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Shard End Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Shard End Dental Practice has three dentists (the principal, an associate and a foundation dentist), three qualified dental nurses who are registered with the General Dental Council (GDC), two trainee dental nurses and a receptionist. The practice's opening hours are 8.30am to 5pm on Monday to Thursday and 8am to 4pm on Friday. The practice closes for lunch each day between the hours of 1pm to 2pm.

Shard End Dental Practice provides mainly NHS dental treatments to patients of all ages but also offers private treatment options. The practice has three dental treatment rooms on the ground floor. Sterilisation and packing of dental instruments takes place in a separate decontamination room. There is a reception with adjoining waiting area on the ground floor.

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. We received comments from 62 patients by way of these comment cards and during the inspection we spoke with two patients.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.

Summary of findings

- Infection control procedures were in place with infection prevention and control audits being undertaken recently. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties.
- Oral health advice and treatment were provided in-line with the 'Delivering Better Oral Health' toolkit (DBOH).
- Staff had been trained to deal with medical emergencies and the provider had emergency equipment in line with the Resuscitation Council (UK) guidelines.
- Local rules were available in all of the treatment rooms were X-ray machines were located and these had been reviewed in January 2017. Records were not available to demonstrate that mechanical and electrical testing of X-ray equipment had been completed on an annual basis.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- The governance systems were effective.
- The practice was well-led and there were clearly defined leadership roles within the practice. 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 for the cleaning and sterilising of dental equipment to ensure suitable procedures are adopted which reduce the risk of splashing contaminated material when dental equipment is rinsed.
- Review the systems in place to ensure that all dental X-ray equipment receives the necessary service and maintenance so that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review the practice's responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

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 events and accidents and guidance was available regarding the Reporting of Injuries, Diseases and Dangerous Occurrences.

Emergency medical equipment was available on the premises in accordance with the Resuscitation Council UK guidelines and staff had undertaken training regarding basic life support.

Staff were suitably qualified for their roles and the practice had undertaken relevant recruitment checks to ensure patient safety.

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.

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. Referrals were made to secondary care services if the treatment required was not provided by the practice.

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 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.

We received feedback from 64 patients who commented that staff were friendly and helpful. Patients also commented that the staff were polite, caring and always tried to accommodate their needs when booking appointments.

Summary of findings

Are services responsive to people's needs?

No action

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 had ground floor treatment rooms. Level access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent or emergency appointments each day. There were clear instructions for patients requiring urgent care when the practice was closed.

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

Are services well-led?

No action

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

There were good governance arrangements and a clearly defined management structure in place. Systems were in place to share information with staff by means of informal daily meetings and regular formal practice meetings. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us that the culture within the practice was open and transparent.

Shard End 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 17 January 2017 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 five members of staff. 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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Detailed systems were in place to enable staff to report incidents and accidents. An adverse incident/near miss file was available. This contained adverse incident and near miss reporting forms. We looked at the records for incidents and near misses reported during 2016. Detailed information was recorded regarding, for example incidents such as staff sharps injuries. We also saw that a copy of the NHS England Never events policy and framework frequently asked questions was available for staff to review.

The practice's health and safety policy included information for staff regarding the reporting of accidents, this recorded that all accidents should be reported to the principal dentist. Staff spoken with confirmed this and all were aware of the location of accident and incident records.

We were shown the separate accident book and saw that 13 accidents had been reported since the practice opened. The last accident reported was dated December 2015. Staff confirmed that incidents and accidents would be discussed as they occurred during the informal meetings which were held at the practice on a daily basis during lunchtime. The principal dentist told us that discussions regarding incidents and accidents would be used to aid learning and to prevent such incidents from re-occurring.

Information regarding the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) was available for staff. Staff spoken with were aware of what issues required reporting under RIDDOR regulations. We were told that there had been no events at the practice that required reporting under RIDDOR.

We discussed national patient safety and medicines alerts with the principal dentist. We were told that these were received into the practice via email. Each staff member had an email account and the principal dentist forwarded copies of any relevant alerts to staff. We were told that these would be discussed informally amongst staff as they were received.

The practice had developed a Duty of Candour policy and information was available to staff in the practice manual and to patients in the waiting area. [Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity].

Documentation we were shown regarding complaints and incidents demonstrated that staff were following the principles of candour.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. Contact details for the local organisations responsible for child protection and adult safeguarding investigations were available. We saw that the policy was implemented in February 2016 and was due for review in March 2017. Staff had signed documentation to confirm that they had read and understood this policy. Staff had also completed the appropriate level of safeguarding training. On-line training was available to all staff.

