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Goodall Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 16 November 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

Goodall Dental Practice has one dentist (principal dentist) who works part time and two qualified dental nurses who are registered with the General Dental Council (GDC) who also work as receptionists. The practice's opening hours are Monday 8.30am to 5pm, Wednesday 8.30am to 5pm and Friday 8.30am to 4pm. On alternate Wednesdays the practice is open from 10am to 7pm. The reception of the practice is open from 9am to 3pm on Tuesday and Thursday to enable patients to book appointments but there is no dentist working on these days (unless an emergency appointment is required).

Goodall Dental Practice provides both NHS and private dental treatment for adults and children. The practice has one dental treatment room on the ground floor. Sterilisation and packing of dental instruments takes place in the treatment room. There is a reception with separate waiting area.

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. During the inspection we spoke with one patient. Overall we received feedback from 11 patients who provided a positive view of the services the practice provides. All of the patients commented that the quality of care was very good and staff were professional, friendly, calming and reassuring.

Our key findings were

Summary of findings

- Systems were in place for the recording and learning from significant events and accidents.
- The practice had not developed a policy regarding duty of candour but we were told that this would be developed.
- 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.
- Oral health advice and treatment was provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- The provider had the majority of emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice. Some items of equipment such as syringes had passed their expiry date. Staff had been trained to deal with medical emergencies although update training was slightly overdue.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice's fire risk assessment was brief and had not been adapted to meet the needs of the practice.
- The governance systems were effective.
- The practice was well-led and there were clearly defined leadership roles. Staff told us they felt supported, involved and they all worked as a team.

There were areas where the provider could make improvements and should

- Review the practice's procedures regarding medicines and equipment to be used in a medical emergency to ensure that all equipment is in date and that medicines as detailed in the guidelines produced by the resuscitation council (UK) are available.
- 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 systems in place to monitor and track the use of prescription pads.
- Review the practice's fire safety procedures and ensure that regular checks are made of all firefighting equipment including smoke detectors, that all staff are involved in fire drills on a regular basis and that the practice undertakes and records details regarding a robust fire risk assessment
- Review the practice's systems to ensure that they are is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 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?

No action

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

Emergency medical equipment and medicines were available on the premise, although some additional items were kept within the emergency medical kit which were not in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines and one medicine was not available. The principal dentist ordered the missing medicine on the day of inspection and removed the excess items. Staff had received training in responding to a medical emergency, although update training was slightly overdue.

Decontamination procedures were effective and the equipment involved in the decontamination process was regularly serviced, validated and checked to ensure it was safe to use. Infection control audits were being undertaken on a six monthly basis. 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?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals for serious pathology were not made in a timely way but we were told that this was under review.

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.

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

Are services caring?

No action

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

We observed the staff to be welcoming and caring towards the patients. Staff treated patients with kindness and respect and they were aware of the importance of confidentiality Patient's privacy and confidentiality was maintained on the day of the inspection. Feedback from patients was positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful.

Summary of findings

Are services responsive to people's needs? We found that this practice was providing responsive care in accordance with the relevant regulations. The practice had good facilities and was well equipped. Patients had good access to treatment and urgent care when required. Patients told us it was easy to get through on the phone to the practice, and they rarely waited long once they had arrived for their appointment. The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference.	**No action**
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. Systems were in place to share information with staff by means of monthly practice meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist. Staff told us that the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team. The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.	**No action**

Goodall 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 16 November 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 all of the staff at this practice. 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.

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.

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No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Systems were in place to enable staff to report incidents and accidents. An accident book and was available in the office area. We were shown the accident recording book but where told that there had not been any patient or staff accidents at this practice. We were told that accidents and incidents would be discussed with staff both informally and at a practice meeting as they occurred.

Staff spoken with confirmed that they would report any accidents to the principal dentist and fill out accident report forms together.

The practice did not have any significant events to report. A significant event policy was available and the principal dentist was identified as the significant events lead. Staff spoken with were aware of whom they should contact for any advice regarding identifying or reporting significant events.

