation Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. Explanations were given to patients in a way they understood and risks, benefits and options available to them were discussed. The practice monitored any changes to the patients' oral health. There were clear procedures for referring patients to secondary care and referrals were made in a timely way to ensure patients' oral health did not suffer.

Staff had received training in the Mental Capacity Act (MCA) 2005 and the principal dentist had a general awareness about the importance of gaining patients' consent and the relevance of the Mental Capacity Act 2005.

Are services caring?

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

Patients were treated with dignity and respect and their privacy maintained. Patient feedback was positive with patients reporting that staff were professional, caring and helpful. Patients said they felt involved in their care. We were told that treatment options, risks and benefits and costs were explained before any treatment was agreed. Nervous patients said that they were made to feel at ease. Staff were able to describe how confidentiality was maintained at the practice. We saw that patient information was handled ensuring confidentiality was maintained.

Patients with urgent dental needs or pain would be seen within 24 hours were necessary.

Are services responsive to people's needs?

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

Patients had good access to treatment and urgent care when required. The practice offered dedicated emergency appointments each day enabling effective and efficient treatment of patients with dental pain. The practice was accessible for people that used a wheelchair or those patients with limited mobility and these patients would be seen in the ground floor treatment room. The complaints policy was available to patients in the waiting room as well as on the practice's website

Are services well-led?

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

Summary of findings

Appraisal and one to one meetings took place on a six monthly basis. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent. Staff said that they were encouraged to undertake training to maintain their professional development skills.

Staff told us they enjoyed working at the practice and felt part of a team.

The practice had undertaken clinical audit, but sometimes failed to document learning points or conduct these audits on a timely basis.

Acocks Green 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 8 February 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; however 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 six members of staff, including the principal dentist. 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 patient treatment records.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Incident and accident reporting systems were in place and staff spoken with were aware of the Reporting of Injuries Diseases and Dangerous Occurrences regulations (RIDDOR). We were told that there had been no incidents to report under RIDDOR regulations. Accident books were available and recorded details of accidents that had occurred. Accident records were brief and did not always record details of advice given or follow up action taken. For example where any sharps injuries were recorded there was no information to demonstrate that staff had been advised to or had attended the occupational health department. There was evidence in practice meeting minutes that accidents had been discussed and details of action taken to prevent accidents reoccurring were recorded. We saw that significant event reporting forms were available. Staff spoken with were aware of what incidents should be recorded as a significant event. The practice manager was responsible for recording and acting upon significant events. We were told that there had been no significant events at the practice.

The practice received national patient safety alerts such as those issued by the Medicines and Healthcare Regulatory Authority (MHRA) via email. Copies of alerts relevant to the practice were stored on the practice's computer and were forwarded by email to dentists. The principal dentist discussed the recent alerts received and confirmed that these alerts were discussed with all staff at a practice meeting.

Reliable safety systems and processes (including safeguarding)

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. We saw that these policies had been reviewed on an annual basis and updated where necessary. The practice had 'safeguarding champions' and the names of these staff were recorded on the policies. (A safeguarding champion is a member of staff who takes the lead regarding safeguarding issues). Staff spoken with were aware of the name of the safeguarding champion, when to raise a safeguarding concern and how to do this. Safeguarding flow charts and contact details were on display giving guidance to staff and contact details for external agencies such as the local authority responsible for investigations. The safeguarding file contained detailed information for staff such as department of health publications regarding safeguarding and the dental team, guidance regarding possible indicators of abuse and contact details to report suspicions of abuse.

Information posters regarding safeguarding were on display in the waiting area for patients.

Staff had recently completed the level of safeguarding training appropriate to their role. Staff were also able to undertake E-learning to complete any training updates. Staff said that safeguarding had been the topic for discussion at a recent informal staff meeting and we were told that they found the discussions beneficial.

We spoke with staff about the prevention of needle stick injuries. They explained that the practice used a system whereby needles were not manually re-sheathed using the hands following administration of a local anaesthetic to a patient. A safe style of syringe was used to reduce the risk of a needle stick injury. The dentists were responsible for ensuring safe disposal of used needles into the sharps bin.

