

Dr Thegan Moodley

Sandon Dental Practice

Inspection Report

80 Sandon Road
Smethwick
West Midlands
B66 4AG
Tel: 0121 429 3572
Website: <http://www.sandon-dental.co.uk/>

Date of inspection visit: 31 January 2017
Date of publication: 03/04/2017

Overall summary

We carried out an announced comprehensive inspection on 31 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

Sandon Dental Practice is a dental practice providing general dental services on a NHS and private basis. The service is provided by three dentists (one of whom is the provider). They are supported by four dental nurses (one of whom is a trainee) and a practice manager. The dental nurses also carry out reception duties.

The practice is located on a main road near a local shopping centre and bus routes. There is wheelchair access to the practice.

The premises consist of a waiting room, a reception area, an office, kitchen, staff room, a storage room, a decontamination room and two treatment rooms on the ground floor. The first floor comprises of another decontamination room, two treatment rooms, an office and a second waiting room. There are toilet facilities on the ground floor for staff and for patients and these are wheelchair-accessible. Two of the treatment rooms were not in use at the time of our visit. The practice opened between 8am and 5pm on Monday to Friday.

The provider is registered with the Care Quality Commission (CQC) as an individual. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Eight patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients. The

Summary of findings

information from patients was entirely positive. Patients were highly satisfied with their experience and they commented that staff were friendly, informative and pleasant. Patients confirmed that their dentist provided clear explanations about their treatment and kept them informed. Those that commented on cleanliness told us that the practice was always clean and tidy.

Our key findings were:

- The practice was organised and appeared clean and tidy on the day of our visit. Several patients also commented that this was their experience.
- Patients were able to make routine and emergency appointments when needed and gave us positive feedback about the service they received.
- An infection prevention and control policy was in place. We saw the decontamination procedures followed recommended guidance. We identified some necessary improvements and these were promptly resolved.
- The practice had systems to assess and manage risks to patients, including health and safety, safeguarding, safe staff recruitment and the management of medical emergencies. We identified some necessary improvements and these were promptly resolved.
- Dental professionals provided treatment in accordance with current professional guidelines.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Practice meetings were used for shared learning.
- The practice demonstrated that they undertook audits in infection control, radiography and dental care record keeping.

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

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review availability of equipment to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK) and the General Dental Council (GDC) standards for the dental team.
- Review the current Legionella risk assessment and implement the required actions.
- Review the practice's recruitment policy and procedures to ensure character references for new staff as well as proof of identification are requested and recorded suitably.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff. We identified some necessary improvements and these were resolved promptly.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit which centred around the frequency of audits and remedial work to the plumbing system to reduce the level of risk in the water system.

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

No action



Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

No action



Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. Patients described staff as friendly and informative. Patients commented they felt involved in their treatment and it was fully explained to them.

No action



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 an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Patients were able to contact staff when the practice was closed and arrangements were subsequently made for these patients requiring emergency dental care.

The practice had an effective complaints process.

The practice offered access for patients with limited mobility.

No action



Are services well-led?

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

There was a clearly defined management structure in place and staff we spoke with felt supported in their own particular roles.

There were systems in place to monitor the quality of the service including various audits. The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

The practice carried out audits such as radiography, dental care record keeping and infection control to help improve the quality of service. All audits had documented learning points with action plans.

No action



Sandon 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.

We inspected Sandon Dental Practice on 31 January 2017. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the provider, the practice manager, two other dentists and three dental nurses. We also reviewed CQC comment cards which patients had completed and spoke with patients. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems in place for staff to report accidents and incidents. We saw records of incidents and accidents and these were completed with sufficient details about what happened and any actions subsequently taken. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

Staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). We reviewed evidence of a RIDDOR reportable incident and found that it had been managed appropriately.

The practice manager was aware of national patient safety and medicines alerts that affected the dental profession. We saw evidence that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). However, the system of obtaining information from the relevant alerts and forwarding the information to staff required a more robust system. There was no evidence that previous alerts had been acted upon and shared with staff; however, the practice manager showed us some relevant alerts saved in their email inbox. Within 48 hours, the practice manager informed us that previous alerts had been printed and stored in a file and these would be discussed in future staff meetings.

Staff we spoke with were aware of the Duty of Candour regulation and a policy was present. 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.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and protection of vulnerable adult policies and procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local safeguarding teams. The practice manager was the safeguarding lead in the practice but the policies had not been updated to reflect this. Staff members we spoke with

were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. Training records showed the safeguarding lead had completed training to an appropriate level in October 2015. One of the dentists had not completed recent training in the safeguarding of vulnerable adults. Within 48 hours, the practice manager sent us evidence that this particular dentist had booked to attend training in March 2017.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We saw a rubber dam kits at the practice and were told that both dentists used them when carrying out root canal treatment whenever practically possible. A rubber dam is a thin, square 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.