Information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) was available. We were told that there had been no events at the practice that required reporting under RIDDOR. Staff we spoke with were all aware of how and when to report an incident under RIDDOR regulations. We saw that reporting forms and information to guide staff was available.

Systems were in place to ensure that all staff members were kept up to date with any national patient safety and medicines alerts. The practice received these alerts via email and any that were relevant were discussed with staff and appropriate action taken as necessary. The dentist discussed the recent medical alerts, for example the alert relating to the 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).

The practice did not have any information for staff regarding Duty of Candour but we were told that this would be developed. Duty of Candour is a legislative requirement for providers of health and social care services to set out requirements that must be followed when things go wrong with care and treatment. For example informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. The principal dentist was named as the safeguarding lead. Staff told us that they would speak with the principal dentist about any suspicions of abuse or to ask for any advice or guidance.

Various pieces of information were available for staff including details of how to report suspected abuse to the local organisations responsible for investigation. For example contact details were available for Child Protection NHS Walsall, Walsall Social Services and the Police Family Protection Unit. We saw evidence that all staff had completed the appropriate level of safeguarding training.

The practice had developed a child/vulnerable adult risk assessment which recorded action taken to mitigate risks. For example the risk of leaving a child in the reception area without parental supervision and the mitigating action of ensuring all staff have disclosure and barring service checks (DBS). 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.

Information regarding child protection and adult safeguarding was contained in the practice information folder which was available for patients to view in the waiting room.

We were told that there had been no safeguarding issues to report.

A clear, detailed needle stick protocol was on display in the staff room and the dentist described the protocol to follow. Contact details for the local occupational health department were available and staff were aware when to contact them. Needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping

stage and the responsibility for this process rested with each dentist. Sharps bins were stored in appropriate locations which were out of the reach of children. These had been dated and signed upon initial use.

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

Medical emergencies

There were some systems in place to manage medical emergencies at the practice. 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. We saw records to demonstrate that weekly checks were made on this equipment to ensure that it was in good working order. We saw that some items within the medical emergency equipment had past their expiry date. For example oropharyngeal airways (these are available in five sizes and support the airway in an unconscious or semi-conscious patient) and syringes. The principal dentist showed us a further set of oropharyngeal airways which were stored with the emergency oxygen. These were in date. The principal dentist confirmed that they would check all items such as syringes and replace any that were out of date.

Staff had all received training in basic life support, although annual update training was slightly overdue. The principal dentist told us that they would arrange for the training to take place as a matter of urgency. Following this inspection we received an email which stated that cardio pulmonary resuscitation and AED training had been arranged for the 21 December 2016. 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 confirmed that this would be arranged as soon as possible.

We were shown the medicines available for use in a medical emergency. We saw that some additional medicines which were not as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. These were removed from emergency medicine kit during the inspection. We saw that the practice did not have a supply of buccal midazolam in line with BNF guidance. Buccal midazolam is a medicine used to stop seizures and is given into the buccal cavity (the side of the mouth between the cheek and the gum). Following this inspection we received email confirmation demonstrating that this medicine had been ordered.

All emergency medicines were appropriately stored in a clearly marked cupboard. Records confirmed that emergency medical equipment and medicines were checked weekly by staff.

Staff recruitment

The practice had a recruitment policy that described the process to follow when employing new staff, and a recruitment checklist provided guidance regarding the recruitment information to obtain. These had been reviewed on the 18 August 2016. Staff had signed and dated these policies to confirm that they had read and would work in accordance with them. Various other employment policies and documents were available such as a new staff checklist, professional development and training policy, job descriptions, grievance, redundancy, sickness and maternity leave policies.

We discussed the recruitment of staff, and we were told that both dental nurses had been employed in 2016. The principal dentist informed us that recruitment procedures required some improvement and new policies were to be introduced in the future. We were shown the recruitment information held for the newly employed staff to enable us to check that recruitment procedures had been followed. We saw that disclosure and barring service checks (DBS) were in place for all staff. We also saw contracts of employment, indemnity insurance and immunisation history information and details of registration with the professional body.