We observed that needle stick/sharps injuries had been reported through the practice's accident reporting system. There had been five 'sharps' injuries, with the last injury being recorded in 2015. We saw that these injuries were caused by matrix bands. A matrix band is a thin metal strip that is positioned around the tooth during placement of certain fillings, these can be very sharp. We saw the minutes of a practice meeting which discussed these injuries and recorded that disposable matrix bands would now be used. The use of disposable bands mitigates the risk involved in changing the bands.

We saw that sharps information was on display and the practice had an inoculation injury policy. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps. (Health and Safety (Sharp Instruments in Healthcare) Regulations 2013).

We spoke to the principal dentist about root canal treatment and we were told that it was carried out where practically possible using a rubber dam. We saw that there was an ample supply of rubber dam kits available. (A rubber dam is a thin, rectangular sheet, usually latex

rubber, used in dentistry to isolate the operative site from the rest of the mouth). The British Endodontic Society recommends the use of rubber dam for root canal treatment.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. There was 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. Staff had received training in how to use this equipment with all staff receiving annual update training. We were told that staff had not been involved in any simulation based cardiorespiratory arrest scenarios as detailed in the quality standards for cardiopulmonary resuscitation practice and training produced by the resuscitation council (UK). The principle dentist said that this would be arranged as soon as possible.

The practice had access to oxygen along with other related items such as manual breathing aids in line with the Resuscitation Council UK guidelines. Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. Emergency medicines and oxygen were all in date and stored in a location known to all staff. We observed that the expiry dates of medicines and equipment were monitored and there were records to demonstrate this. We saw that one medicine was not recorded on the check sheet but we were told that this would be amended immediately following the inspection.

Staff recruitment

We discussed the recruitment of staff and looked at three recruitment files in order to check that recruitment procedures had been followed. We saw that files contained pre-employment information such as written references, proof of identity, details of qualifications and registration with professional bodies. 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. We saw that staff had signed an annual disclaimer to confirm that there had been no changes to their criminal record.

There were enough staff to support dentists during patient treatment. We were told that the hygienist who worked each Friday and a Saturday morning once per month at the practice worked alone. The hygienist worked under prescription from the dentist (meaning that the patient would have been seen by the dentist before being treated by the hygienist) and also completed some private work. A dental nurse completed any decontamination of used dental instruments for the hygienist and dental nurses worked with the hygienist if they needed to complete six point charting (A process in which the clinician lists and describes the health of teeth and gums). We were told that there was always a dental nurse available to provide assistance if required on the day that the dental hygienist worked at the practice.

We were told that there was enough staff to provide cover during times of annual leave or unexpected sick leave. The practice manager was able to cover the reception and there was a sufficient number of dental nurses and dentists to provide cover when required. We were told that part time staff would work additional hours to help out in times of need. Procedures in place at the practice helped to plan for staff absences to ensure the service was uninterrupted.

Staff we spoke with said that they enjoyed working at the practice and were proud of the work they did. The principal dentist told us that approximately three times per year they paid for a team building/social event for all staff. They said that staff worked well as a team and were motivated and hard working.

Monitoring health & safety and responding to risks

Systems were in place to monitor and manage risks to patients, staff and visitors to the practice and to deal with foreseeable emergencies. A health and safety poster was on display in the reception and office area and health and safety policies were readily available to staff. Staff were aware of the location of the policy and said that they could access this information at any time.

We saw that health and safety risk assessments had been completed, for example regarding staffing, electrical safety and a general practice risk assessment. British Dental Association advice regarding risk assessments was also available for staff. An external company had completed a fire risk assessment in February 2016 whilst undertaking maintenance checks on firefighting equipment at the practice. Appropriate fire signage was in place and staff

were aware of the 'muster points' to meet outside of the building in case of fire. We saw records to demonstrate that two fire drills were completed each year and we were told that fire training was booked to take place in February 2016.

The fire log book contained the details of the weekly fire checks completed. The last record seen was dated 2015. We were told that staff were completing these checks and records but the practice manager could not find these at the time of the inspection. Following this inspection we were shown evidence to demonstrate that these records were available and had been completed on a weekly basis.

The practice had measures in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. Records of all the substances at use in the practice which may pose a risk to health were kept. Staff spoken with were aware of COSHH requirements.

