Mr. Ellic Thompson

First Dental

Inspection Report

124 High Street
Bloxwich
Walsall
West Midlands
WS3 2DG
Tel: 01922 475994
Website: www.firstdental-bloxwich.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 6 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

First Dental is a dental practice providing general dental services on a NHS (predominantly) and private basis. The service is provided by four dentists (one of whom is a specialist orthodontist). They are supported by seven dental nurses (one of whom is a trainee), a practice manager and a receptionist. The dental nurses also carry out reception duties. Two of the dentists also carry out inhalation sedation at the practice for children.

The practice is located on a main road near local amenities and bus routes. There is wheelchair access to the practice. The premises consist of a waiting room, reception area, office, kitchen, staff room, storage room and four treatment rooms on the ground floor. The first floor comprises of a decontamination room, a storage room, two treatment rooms and an office. There is also an area for taking and developing X-rays on the ground floor. The practice opens at 8:50am on Monday to Friday and closing times vary between 1:30pm and 7pm.

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.

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

Summary of findings

patients. The information from patients was overwhelmingly complimentary. Patients were positive about their experience and they commented that staff were friendly and polite.

Our key findings were:

- The practice was organised and appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patients told us they found the staff polite and friendly. Patients were able to make routine and emergency appointments when needed.
- An infection prevention and control policy was in place. We saw the decontamination procedures followed recommended guidance.
- 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. Some improvements were required in some of these areas.
- Dental professionals provided treatment in accordance with current professional guidelines.
- 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.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping. However, the audit in infection control was overdue at the time of our visit.
- Practice meetings were not held regularly and these should be used for shared learning.

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 the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance
- Review its responsibilities as regards to the Control of Substances Hazardous to Health (COSHH) Regulations 2002 and, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review staff training to ensure that staff who are involved in conscious sedation have received the appropriate training (including refresher training) and skills to carry out the role giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015.
- Review the protocol for completing detailed records relating to recruitment of staff. This includes ensuring recruitment checks, including references and proof of identification, are suitably obtained and recorded.

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.

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 but we identified necessary improvements on the day of our visit. .

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. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines.

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 on the practice's risk assessment for Legionella prevention.

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).

Are services effective?

No action

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.

The practice offered inhalation sedation to its younger patients who were anxious. The dentists had received appropriate training but were due refresher training.

Are services caring?

No action

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 highly positive about the care they received

Summary of findings

from the practice. Patients described staff as friendly and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding. Several patients commented that the practice was child-friendly. Several patients told us they would recommend this practice to their family and friends.

Are services responsive to people's needs?

No action 

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 full access for patients with physical disabilities.

Are services well-led?

No action 

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 methods to successfully gain feedback from patients. Staff meetings did not place on a regular basis but they were due to be held on a weekly basis in the near future. .

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. One audit was overdue but this was completed soon after our visit and demonstrated 100% compliance with national guidance.

First Dental

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 First Dental on 6 October 2016. 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). No RIDDOR reportable incidents had taken place at the practice in the last 12 months.

There was a policy present on national patient safety and medicines alerts that affected the dental profession. We were told that the provider had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The provider was responsible for obtaining information from relevant emails and forwarding this information to the rest of the team; however, there was some doubt amongst staff regarding this process. Within 48 hours, the provider informed us that they now held all staff's email addresses so that relevant information could be easily forwarded to them. Not all staff we spoke with were aware of the practice's arrangements to report any adverse drug reactions.

Some of the staff we spoke with were not aware of the duty of candour regulation. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment. Within two working days, the provider informed us that a staff meeting had been arranged for the following week and discussion of this regulation was on the agenda. Written material had also been prepared for the staff.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult 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. Staff members we spoke with were all knowledgeable about safeguarding. We reviewed the practice's processes when carrying out safeguarding referrals to the local safeguarding team and found these were made in a timely and appropriate manner. Training records showed that the safeguarding lead had completed training in September 2016. We were told that all staff had completed training within the last two years.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. We were told that all dentists used them when carrying out root canal treatment whenever practically possible.

All staff members we spoke with were aware of the whistleblowing process within the practice and there was a policy present. 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 in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an automated external defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Are services safe?

Staff received annual training in the management of medical emergencies. 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 daily checks of the AED and weekly checks of the emergency medicines and oxygen. The emergency medicines were all in date and stored securely.

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

Staff recruitment

We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of staff's dental indemnity and General Dental Council (GDC) registration certificates. Some of the records contained references, curricula vitae and employment contracts. None of the records contained staff identity verification.

There were also Disclosure and Barring Service (DBS) checks present for two staff members. 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 provider had completed written risk assessments for staff that did not recent previous DBS certificates.

The practice had a recruitment policy for the safe recruitment of staff but it was not comprehensive. Within two working days, the provider sent us evidence of a detailed and dedicated policy.

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

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 arrangements in place to monitor health and safety. We reviewed several risk management policies. Examples included pregnant workers, aggressive patients and latex gloves. We saw evidence that the fire extinguishers had been serviced in December 2015. A fire drill had taken place the day before our visit and this was the only one that had been documented. The provider told us they carried out weekly fire alarm tests but these were not documented. Within two working days, the provider showed us evidence of a checklist that would be used to document the weekly checks. We were also told that fire drills would take place every six months. There were three fire exits on the ground floor. The provider carried out a fire risk assessment in July 2016. One of the staff members had undertaken fire marshal training. Fire evacuation instructions were clearly displayed in the waiting room, staff room and practice manual.