We were told that verbal references had been obtained but there was no documentary evidence to confirm this. There was no evidence that staff had completed a pre-employment medical questionnaire.

No action

Are services safe?

The practice planned for staff absences to ensure the service was uninterrupted. We were told that a part-time member of staff at another practice owned by the principal dentist would be available to provider cover during times of annual leave or unexpected sick leave.

There was enough staff to support the dentist during patient treatment. We were told that the dentist always worked with a dental nurse.

The practice had developed a policy and risk assessment regarding lone working. This detailed the security measures in place to protect staff at times when they worked at the practice alone.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that the practice had developed a folder which contained various pieces of health and safety information. For example a comprehensive health and safety checklist and a health and safety general statement of policy dated 18 August 2016. The principal dentist was the named lead regarding infection control, radiation safety and health and safety. All staff spoken with said that the principal dentist was always available to provide health and safety advice when required. A health and safety poster was on display in the office area.

Numerous risk assessments had been completed such as a practice risk assessment, radiation, sharps, hepatitis B non-immunised staff or non-responder and a fire risk assessment. Risk assessments were reviewed on an annual basis. The date of last review for the practice risk assessment was 16 August 2016.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire risk assessment was brief and did not include all information for example there was no mention of the firefighting equipment available at the practice.

Records seen confirmed that fire extinguishers were subject to routine maintenance by external professionals in July 2016. The practice's risk assessment recorded that smoke alarm batteries were to be changed on an annual basis. There was no evidence available to demonstrate that this had been completed.

Fire drills took place on an annual basis with the date of the last fire drill being 8 August 2016.

A well organised COSHH file was available. Data sheets were available in this file for all substances used at the practice which may pose a risk to health including cleaning materials.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment room, waiting area, 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. A log was kept detailing all areas to be cleaned. An environmental cleaning policy had been developed which had been reviewed on 1 November 2016. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area.

The practice had not developed a general infection prevention and control policy statement. We were told that the principal dentist was the infection control lead and was responsible for ensuring infection prevention and control measures were followed.

Staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

The practice did not have a bodily fluids spill kit which would be used to hygienically clean spills of bodily fluids and the mercury spillage kit was out of date.

Infection prevention and control audits were completed on a six monthly basis. The decontamination lead from Walsall Health Care Trust had completed an audit on an annual basis with the date of the last audit being 6 May 2016. An annual in-house audit was also completed by staff at the practice. The last audit completed was 11 September 2016. We saw evidence of previous audits completed.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff wore clean uniforms each day and the style of uniform

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.

We looked at the procedures in place for the decontamination of used dental 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). Decontamination of used dental instruments took place in the treatment room. The treatment room had clearly identified zones in operation to reduce the risk of cross contamination.

The dental nurse showed us the procedures involved in manual 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 zone to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. All clean instruments apart from mirrors and probes were packaged; date stamped and stored in accordance with current HTM 01-05 guidelines. We were told that in future mirrors and probes would also be pouched as appropriate.

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) they described the method they used which was in line with current HTM 01 05 guidelines.

The practice had developed a file of information regarding legionella. This included a prevention policy which had been reviewed on an annual basis and a risk assessment regarding Legionella. An external agency carried out the risk assessment in 2011. As there had been no changes at the practice and a low risk was identified during the initial risk assessment, annual internal risk assessments were being completed. Records were available to confirm that monthly routine temperature monitoring checks were being completed with the last entry recorded in November 2016.

We discussed clinical waste and looked at waste transfer notices. We saw that the practice had a contract in place regarding the disposal of clinical and municipal waste. The company contracted to collect the waste had completed a pre-acceptance audit on 9 March 2016. (The Environment Agency requires that producers of waste must provide an audit of their waste before it can be legally collected by a licensed waste carrier. This is known as a pre-acceptance audit). Evidence seen demonstrated that clinical waste was collected every few weeks. Clinical waste was securely stored in a suitable location. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

The practice had maintenance contracts for essential equipment and records seen demonstrated the dates on which the equipment had recently been serviced. For example compressors had been serviced in March 2016 and the autoclave serviced on 17 October 2016. 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.