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. Practice staff completed all environmental cleaning of both clinical and non-clinical areas. Staff described the cleaning undertaken which was in line with the practice's policies and procedures. Patient feedback reported that the practice was always clean and tidy. There were hand washing facilities in each treatment room and adequate supplies of liquid soaps and paper hand towels were available throughout the premises. Posters describing hand washing techniques were displayed in the dental treatment rooms and the decontamination room.

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

Infection prevention and control audits were completed on an annual basis. The last audit was undertaken in July 2015 and the practice achieved an assessment score of 92%. The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months.

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' published by the Department of Health sets out the processes and practices essential to prevent the transmission of infections. Decontamination is the process by which dirty and contaminated instruments are bought from the treatment room, washed, inspected, sterilised and sealed in pouches ready for use again. A separate decontamination room was available for instrument processing. We observed that the practice had good protocols for transporting, cleaning and processing of instruments as identified in HTM 01-05. The decontamination room had dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified. We saw that there was one ultrasonic cleaner (an ultrasonic cleaner is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a solvent solution) and two autoclaves available (a device for sterilising dental and medical instruments).

A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. We saw that manual cleaning was appropriately carried out at the start of the process including completing a visual inspection using an illuminated magnifying glass before instruments were sterilised in an autoclave. We observed that the bulb in the illuminated magnifier produced a very dim light and staff confirmed that the bulb required replacing. Staff wore personal protective equipment during the process to protect themselves from injury which included heavy duty gloves, aprons and protective eye wear. There was a hand washing station with appropriate hand washing signage, liquid soap, gel and disposable towels.

There was a clear flow of instruments through the dirty to the clean area. Clean instruments were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. However, the practice had recently been advised to keep stock items such as mirrors and probes in a lidded box for up to one week which could lead to contamination due to repeated access. The principal

dentist confirmed that this practice would be stopped immediately and in future all items would be pouched. We received email confirmation following this inspection that all dental equipment was now appropriately pouched.

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. However staff were completing some checks on the ultrasonic cleaner on a monthly basis. HTM 01-05 recommends that these tests are completed on a weekly basis. The principal dentist said that weekly tests would be completed in future.

One of the spill kits available had passed its expiry date; these were used to treat any spillage of blood or bodily fluid to reduce the potential for spread of infection. We saw evidence that a new spill kit had been ordered.

The practice had systems in place to reduce the risk of Legionella. This is a bacterium that can contaminate the water supply of buildings. The practice had an external assessment carried out in December 2015. This documented that the practice should be checking the water temperature and we saw records to demonstrate that this was being carried out. In addition we discussed the management of dental unit water lines with a dental nurse and found that a comprehensive regime of flushing and disinfecting the water lines was in place.

Equipment and medicines

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the autoclave had been serviced and calibrated in December 2015. The practice had recently purchased a new ultrasonic cleaner which was less than a year old and did not require servicing up to the time of our inspection. X-ray machines had been serviced and calibrated and compressor vessel checks undertaken in 2016. Portable appliance testing (PAT) for all electrical appliances had been carried out in February 2016. Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered and an audit trail of local anaesthetic was also recorded separately. These medicines were stored safely for the protection of patients. We found that prescription pads were securely stored to prevent loss due to theft.

Radiography (X-rays)

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. We saw evidence to demonstrate that the principal dentist was up to date with the required continuing professional development on radiation safety; there was no information available to demonstrate that other dentists who worked at the practice had undertaken any recent update training regarding this.

Local rules were available in all treatment rooms where X-ray sets were located for all staff to reference if needed. We saw copies of the critical examination packs for each of the X-ray sets along with the maintenance logs. The maintenance logs were within the current recommended interval of three years. We saw that signs were in place on doors conforming to legal requirements to inform patients that X-ray machines were located in the room. We saw certificates that showed maintenance for this equipment was completed at the recommended intervals.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. We saw an X-ray audit had been carried out in October 2015. This included assessing the quality of the X-rays which had been taken. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. The results of the most recent audit confirmed the practice was compliant with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Clinicans demonstrated a clear understanding of guidelines available such as National Institute for Health and Care Excellence NICE and the Federation of General Dental Practice. We were told that dentists used current NICE guidelines to guide their practice particularly in respect of recalls of patients and antibiotic prescribing.