All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were not aware of 'never events' and the practice did not have written processes to follow to prevent these happening. For example, there was no written process to make sure they did not extract the wrong tooth. However, staff described to us the methods they used to prevent such incidents from occurring.

The practice had processes in place for the safe use of needles and other sharp instruments.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies in the practice were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). However, some necessary improvements were required. The practice had access to oxygen, emergency medicines and limited emergency

Are services safe?

resuscitation kits. There was an automated external defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm.

The practice did not hold portable suction equipment. This is used to clear the airway to enable a patient to breathe. We also noted that two (out of four) oropharyngeal airways had date-expired. These are medical devices that are used to maintain or open a patient's airway. The practice did not hold a spacer device for inhaled bronchodilators. This is a device used to increase the ease of administering aerosolised medication from an inhaler. We saw evidence that these items had all been ordered on the same day as our visit and were due to arrive on the next day.

Staff received annual training in the management of medical emergencies. There was also an appointed First Aider who had received training in 2013. The practice took responsibility for ensuring that all of their staff received annual training in this area. All equipment and medicines were stored in a secure but accessible area.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented weekly checks of the emergency oxygen, AED and the emergency medicines. The emergency medicines were all in date and stored securely.

A glucagon injection kit is used to treat episodes of severe hypoglycaemia which is defined as having low blood glucose levels. This was available at the practice and the glucagon was not stored in the refrigerator. The manufacturer states that it can be stored outside the refrigerator but this does shorten the shelf life. Staff were able to demonstrate that the expiry date had been amended appropriately.

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

Bodily fluid spillage and mercury spillage kits were available to deal with any incidents.

Staff recruitment

We looked at the recruitment records for three members of the practice team. One staff member was recruited under the current recruitment processes (by the new practice

manager). These were satisfactory apart from the absence of staff identity verification. The records contained evidence of written references, a contract, a curriculum vitae and proof of immunisation status.

There were also Disclosure and Barring Service (DBS) checks present for two staff members (including one for the most recently recruited member). The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults.

The records and processes we reviewed for the other two staff members had been superseded and lacked evidence of references and DBS checks. Within 48 hours, the practice manager sent us evidence that they had applied for DBS checks for two staff members that had not previously had these carried out.

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

The practice had a recruitment policy for the safe recruitment of staff; however, this did not have specific information about the acceptance of historical DBS checks. Within two working days, the practice manager told us they had amended their recruitment policy and this was more specific and contained all relevant details.

Monitoring health & safety and responding to risks

We saw evidence of a business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had systems to identify and mitigate risks to staff, patients and visitors to the practice. We saw evidence that the fire extinguishers had been serviced in March 2016. Fire drills took place every three months to ensure staff were rehearsed in evacuation procedures. Fire safety information was displayed clearly throughout the premises. Staff were carrying out monthly tests of the smoke detectors but had not tested them since October 2016. There were fire exits on the ground floor but one of these did not have clear signage to show where the evacuation point was. Within 48 hours, we received

Are services safe?

photographic evidence that staff had displayed an appropriate sign in a prominent position on this fire exit. Fire risk assessments were carried out in 2010 and 2013 but these were brief and not entirely specific to the practice. The practice manager contacted us after the inspection with evidence that an external contractor had been booked to complete a fire risk assessment and fire marshal training in mid-March.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them. We saw evidence that this was reviewed regularly.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The policy was reviewed annually and was dedicated to the practice. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. However, some improvements were required. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed three treatment rooms and the decontamination rooms and found them to be visually clean. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition. Dental chairs were covered in non-porous material which aided effective cleaning.

Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

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

Decontamination procedures were carried out in a dedicated decontamination room and there was one on each floor. In accordance with HTM 01-05 guidance, an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

Sharps bins were appropriately located and out of the reach of children. However, not all were signed, dated and wall-mounted. We observed waste was separated into safe and lockable containers for fortnightly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. There appeared to be sufficient instruments available and staff confirmed this with us. Staff we spoke with were aware of disposable items that were intended for single use only.

Staff used an ultrasonic cleaning bath to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. An ultrasonic cleaning bath is a device that uses high frequency sound waves to clean instruments. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place; however, not all of the records had the test dates on them. The practice manager told us this had been addressed as a matter of urgency and would also be discussed at the next staff meeting.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument – this included all the necessary information and was easily accessible. Staff we

Are services safe?

spoke with were familiar with the Sharps Regulations 2013 and there was a policy present. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments. The practice used a disposable syringe system which is designed to prevent injuries from contaminated needles. One of the dental nurses told us they were occasionally involved in dismantling the used syringes for local anaesthetic but this process involves more members of staff handling sharp instruments. Within 48 hours, the practice manager told us that all staff have been told that only the dentists will dismantle the used syringes.