Prescription pads were securely stored to prevent their loss due to theft; however there was no logging system in place to account for prescriptions issued.

We saw that one of the emergency medicines (Glucagon) was stored in the emergency medicines kit. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that if this medicine was stored at room temperature the expiry date should be adjusted and this had been done.

Radiography (X-rays)

The registered manager told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure equipment was operated safely and by qualified staff only. We saw evidence that the dentist was up to date with the required continuing professional development on radiation safety.

Comprehensive local rules were available in each of the treatment rooms were X-ray machines were located for all staff to reference if needed.

We saw that the X-ray equipment was fitted with collimators – this is good practice as it reduces the radiation dose to the patient.

No action

Are services safe?

Copies of the critical examination packs and acceptance tests for each of the X-ray sets were available for review. We were not shown evidence of annual mechanical and electrical testing of X-ray units.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines.

We saw that annual X-ray audits were completed with the date of the last audit being 17 June 2016. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

During the course of our inspection patient care was discussed with the dentists and we were shown up to date detailed electronic dental care records, which helped to illustrate our discussions.

Records demonstrated that comprehensive screening took place including the condition of the gums using the basic periodontal examination (BPE) scores. (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). Scores over a certain amount would trigger further, more detailed testing and treatment. The Dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. Screening of the soft tissues inside the mouth, as well as the lips, face and neck was carried out to look for any signs that could indicate mouth cancer.

Risk factors such as oral cancer, dental decay and gum disease were taken into consideration to determine the likelihood of patients experiencing dental disease, and the dentists used National Institute for Health and Care Excellence (NICE) guidelines to determine how frequently to recall patients. Patient care records demonstrated that risk factors had been documented and discussed with them.

A comprehensive medical history form was completed by patients at every examination appointment, and updated verbally at every other attendance. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners (FGDP) directive. The principal dentist was aware of the new FGDP guidance and had purchased a copy of this document. We were told that a review of record keeping and audits would take place in line with this guidance.

The practice had various policies which helped to improve outcomes for patients such as the policy for making clinical decisions which was reviewed on 18 August 2016 and the oral cancer screening policy which was reviewed on 15 August 2016.

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). We saw that a copy of the DBOH was available for staff to review as required. DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. High concentration fluoride was prescribed for adults as required and advice and guidance was given about dental hygiene

Medical history forms completed by patients included questions about smoking and alcohol consumption. Patients we spoke with told us that they were asked regularly to update their medical history. Information about local smoking cessation clinics was available for patients. Patients with a high level of dental caries were given advice about dietary intake and foods which contain hidden sugars which may be harmful to teeth.

The dentist gave oral health advice and where necessary explained interdental cleaning techniques. Free samples of toothpaste were available for patients from the reception desk and patients were able to purchase a range of oral hygiene products.

Staffing

Practice staff included a principal dentist, two part time dental nurses who also worked as receptionists. Both of the dental nurses had been employed during 2016. Records seen demonstrated that these staff had completed a period of induction to familiarise themselves with the systems and policies at the practice. Induction records included familiarising the staff member with emergency procedures including fire and emergency medicines and equipment, safeguarding and confidentiality.

Appraisal systems were in place although both dental nurses were newly employed at the practice and had not as yet received their annual appraisal. Staff spoken with told us that they would speak with the principal dentist at any time to discuss training needs, issues or concerns. Staff told us that the principal dentist had asked for a copy of all continuing professional development (CPD) training certificates so that a discussion could be held regarding this at their forthcoming appraisal meeting. CPD is a compulsory requirement of registration as a general dental professional.

No action

Are services effective?

(for example, treatment is effective)

We saw evidence to demonstrate that staff had undertaken core CPD training such as safeguarding, infection control and basic life support training. We were told that staff at the practice attended an annual core CPD training day together.

Records seen confirmed that professional registration with the GDC was up to date for all relevant staff and monitoring systems were in place to ensure staff maintained this registration.

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 oral surgery, oral medicines and orthodontics.