The principal dentist described to us how they carried out their assessment of a patient. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw that comprehensive medical history forms were filled in and signed by the patients annually. We saw evidence to demonstrate that the medical history form was discussed at every visit and details updated on the computer. The principal dentist told us that in future medical history forms would be signed by the patient at every check-up.

An assessment was then carried out on the patient's teeth, gums and soft tissues and checked for any signs of mouth cancer. We saw evidence of this as part of the dental care records. Records demonstrated that the findings of the assessment and details of any treatment carried out were recorded appropriately. Details of the gums had been recorded using the basic periodontal examination (BPE) screening tool. (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). High BPE scores result in further investigation and in depth treatment

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice, details of smoking cessation and general dental hygiene procedures such as brushing techniques. Consultations, assessments and treatment were carried out in line with recognised general professional guidelines.

Health promotion & prevention

We discussed 'The Delivering Better Oral Health Toolkit' with the principal dentist. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). We saw that information regarding diet and oral health was on display in the reception area. We were told that adults and children attending the practice were advised during their consultation of the steps to take to maintain healthy teeth. Dietary, smoking and alcohol advice was given to them where appropriate. Information leaflets were available regarding stopping smoking and foods that may be harmful to teeth.

We were told that free samples of toothpaste, tepe brushes and indicator toothbrushes were occasionally available. The practice also sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area. A dentist had visited a local school to provide oral hygiene instruction and advice on healthy eating.

Staffing

Practice staff included the principal dentist, one part time and two full time dentists, a practice manager and receptionist. A dental hygienist also worked part time and six dental nurses (two part-time and four full-time) provided support. Staff spoken with said that they enjoyed their work, were well supported and all said that staff worked together well as a team.

Staff confirmed that they received regular training including safeguarding and cardio pulmonary resuscitation. We were told that the practice manager was supportive and ensured that staff had good access to ongoing training to support their skill level. 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. Staff CPD records were not available on the premises at the time of inspection. The practice manager told us that they had systems in place to ensure all staff remained registered with the GDC. We saw that staff were required to produce their CPD records as part of the appraisal process and records of information seen were kept. Support would be given to staff who were falling behind their CPD requirements. Staff told us that they were given time to access e-learning and to attend external training courses. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Two dental nurses were undertaking radiography training to enable them to take X-rays. We were told that some training updates were slightly out of date but training had been booked, for example infection

Are services effective?

(for example, treatment is effective)

control training would be booked and fire safety training had been booked for February 2016. Records showed professional registration with the GDC was up to date for all relevant staff.

Appraisal and one to one meetings were held on a six monthly basis. Staff told us that they were able to discuss issues or concerns, working practices or training requirements. Staff said that there was an inclusive, supportive atmosphere at the practice and team working was encouraged.

We saw records to demonstrate that new staff received an induction from the practice manager. Staff spoken with confirmed that the induction process gave them the information needed to perform their job role at the practice.

Working with other services

Systems were in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. For example orthodontic or oral surgery treatments. Copies of referral letters were kept on patient records. We saw a copy of a comprehensive template that was used to refer patients to hospital if they had a suspected oral cancer. Evidence seen showed that this had been used recently. The referral was fast-tracked through the system to ensure timeliness in making the referral and followed up promptly to ensure receipt. We were told that there were no patient complaints relating to referrals to specialist services.

Consent to care and treatment

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent. Staff confirmed individual treatment options were discussed with each patient. Patient care records we saw demonstrated this; risk and benefits of possible treatment were recorded along with details of any treatment declined. We were told that patients were shown models, and given verbal and written information such as diagrams, pictures and information leaflets. Patients were directed to appropriate websites to enable them to gather further information. Patients were given time to consider treatment options and support to help them make decisions about treatment. Treatments agreed were always reviewed at the first appointment to ascertain the patient's understanding. Patient care records seen evidenced that the practice had a robust consent process in place.