Staff told us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All clinical and non-clinical areas were cleaned daily by an external cleaner. The practice had a dedicated area for the storage of their cleaning equipment.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We reviewed the audit from September 2016 and this demonstrated 99% compliance. The audit prior to this was in October 2015 so almost 12 months had lapsed. Action plans were documented subsequent to the analysis of the results. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings. The practice manager informed us that they would ensure these audits were carried out every six months.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range. The practice also carried out and documented quarterly checks of the water quality. We reviewed the Legionella risk assessment and this was carried out by an external contractor in July 2016. The specialist had made recommendations but not all of these had been enacted by the practice. Within two working

days, the practice manager sent us evidence that they had contacted an external contractor regarding these outstanding actions to reduce the level of risk in the water system.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves. The ultrasonic cleaning bath had not been serviced recently. Within 48 hours, the practice manager informed us that they were due to source a service contract from an external company to carry this service out.

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirm that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in January 2016.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The prescription number was recorded in the patients' dental care records. The practice kept a log of prescriptions given so they could ensure that all prescriptions were tracked. All prescriptions were stamped only at the time of issue.

There was no separate fridge for the storage of dental materials. Within 48 hours, the practice manager informed us that an additional fridge had been provided and they would begin monitoring the temperature of it to ensure it remained within the recommended parameters.

Stock rotation of all dental materials was carried out on a regular basis by the dental nurses and all materials we viewed were within their expiry date. A system was also in place for ensuring that all processed packaged instruments were within their expiry date.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used digital X-rays.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed.

Are services safe?

We did not see evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this. The practice manager contacted the HSE to inform them about this soon after our visit.

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

We saw evidence that the dentists were up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

We saw evidence that the practice carried out an X-ray audit in January 2017. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that the results were analysed and reported on.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date, detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

We spoke with two dentists about the oral health assessments, treatment and advice given to patients and they showed us a selection of patient dental care records to corroborate this. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were documented in the records we viewed. This should be updated and recorded for each patient every time they attend.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE for all adults and children aged 7 and above (as per guidelines). We saw evidence that patients diagnosed with gum disease were appropriately treated.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentists told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The dentists we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

There were oral health promotion leaflets available in the practice to support patients in looking after their health. Examples included information on stopping smoking and oral cancer.

The practice was aware of the provision of preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive oral hygiene advice. Where required, toothpastes containing high fluoride were prescribed.

The practice promoted oral health in the local community using various methods. A local GP had contacted the practice and asked the staff to visit a local care home to give dietary advice and instructions about oral hygiene. This was aimed at the patients and their carers. Consequently, the dentist had visited two care homes and was also considering visiting the local playgroup to focus on similar instructions for the parents/guardians of babies and toddlers.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This included areas such as fire safety, confidentiality and safeguarding.

Staff maintained the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC (apart from the trainee dental nurse as only qualified staff can register).

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that dental nurses were often transferred from the provider's other local practice and staff were happy to travel between the two locations if required. We were told that this arrangement worked well because the practice would pay for travel expenses incurred. Occasionally, the practice utilised a locum dental nurse agency.

Are services effective?

(for example, treatment is effective)

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

We were told that the dental nurses were encouraged to carry out further training. One of the dental nurses was in the process of enquiring about additional training which would enable them to deliver oral health promotion to patients.

A dental nurse always worked with each dentist and an additional nurse was usually available each day to help with decontamination procedures. The General Dental Council (GDC) recommends that dental staff are supported by an appropriately trained member of the dental team at all times when treating patients.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist dental services for complex oral surgery. We viewed two referral letters and noted that they were comprehensive to ensure the specialist services had all the relevant information required.

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

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. We were shown specific consent forms for more complex items of treatment such as extractions and root canal treatment. Staff ensured these were signed and dated by the patients prior to commencing treatment. Staff ensured patients gave their consent before treatment began and this was recorded in the dental care records.

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Staff members we spoke with were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Staff and patients told us that written treatment plans were provided. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Eight patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients. The information from patients was entirely positive. Patients were highly satisfied with their experience and they commented that staff were friendly, informative and pleasant. Patients confirmed that their dentist provided clear explanations about their treatment and kept them informed. Those that commented on cleanliness told us that the practice was always clean and tidy.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. Staff told us they had individual passwords for the computers where confidential patient information was stored. There was a room available for patients to have private discussions with staff. We observed

that staff members were helpful, discreet and respectful to patients on the day of our visit. There was a policy about the importance of confidentiality and staff had signed this to demonstrate understanding and awareness.