The dentists completed proformas or referral letters to ensure the specialist service had all the relevant information required. The practice had a procedure for the referral of a suspected malignancy. This involved sending a letter by first class post; the principal dentist confirmed that this system was under review to provide a more robust service for sending referral documents, in these cases.

Consent to care and treatment

A consent policy had been implemented and reviewed on an annual basis. Reference was made to the Mental Capacity Act 2005 (MCA) in this policy. The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Discussions were held with the principal dentist who demonstrated an understanding of the principles of the MCA and best interest decisions. The dentist discussed previous experiences regarding obtaining consent for patients who lacked capacity.

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. We saw that consent was reviewed as part of a recent record card audit. From discussions with the dentist and patient care records we were shown we identified that the practice had robust consent processes in place. We were told that patients were given verbal and written information to support them to make decisions about treatment; patients were shown X-rays or pictures to help with their understanding. Discussions about options were notated in records. Patients were asked to describe the treatment plan or options discussed to determine their understanding. There was evidence in records that consent was obtained.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. 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.

A television in the reception area showed information about the practice; this helped to distract anxious patients. Staff said that they made every effort to relax anxious patients by talking with them in a calm and reassuring manner. We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. There was a friendly, relaxed atmosphere at the practice.

Patients' clinical records were stored electronically. Computers were password protected and backed up on a daily basis to secure storage. 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. Staff said that they would ask patients to write down personal sensitive information or they could speak with them in an unused treatment room if a confidential discussion was requested.

Patients provided overwhelmingly positive feedback about the practice on comment cards which were completed prior to our inspection. Patients we spoke with during the inspection said that they were always treated with respect; we were told that staff were caring, helpful and professional.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Staff told us that a model of the mouth was often used to explain treatments to patients. We were told that they took their time to fully explain treatment, options, risks and fees. We saw that clear treatment plans were given to patients which detailed treatment and costs. A treatment plan detailing costs was printed off the computer system for private patients. We saw evidence in the records that we were shown that the dentists often recorded "treatment options discussed" without recording further information regarding the options discussed. However patients confirmed they felt involved in their treatment and it was fully explained to them.

Information about NHS and private costs were available in the practice information folder which was kept in the waiting area for patients to review.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

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. There were vacant appointment slots to accommodate urgent appointments. We were told that 'emergency appointment' slots were kept free before the practice closed each day for lunch. Once these appointments were filled patients were asked to visit the practice and were told that they would have to sit and wait to see the dentist.

Staff told us that patients were usually able to get an appointment on the same day of their telephone call on a Monday, Wednesday or Friday and within the same week if they telephoned on a Tuesday or Thursday. Patients were always able to get an appointment within 24 hours if they were in dental pain.

Tackling inequity and promoting equality

The practice had policies to support staff in understanding and meeting the needs of patients regarding equality and diversity (reviewed on 18 August 2016) and equal opportunities which had been reviewed on 8 January 2016.

The practice did not have a hearing induction loop for use by people who were hard of hearing. However, we were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

We asked about communication with patients for whom English was not a first language. We were told that two staff members were able to speak Punjabi and could communicate with patients who spoke this language. We saw that contact details for a translation service were available for use if required and the principal dentist told us that they would consider more extensive use of these services in the future as required.

This practice was not suitable for wheelchair users; there were a few small steps to gain access to the front of the building and the pavement was not large enough to accommodate a portable ramp. There was also a small internal step to gain access to the treatment room and another to the patient toilet. We saw that grab rails had been fitted next to internal steps to assist patients if required. The practice did not have an adapted toilet to meet the needs of patients with a disability. We saw that a disability discrimination act audit had been completed but there were limitation on the building which would not enable further adaptations to be completed.

Access to the service

The practice was from 8.30am to 5pm on Monday and Wednesday and 8.30am to 4pm on Friday. On alternate Wednesdays the practice was open from 10am to 7pm. The reception of the practice was open from 9am to 3pm on Tuesday and Thursday to enable patients to book appointments but there is no dentist working on these days (unless an emergency appointment is required). The opening hours were displayed in the entrance to the practice and on the practice's website, however we were told that these details were incorrect and required updating.