The principal dentist had been identified as safeguarding lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. We were told that there had been no safeguarding issues to report.

The practice had an up to date Employers' liability insurance certificate. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We discussed sharps injuries with the principal dentist and we looked at the practice's sharps policies. We were told that there had been sharps injuries at the practice previously which had resulted in the practice changing to the use of safer sharps and disposable matrix bands. A matrix band is a thin metal strip that is positioned around the tooth during placement of certain fillings, they can be very sharp and so the use of disposable bands mitigates the risk involved in changing the bands. Dentists took responsibility for disposal of sharps.

Sharps information was on display in treatment rooms and other locations where sharps bins were located. This recorded the contact details for the local occupational health and the accident and emergency department.

No action

Are services safe?

Sharps bins were stored in appropriate locations which were out of the reach of children. We found that the practice was complying with the Health and Safety (Sharp instruments in healthcare) Regulations 2013.

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, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support in December 2016.

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. However records seen did not demonstrate that checks were made on the other equipment available at the practice to be used in a medical emergency. For example airways and spacer devices. We saw that the valve inside the self-inflating bag had come away from the main chamber rendering the device unusable quickly in an emergency. We also saw that the mask available was not bagged and had become dusty.

The principal dentist confirmed that new pieces of equipment would be purchased immediately. Following this inspection the principal dentist forwarded evidence to demonstrate that a new self-inflating bag and mask had been ordered and received the day following this inspection.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored and we were told that these were checked on a weekly basis to ensure they were within date for safe use. However, expiry dates were not recorded on the records seen. The principal dentist confirmed that expiry dates were recorded on the practice's computer system with a reminder that the medicine required replacing one month before the expiry date. We were told that expiry dates would be included on the check list immediately. It was also noted that the staff member checking the emergency medicines and equipment was not signing documentation. This task had been delegated to one member of staff and we were told that they would be asked to sign records in future. Following this inspection the principal dentist confirmed the changes implemented such as the addition of all emergency medical equipment and medicine expiry dates on the weekly checklist and another member of staff to assist with the assessment of equipment and medicines.

We saw that the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF).

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. The principal dentist was the designated first aider.

Staff recruitment

We discussed the recruitment of staff and were shown staff recruitment files. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all recruitment files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary and a Disclosure and Barring Service (DBS) check (or a risk assessment if a DBS was not needed). We looked at three staff recruitment files and saw that the information required was available. A standard layout was used in each file for ease of access to information.

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.

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 health and safety policy which had been reviewed on an annual basis. The principal dentist was the named lead regarding health and safety. All staff spoken with said that they could speak with the principal dentist for health and safety advice if required. Staff had signed documentation to confirm that they had read and understood the health and safety policy. A health and safety poster was on display in the staff kitchen.

Numerous risk assessments had been completed. For example, we saw risk assessments for fire, radiation, sharps injury, hepatitis B non-immunised staff or non-responder, pregnant and nursing mothers, trainee dental nurses, work experience students and a general practice risk assessment. Risk assessments were reviewed on an annual basis.

We discussed fire safety with staff and looked at the practice's fire risk assessment which had been completed in 2016. Other records available included details of an annual fire drill which took place on 23 May 2016 and details of staff fire safety training.

Records seen confirmed that fire extinguishers were subject to routine maintenance on April 2016 by external professionals. Records were also available to demonstrate that a visual check was completed of fire extinguishers on a monthly basis. The fire alarm system was last serviced on 12 April 2016 and records available demonstrated that annual maintenance and servicing had been completed prior to that date.

Emergency lighting had been serviced in April and October 2016. Staff were completing weekly fire alarm checks which involved checking aspects of the fire safety system such as call points and automatic door releases.

We looked at the practice's COSHH file; details of all substances used at the practice which may pose a risk to health were recorded in this file.

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. Dental nurses who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas.

Infection prevention and control policies and procedures had been developed to keep patients safe. These had been reviewed on an annual basis with the last review taking place on 9 January 2017.

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

Infection prevention and control audits were completed on a six monthly basis with the date of the last audit being September 2016. We looked at some of the recent audits and saw that outcomes, improvements and action plans were recorded. Records demonstrated that all staff had undertaken training regarding the principles of infection control.

Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff 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.

We looked at the procedures in place for the decontamination of used dental instruments. Decontamination of used dental instruments took place in a separate decontamination room which had clearly identified zones in operation to reduce the risk of cross contamination. A dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. There was a clear flow of instruments through the dirty zone to the clean area. Staff wore PPE during the process to protect themselves from injury which included gloves, aprons and protective eye wear. We found that instruments were manually cleaned, placed in an ultrasonic bath, rinsed, inspected under an illuminated magnifier and then sterilised in an autoclave. We saw that staff were rinsing equipment under running water which was not in line with the practice's procedure which required instruments to be submerged in water for rinsing. This would prevent splashing of possible

contaminated material. We discussed this with the principal dentist who confirmed that they would discuss this with staff and ensure the correct procedure was followed.