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. We were told that staff had undertaken training regarding the Mental Capacity Act as part of their safeguarding training. The principal dentist told us that they were considering discussing this further to assess staff competency about this topic. Staff spoken with had a clear understanding of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Staff we spoke with explained to us how patients' information was kept confidential. Practice computer screens were not overlooked which ensured patients' confidential information could not be viewed at reception. If computers were ever left unattended they would be locked to ensure confidential details remained secure. There was a sufficient number of staff on duty each day to ensure that the reception area was always staffed when the practice was open.

On the day of our visit we witnessed patients being treated with dignity by reception staff. Staff were seen speaking with patients over the phone and in the reception and they were friendly and helpful. Staff displayed a caring attitude not only towards patients but also towards each other. Feedback from our discussions with patients and comment cards was all positive and staff were described as pleasant, kind, understanding, caring and polite. Patients who were anxious about receiving dental treatment told us that staff made them feel relaxed.

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 were told that patients would be able to have a confidential discussion with staff in a room located behind the reception if required.

Involvement in decisions about care and treatment

Information regarding NHS costs was clearly displayed in the waiting area and information leaflets regarding some of the treatments undertaken at the practice were also available. Staff told us that they always provided verbal information to patients to enable them to make informed choices and patients we spoke with confirmed this. We saw comprehensive records showing a thorough screening process, robust examinations and treatment plans and details of discussions regarding treatment options and risks. Patients we spoke with confirmed that treatment options were always explained to them, and they were given ample opportunity to ask questions about their treatment.

We spoke with the principal dentist about the Gillick competency test. The test 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. The principal dentist demonstrated a good understanding of Gillick principles.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and found the premises and facilities were appropriate for the services delivered. The practice provided NHS and some private treatment. NHS treatment costs were clearly displayed in the waiting area. We were told that private treatments were rarely provided but a written estimate of costs would always be given to the patient. The practice had a website which described the range of services offered to patients. A link from the website provided patients with information on NHS dental services and costs. Other information available to patients included the complaints procedure and practice patient information leaflet. The complaints procedure was also available on the website and details of other organisations that patients can contact if they are unhappy with the outcome of their complaint were available.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Slots were left vacant each morning and afternoon to accommodate urgent appointments. When these slots were filled patients would still be seen but were told that they would have to sit and wait to see the dentist. The practice offered late evening opening for booked appointments (until 7.00 pm) on a Monday and was open on a Saturday morning once per month.

Tackling inequity and promoting equality

The practice was located on the ground and first floor of a converted building on a busy street. There were no car parking spaces but patients would be able to park in nearby pay and display car parks or close to the practice which had time restricted on street parking.

Entrance to the dental practice was suitable for patients with mobility difficulties or wheelchair users. There was one treatment room and a toilet which had been adapted to meet the needs of disabled patients on the ground floor and four treatment rooms on the first floor. The reception and main waiting area were also on the ground floor.

We saw that the practice had an equality and diversity policy and staff spoken with confirmed that they were aware where the policy was kept. However, staff had not received training regarding equality and diversity. Staff told us that they had contact details for an interpretation service which could be used for those patients whose first language was not English. However, as at the date of this inspection this had not been necessary as staff at the practice who spoke a variety of languages (Polish, Urdu, Hindi, Arabic and Patwa) had met patient's needs.

Access to the service

The practice was open from 9am to 5pm Monday to Thursday and 9am to 3pm on Friday. Pre-booked appointments were also available on a Monday evening between 5pm and 7pm and on the first Saturday morning of each month. The practice displayed its opening hours on the premises and on the practice website. Staff we spoke with told us that patients could access appointments when they wanted them. Emergency appointment slots were kept each day for those patients that were in pain. These patients would be seen by a dentist within 24 hours if necessary. Patients who wished to book a routine appointment with a named dentist may have a longer wait but patients we spoke with said that they did not have any difficulty getting through to the practice on the telephone or obtaining an appointment with a dentist. Patients' feedback confirmed that they were happy with the availability of routine and emergency appointments.

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. The policy also recorded contact details such as NHS England, the Parliamentary and Health Service Ombudsman, the General Dental Council (GDC) and the Dental Complaints Service. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. A copy of the complaints policy was on display in the reception area. We were told that this could be translated into any language if requested by the patient. We saw that the complaint policy had been reviewed on an annual basis. The practice website also gave patients a copy of the complaint policy, information regarding NHS complaints advocacy and gave the contact details of the GDC.