A telephone answering machine informed patients that the practice was closed at lunchtime and also gave emergency contact details for patients with dental pain when the practice was closed including during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone or in person. The website also recorded the practice's email address and patients could request a call back if they wished to discuss anything with the dentist. Emergency appointments were set aside for the dentist every day that the practice was open; this ensured that patients in pain could be seen in a timely manner. Patients commented that they were able to see a dentist easily in an emergency.

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 which provided guidance about how to handle a complaint and the timeframes for responding to complaints. This included acknowledging and providing a formal response to the complaint within a set timescale. Details of how patients could make a complaint were contained in the practice information folder which was available in the waiting area. Patients were also able to complain through the practice website if they preferred. Staff spoken with were

No action

Are services responsive to people's needs?

(for example, to feedback?)

knowledgeable about how to handle a complaint. Staff told us that there was a complaints logging form to complete and they would always apologise and try to sort out any issues immediately. All information would be sent to the principal dentist.

The complaint policy recorded contact details such as NHS England, the Parliamentary and Health Service Ombudsman and the Private 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.

We were told that no complaints had been received at the practice within the last 12 months. Complaints information seen confirmed this. We saw that where complaints had been received information was recorded regarding any investigation and action taken.

The principal dentist confirmed that there was no information regarding 'Duty of Candour' available on file for staff to review. We were told that this information would be made available to staff immediately following this inspection.

No action

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service. Staff were aware of

their roles and responsibilities and were also aware who held lead roles within the practice such as complaints management, safeguarding and infection control.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints,

safeguarding, and infection control policies. Systems were in place to review these policies on at least an annual basis and these were discussed with staff during practice meetings. Information regarding data protection, confidentiality and freedom of information was also available to guide staff. Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, sharps, infection prevention and control, radiography and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. These included six monthly infection prevention and control audits, audits regarding clinical record keeping and radiography. We saw evidence to demonstrate that all audits and risk assessments were reported on and action plans completed.

An information governance file had been developed which contained various pieces of information such as the practice's statement of purpose and a copy of the Information Commissioners Certificate. Staff had completed information governance training in January 2016.

Leadership, openness and transparency

Staff we spoke with had a good understanding of their obligations under the duty of candour although the practice had not developed a policy in relation to this. Staff told us that they worked well as a team and provided support for each other. The principal dentist was aware of some minor shortfalls within the practice and was keen to address issues found during our inspection. Staff we spoke with told us that they felt supported and involved at the practice.

We saw that practice meetings took place on a monthly basis and brief minutes of meetings were kept. We were told that informal meetings were held on a daily basis were discussions were held regarding the day ahead and staff were able to raise any issues or concerns. Staff told us there was an open culture within the practice and they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately.

Staff said that they would speak with the principal dentist if they had any issues they wanted to discuss. We were told that the principal dentist was open and approachable and always available to provide advice and guidance. We were told that this was a very small team who worked well together and supported each other as necessary.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a six monthly basis. Walsall Health Care Trust completed an annual infection control audit on an annual basis and the practice completed an in-house infection control audit on an annual basis. We saw that reports and action plans were available. The last audit completed by Walsall Health Care Trust was dated 6 May 2016 and the practice's in house audit was 11 September 2016. Other audits included radiography and record card. We saw that record card audits had been completed in June and August 2016 and a radiography audit in June 2016. Action plans were recorded as required and reported upon.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The dental nurses were newly employed at the practice during 2016 and had not had an annual appraisal as they had recently completed their probationary period. Systems were in place to monitor staff CPD to ensure they met these requirements and staff said that were encouraged and supported to undertake training.

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

No action

Are services well-led?

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. Patients were able to contact the practice via their website to leave comments or ask questions and there was a 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 during one month a year; the results were reviewed and correlated. An analysis of the 2016 survey results was available for review in the audit file. Staff spoken with said that as they were a small team ongoing feedback was given to staff regarding the results of satisfaction surveys and the FFT. A more formal discussion would also be held at a staff meeting if there was anything of note to report.