Clean instruments were packaged; date stamped and appropriately stored in cupboards and rotated to ensure appropriate usage. However, we saw three items of equipment which had been incorrectly dated. These were removed to be re-sterilised.

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.

A risk assessment regarding Legionella had been carried out by an external agency on 14 July 2015. The risk assessment recommended that monthly water temperature records were kept and that staff completed training regarding legionella. Notes recorded on the risk assessment demonstrated action taken to address recommendations.

The practice had a waste contractor in place to dispose of hazardous waste. We looked at waste transfer notices and the storage areas for clinical and municipal waste. Clinical waste was securely stored in an area that was not accessible to patients. 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 fire safety equipment had been serviced in April 2016, compressors in January 2017 and the autoclaves serviced in November 2016 and January 2017. 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. We were not shown records to demonstrate the date of the last service of dental chairs.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) on 6 January 2017. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Records were available to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. However, fridge temperatures were only recorded on a weekly basis. The principal dentist confirmed that they would purchase a minimum/maximum thermometer for the fridge and monitor and record the fridge temperature on a daily basis.

Prescription pads were securely stored and a log of each prescription issued was kept.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered.

Radiography (X-rays)

The principal dentist 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. The principal dentist was the RPS and an external company had been contracted to provide RPA services. We saw evidence that the dentist was up to date with the required continuing professional development on radiation safety.

The practice had three intra-oral X-ray sets which all had rectangular collimators fitted. Intra-oral X-rays take an image of a few teeth at a time and rectangular collimators reduce the amount of radiation to the patient by decreasing the amount of radiation scatter.

We saw that the practice had notified the Health and Safety Executive that they were planning to carry out work with ionising radiation. Local rules were available in each of the treatment rooms were X-ray machines were located for all staff to reference if needed. These had been reviewed in January 2017.

Copies of the maintenance logs for each of the X-ray sets were available for review. The maintenance logs were within the current recommended interval of three years. Critical examination packs for each of the X-ray sets were

No action

Are services safe?

also available. However the annual mechanical and electrical service was last completed on 2 March 2015 and was therefore overdue. The principal dentist confirmed that they would ensure that this test was completed.

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 a recent X-ray audit completed in January 2017. Audits were not operator specific and therefore did not identify which dentist had taken the X-ray. Operator specific audits would help identify that best practice is being followed by each dentist and highlight improvements needed to address shortfalls in the delivery of care for each individual dental clinician at the practice. The principal stated that they were reviewing their computer software to establish whether operator specific audits could be completed.

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 two dentists and we saw dental care records to illustrate our discussions. The practice kept up to date detailed electronic dental care records.

Medical history forms were given to patients to fill in when they initially registered at the practice. Dentists told us that these were verbally checked with patients at every appointment. This ensured that the dentist was kept informed of any changes to the patient's general health which may have an impact on treatment.

We were told that following discussions and update of medical history records, an examination of the patient's teeth, gums and soft tissues was completed. Detailed records were kept which included details of the condition of the teeth and 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.

Risk factors such as oral cancer, dental decay, gum disease and patient motivation to maintain oral health were taken into consideration to determine the likelihood of patients experiencing dental disease. Smoking and alcohol intake were recorded as part of the oral cancer assessment.

The Dentist told us that where relevant, preventative dental information was given in order to improve the outcome for the patient. Oral hygiene assessments were recorded.

Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE), particularly in respect of lower wisdom teeth removal and in deciding the appropriate length of time to recall patients for a check-up.

Patient dental care records that we were shown demonstrated that the dentist was following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

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). 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. A dental nurse told us that large scale models of the mouth were used to demonstrate tooth brushing to help ensure patients understood the correct techniques to be applied. Interdental cleaning and flossing was also explained to patients and we were told that information leaflets were given to patients as necessary. Patients we spoke with confirmed this.

Medical history forms completed by patients included questions about smoking and alcohol consumption. A dental nurse explained that new patients initially completed and signed a paper copy record regarding their medical history and this was checked at every visit to the practice and signed by the patient. Patients we spoke with told us that they were asked regularly to update their medical history. A poster on display in the reception reminded patients to speak to dental staff if there had been any changes to their medical history.

Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice. Staff said that where necessary contact details for smoking cessation were given to patients. Feedback from one patient spoken with was that they had been commenced smoking cessation following information given by the dentist and this had been successful.