We were told that the practice appropriately supported children and anxious patients using various methods. Longer appointments were arranged to allow additional time for discussions. They also had the choice of seeing a male or female dentist at the practice. Patients could also request a referral for dental treatment under sedation.

The computer system at the practice had a feature that enabled nervous patients to be identified quickly by all staff. This would enable staff to adapt their approach, if deemed appropriate and necessary.

Involvement in decisions about care and treatment

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

Examination and treatment fees were displayed in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as two treatment rooms were on the ground floor. There were toilet facilities available on the ground floor and these were wheelchair-accessible.

The practice had an appointment system in place to respond to patients' needs. We reviewed comments made by patients and found that they were usually seen on time and that it was easy to make an appointment. Staff told us they would inform patients if the dentist was running late – this gave patients the opportunity to rebook the appointment if preferred. We saw some evidence of double-booked appointments but we also saw that empty slots were available throughout the sessions to allow time to catch up.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We reviewed the appointment system and saw that dedicated emergency slots were available on a daily basis to accommodate patients requiring urgent treatment. If these slots became unavailable, the practice was able to accommodate patients by utilising a 'sit and wait' policy.

Patient feedback confirmed that the practice was providing a good service that met their needs. The practice sent appointment reminders to all patients that had consented. The method used depended on the patient's preference, for example, via text message or telephone reminders. The patient's preference was recorded on their record.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. We saw evidence that some staff had completed training in equality and diversity. There was also a practice policy present about promoting equality. The practice did not have an audio loop system for patients who might have hearing impairments. However, the practice used various methods so that patients with hearing impairments could still access the services.

The dentists and dental nurses spoke a variety of languages and these included Urdu, Bengali, Punjabi and Gujarati. We were told that they had not encountered any problems communicating with patients if they were unable to speak fluent English.

Access to the service

Feedback from patients confirmed they could access care and treatment in a timely way and the appointment system met their needs. The practice was currently accepting new NHS patients.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment via the telephone answering service. Details were also displayed at the main entrance to the practice.

The practice's opening hours were between 8am and 5pm on Monday to Friday.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice. This included details of some external organisations in the event that patients were dissatisfied with the practice's response. Within two working days, the practice manager informed us that additional organisations had been added and this information was laminated and displayed in the reception area for patients' perusal.

No complaints had been received by the practice in the 12 months prior to our visit. We reviewed older complaints and saw evidence that they had been recorded, analysed and investigated. However, the complaints file required updating and organising. The practice manager informed us that this was carried out within 48 hours of our visit. There was a designated complaints lead. We found that complainants had been responded to in a professional manner. We were told that any learning identified was cascaded personally to team members and also discussed in staff meetings. We saw examples of changes and improvements that were made as a result of concerns raised by patients.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. The provider also had telephone availability on all working days.

The current practice manager was experienced in the management of dental practices but had managed Sandon Dental Practice for just over a month. The previous practice manager was in post for many years and the practice was currently in the process of updating many areas of governance to reflect the recent changes. The practice had identified some areas of improvement themselves prior to our visit and were working to resolve any shortfalls. Within 48 hours, the practice manager informed us that all policies had been updated to reflect changes that had occurred at the practice since they had taken over this role.

We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. The practice had risk assessments for areas such as handling sharp instruments, autoclaves and display screen equipment.

The practice was a member of the BDA (British Dental Association) Good Practice scheme. (This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities).

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead, complaints lead and infection control lead.

The provider had systems in place to support communication about the quality and safety of services.

Staff told us they were aware of the need to be open, honest and apologetic to patients if mistakes in their care were made. This was in line with the Duty of Candour regulation.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The GDC requires all registrants to undertake CPD to maintain their professional registration.

Staff audited areas of their practice as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. Other audits were also available and these included audits on hand hygiene. We saw examples of changes made to the practice's processes as a direct result of audit findings.

Staff meetings took place every two months. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as confidentiality, fire safety and infection control had been discussed in the last 12 months.

All staff (apart from the dentists) received annual appraisals. The dentists had been appraised in the past but not currently. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed. We reviewed four appraisals and these were comprehensive.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings but this was not always documented. Within 48 hours, the practice manager informed us this would be routinely discussed at all future practice meetings. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from

Are services well-led?

patients undergoing NHS dental care. Patients previously had the opportunity to complete satisfaction surveys in 2015 but these were removed since the introduction of the FFT.

Patients had made comments on the NHS Choices website and these were mostly positive (but some were negative). The practice had not responded to the entries on the

website. Within 48 hours, the practice manager informed us they had contacted NHS Choices and were awaiting a password to enable them to log in and respond to comments. We were told they would be logging in regularly to respond to all comments made by patients.

Staff we spoke with told us their views were sought and listened to.