All staff spoken with were aware who held the lead role regarding recording and handling complaints at the practice. Staff said that patients were always offered a

Are services responsive to people's needs?

(for example, to feedback?)

meeting with the practice manager and that they apologised to patients both in person and in letter form. The practice manager told us that they had not received any verbal complaints but these would also be responded to in writing. We saw that the practice had a complaint log which recorded details of any complaints received. We saw that meetings with patients were offered and apologies were always given.

Are services well-led?

Our findings

Governance arrangements

The practice had arrangements in place for monitoring and improving the quality of services provided for patients. Governance arrangements in place helped to ensure risks were identified, understood and managed appropriately. For example, risk management processes regarding fire safety, health and safety and infection control were in place to ensure the safety of patients and staff members. Staff we spoke with were aware of their roles and responsibilities within the practice.

The practice had policies and procedures in place to support the management of the service, and these were readily available for the staff to reference. These covered a wide range of topics, for example infection control, health and safety, complaints and safeguarding.

Regular staff meetings were held to discuss issues relevant to the practice. Staff said that there was an inclusive atmosphere at the practice and expressed the feeling that they were all part of a team. Staff confirmed that there were clear lines of responsibility which were overseen by the practice manager who was working hard to improve governance.

Leadership, openness and transparency

The culture of the practice was open and supportive. Staff we spoke with described a close team working relationship, with all staff willing to help each other out in times of need. A culture of honesty, transparency and openness was also described. Staff said that they were actively encouraged to raise concerns and speak with the management team regarding any issues.

We found staff to be hard working, caring and committed to the work they did. Staff were motivated and enjoyed working at the practice and were proud of the service they provided to patients.

Formal practice meetings were held on a regular basis. Staff said that they were encouraged to speak out during these meetings and were always kept up to date with any changes at the practice.

Learning and improvement

Staff working at the practice were supported to maintain their continuing professional development CPD) as required by the General Dental Council. CPD and training needs were discussed during appraisal meetings and support was offered if required. Staff confirmed that they were encouraged to undertake training.

Acocks Green Dental Practice is a training practice and there is one trainee dentist at the practice. We spoke with the trainee dentist who told us they were given dedicated training time each week and that the trainer had an open door policy and was always available to provide assistance. This trainee dentist told us that they would like to continue working at the practice following completion of their training.

The practice undertook clinical audit to ensure the effectiveness of the service, and highlight any areas for improvement. However these audits did not fulfil all requirements. For example the infection control audit was undertaken on an annual basis, when published guidance says it should be six monthly. The last radiography audit was undertaken in October 2015 and record card audit in December 2015. X-ray and record keeping audits were not being completed in line with Federation of General Dental Practice guidelines for each clinician. The principal dentist confirmed that changes would be made to this and other audits to develop a structured audit plan to ensure completed audit cycles would be established. We saw that the variability in clinical recall intervals had been audited. Improvements were noted in the second cycle of this audit.

Staff meetings were held on a regular basis. We saw that an audit of practice meetings had been completed to try and improve the format of these meetings. Staff spoken with confirmed that they had an informal staff meeting the week prior to our inspection and safeguarding was discussed. Vital signs reports (which include measures to help with monitoring contracts across areas such as activity, access and quality) are discussed at staff meetings. Actions to be taken to meet targets were discussed at these meetings.

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. We saw that the NHS Friends and Family Test (FFT) was available in the reception area for patients to complete. The FFT is a national programme to allow patients to provide feedback on the services provided. We looked at some results and saw that these recorded

Are services well-led?

positive comments and patients were extremely likely to recommend the dental practice. The results available on the NHS Choices website recorded that 100% of patients would recommend this dental practice (23 responses).

Since the implementation of the FFT the practice had not undertaken its own patient survey. We saw that there was a comment book available for patients to complete and the practice had received compliments cards which were on display.

Staff were actively encouraged to give feedback through the practice meetings, or their appraisal meetings which were held approximately six monthly.