Oral health promotion leaflets and information about dental treatments were on display in the waiting room. Details of discussions regarding improving oral health were recorded in patient dental care records.

Free samples of toothpaste were available in the waiting room and we were told that patients were given advice if required regarding oral hygiene products to use.

Staffing

Practice staff included three dentists (the principal, an associate and a foundation dentist), three qualified dental nurses who were registered with the General Dental Council (GDC), two trainee dental nurses, and a receptionist.

There were enough staff to support dentists during patient treatment. We were told that all dentists worked with a

No action

Are services effective?

(for example, treatment is effective)

dental nurse. The practice planned for staff absences to ensure the service was uninterrupted. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave. One of the dental nurses worked part time and they told us that they often covered staff leave. Locum dentists had been used in the past to cover times when dentists were unavailable.

We discussed staff training with the principal dentist and with a dental nurse. Training was provided to staff via attendance at courses, in-house and on-line training. Staff spoken with said that they received all necessary training to enable them to perform their job confidently and were able to ask for help and advice as required.

We were told that discussions were held with staff about continuing professional development (CPD) on an ongoing basis. We were shown staff CPD files. CPD is a compulsory requirement of registration as a general dental professional. We saw evidence to demonstrate that staff had undertaken core CPD training such as safeguarding (including mental capacity), infection control and basic life support. Staff had also completed training in other specific dental topics such as decontamination, health and safety, hand hygiene and emergency oxygen therapy in a dental practice.

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.

Appraisal systems were in place. Staff told us that appraisal meetings were held on an annual basis. Staff said that these meetings were used to discuss working practices and any issues or concerns. We saw that personal development plans (PDP) were available for staff. However these were not available for the 2016 appraisals for dental nurses. The principal dentist felt that it was the responsibility of staff to complete their own personal development plans to include training they wished to undertake. However we were told that staff would be encouraged to give some thought to training needs and complete these documents. Following this inspection we received confirmation from the principal dentist that PDP were available for all staff but had been misfiled.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required sedation, oral medicines and community services.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. These referrals were made by way of the computer system and emailed to the hospital over a secure email. This ensured that referrals were received and could be actioned in a timely fashion. Records were comprehensive and dentists followed the Faculty of General Dental Practice (FGDP) guidelines when making notes for these referrals.

Consent to care and treatment

The practice had developed a consent policy which had been 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. Staff had recently received in-house training regarding the MCA. There were no examples of patients where a mental capacity assessment or best interest decision had been needed.

Dentists we spoke with described to us the process they used to ensure they had obtained full, valid and educated consent. We were told that patients were given verbal and written information to support them to make decisions about treatment. Information leaflets were available to assist with the decision making process. In addition a written treatment plan with estimated costs was produced for all patients to consider before starting treatment. Patient care records we were shown contained records of detailed discussions held with patients and there was evidence that consent was obtained.

We spoke with the principal dentist about the Gillick competency. This assesses 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.

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. Music was played in the waiting area; this helped to distract anxious patients. Staff said that they could speak to patients in an unused treatment room or the staff kitchen if patients needed to speak with staff in private.

The practice did not keep paper records, reducing the opportunity for confidential information to be overseen. Computers were password protected and regularly backed up to secure storage. If computers were ever left unattended 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.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. 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 friendly, caring, helpful and professional. Comment cards recorded that anxious patients were made to feel relaxed and at ease.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. We were told that staff took their time to fully explain treatment, options, risks and fees. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. Clear treatment plans were given to patients which also detailed possible treatment and costs. Patients commented they felt involved in their treatment and it was fully explained to them. We were told that staff spent their time explaining treatment options, risks and benefits.

Information about NHS costs were available 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

At the time of our inspection the practice were taking on new NHS patients and a new patient appointment could be secured within a few days of the initial contact. During the inspection we observed the receptionist accommodating patient's needs regarding appointment times. Feedback from patients indicated that the practice made every effort to secure an appointment at a time and day that was convenient.

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. Vacant appointment slots would be used to accommodate urgent appointments. Once vacant 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.

Feedback confirmed that patients were not kept waiting beyond their appointment time.

Tackling inequity and promoting equality

Staff spoken with told us that they did not have difficulty communicating with patients who were hard of hearing as these patients had been visiting the practice for many years. We were told the contact details for British sign language interpreters would be obtained and sign language interpreters would be used as needed. The practice however did not have a hearing induction loop for use by people who were hard of hearing and no contact details for 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 the majority of patients were able to communicate using English language. We saw that contact details for a translation service were available for use if required and a poster on display in the reception area advised patients that they could ask at reception if they required the use of an interpreter. Although this poster was written in English and not available in any other languages.

This practice was suitable for wheelchair users, having ground floor treatment rooms with level access to the front of the building and an adapted toilet to meet the needs of patients with a disability.

Access to the service

The practice was open from 8.30am to 5pm on Monday to Thursday and 8am to 4pm on Friday (closed between 1pm to 2pm). The opening hours were displayed in the entrance to the practice and on the practice leaflet.

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 appointment system enabled patients in pain to be seen in a timely manner. Although dedicated emergency appointments were not set aside for the dentists each day patients that the practice was open; we were told that there were always some vacant slots available. When these were filled patients would be told to sit and wait to see the dentist. Patients spoken with and comment cards received confirmed that patients were always able to see a dentist easily in an emergency.

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 recorded contact details such as NHS England and the Care Quality Commission. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. Patients were given information on how to make a complaint. We saw that a copy of the complaints policy was on display in the waiting area. A Healthwatch statement regarding dental complaints was also on display for patients to view.

Staff told us that they would record details of any complaints received, initially offer an apology and pass details of the concerns to the principal dentist who was the complaint lead. Staff said that they aimed to resolve all complaints immediately and complainants were always offered an apology and a meeting with the principal dentist.

No action

Are services responsive to people's needs?

(for example, to feedback?)

As part of induction training all staff read the practice's complaints policy and staff were required to read this document on an annual basis.

We saw that one complaint had been received during 2016 and one during 2017. Details of the complaint, correspondence and any action taken were recorded on the complaint file.

Information regarding 'Duty of Candour' was available on file for staff to review and on display in the waiting room. This recorded that patients would be informed of any incident that affected them; they would be given feedback and an apology. Staff spoken with felt that by being open and honest, offering an initial apology and immediate assistance to sort out any problems mitigated the risk of receiving complaints.

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 confirmed that the principal dentist held the majority of 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 in the practice manual. Staff had signed documentation by each policy to confirm that they had read and understood the policy.

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.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff confirmed that the culture was open and supportive. We were told about social events organised for staff to encourage team bonding. Staff told us that they worked well as a team, provided support for each other and were praised by the management for a job well done. We were told that everyone at the practice was friendly and helpful.

Complaints systems encouraged candour, openness and honesty. Staff were aware of their responsibilities regarding Duty of candour.

Staff told us that the principal dentist was approachable and helpful. They said that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately. We saw that previously staff meetings had taken place approximately four times per year but there had been fewer formally documented meetings held during 2016. Staff we spoke with confirmed that informal meetings were held on a daily basis during lunchtime. Staff said that they were able to speak out about issues or concerns at any time including informal and formal practice meetings.

We spoke with staff about communication within the practice. We were told that the principal dentist was always available, either on the telephone or in the practice, to provide assistance and advice.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. As well as regular scheduled risk assessments, the practice undertook clinical audits. We were shown the recent audits completed within the last 12 months regarding the six monthly infection prevention and control, clinical record keeping, pain history, oral cancer risk factors, health and safety self-assessment, waiting time and radiography audits. We saw evidence to demonstrate that all audits and risk assessments were reported on and actions taken recorded. We noted that the radiography and record card audit were not operator specific. For example they did not identify the results for each individual dentist which would not provide targeted results. The principal dentist was in discussions with the computer software provider to try and ensure that future audits could be operator specific.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The principal dentist had introduced a system of monitoring to ensure staff were up to date with their CPD requirements. Staff said that they received email reminders when training was due and confirmed that support was provided to enable them to complete any training required. Annual appraisal meetings were held and staff confirmed that they were encouraged to undertake training.

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. The receptionist told us that it was their responsibility to capture feedback from patients. We were told that either the Friends and Family Test (FFT) or a satisfaction survey developed by the foundation dentist was given to patients to complete. A poster on display asked patients to complete the FFT.

The FFT which is a national programme to allow patients to provide feedback on the services provided. At the time of this inspection 100% of patients who responded to the FFT (31 patients) would recommend the practice. The results of

No action

Are services well-led?

the December 2016 FFT were on display in the waiting area. This recorded that 93% of patients were extremely likely to recommend the dental practice and 7% were likely. Patients spoken with during the inspection all confirmed that they would and already had recommended the dental practice to friends and family.

Staff spoken with told us that any patient feedback was always discussed during informal practice meetings.

Staff said that they would speak with the principal dentist if they had any issues they wanted to discuss. We were told that the management team were open and approachable and always available to provide advice and guidance. Staff spoken with felt that Shard End Dental Practice was a very friendly place to work and everyone worked well together as a team.