We were told that staff accessed information online regarding COSHH (Control of Substances Hazardous to Health 2002). A dedicated file was not available at the practice where risks associated with hazardous substances had been identified. Within two working days, the provider informed us that their software specialist would organise a COSHH file. They had asked staff to write an updated and comprehensive list of all substances used at the practice.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. 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)'. 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 two treatment rooms and the decontamination room to be visually clean. Many 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.

Are services safe?

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. 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. 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. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. 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, weekly and quarterly. We saw records which confirmed these had taken place.

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 spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

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. The most recent audit was in December 2015 so this was overdue. Within two working days, the provider sent evidence to us that this audit had been completed. The practice had achieved 100% compliance in infection control procedures according to the audit findings.

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. The practice had carried out an internal Legionella risk assessment but there was no evidence that an external specialist had carried one out. Within two working days, the provider informed us that they had arranged for an external risk assessment to be carried out the following week. Regular temperature checks of the water system are recommended to ensure that the water remains within the recommended temperature range. The practice was not carrying out any checks at the time of our visit. However, the risk assessment recommended the frequency and temperature range for this and the provider confirmed they would be carrying these checks on a monthly basis (in line with their recent risk assessment).

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels, X-ray sets and autoclaves.

Are services safe?

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 2015.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. All prescriptions were stamped only at the time of issue. The prescription number was recorded in the patients' dental care records. The practice did not keep a log of prescriptions given so they could not ensure that all prescriptions were tracked. Within two working days, the provider informed us they had introduced a new system which allowed the tracking of prescriptions.

Stock rotation of all dental materials was carried out on a regular basis by the dental nurse 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 traditional X-rays. Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these.

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.

We saw 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 X-ray equipment in the treatment room 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 September 2016. 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 corroborated what they told us by looking at patient dental care records. 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 some children aged 7 and above. 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.

The dentists offered inhalation sedation at the practice for children who were very nervous of dental treatment. We found that staff had put into place systems to underpin the safe provision of conscious sedation. The systems supporting sedation included pre and post sedation written instructions as well as consent forms. The appropriate sedation equipment (and emergency equipment) was present and had been serviced in June 2016. The sedation gases were stored according to the current safety requirements. Equipment was present to monitor the oxygen saturation levels of the patients undergoing sedation.

We saw evidence that the two dentists involved in sedation had undertaken training (in 2007 and 1994) but neither had received any refresher training since then. One of the dental nurses had received training in 2003 and there was no evidence that the other dental nurse training had received training for this role. These findings were discussed with the provider. Within 48 hours, they informed us that the dental nurses will receive in-house sedation training before the end of October. Following this, they would also attend external training. The provider also requested the dentists to book suitable training for themselves at the earliest opportunity.

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 and posters available in the practice to support patients in looking after their health. Examples included information on stopping smoking, dietary advice and oral hygiene.

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.

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 infection control and handling complaints.

Staff told us they were encouraged to maintain the continuous professional development required for

Are services effective?

(for example, treatment is effective)

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. Occasionally, the practice utilised a locum dental nurse agency.

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. Some of the dental nurses had completed additional training which enabled them to educate patients about oral health.

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 four referral letters and noted that they were comprehensive to ensure the specialist services had all the relevant information required. Patients were given the option of receiving a copy of their referral letter. Staff kept a log of all referrals so they could monitor when they were sent and when the responses were received.

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. 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

Sixteen patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was overwhelmingly positive about the care they received from the practice. They described staff as friendly and polite. Nervous patients said they felt at ease here and others praised the staff for their child-friendly approach. Others commented that it was easy to make an appointment and easy to visit the practice with a pushchair. Some patients commented that they had attended this practice for many years, even decades. Several patients would recommend this practice to family and friends.

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. There was a room available for patients to have private discussions with staff and there was information about this in the waiting room. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

We were told that the practice appropriately supported children and anxious patients using various methods. They also had the choice of seeing male of female dentists at the practice. The practice offered sedation for children. Adult patients could 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 and on the practice website.

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 four treatment rooms were on the ground floor. There were toilet facilities available on the ground floor and these were wheelchair-accessible. One of the treatment rooms had a widened doorway and this could accommodate larger wheelchairs.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us 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.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. The practice utilised a 'sit and wait' policy for their patients requiring urgent treatment. We saw that many patients failed to attend their appointments. Consequently, the dentists could accommodate additional patients requiring urgent treatment

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. The practice recognised the needs of different groups in the planning of its services. 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 such as providing written information. Also, the practice had access to sign language interpreters, if required.

The practice had access to an interpreting service but we were told that they rarely needed to use it. The dentists spoke a variety of languages and we were told that they had not encountered any problems communicating with patients.

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 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. Information was also available on the practice website and in the information leaflets for patients.

The practice opened at 8:50am on Monday to Friday and closing times varied between 1:30pm and 7pm.

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 and accessible to patients. This included details of external organisations in the event that patients were dissatisfied with the practice's response.

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. There was a designated complaints lead and all verbal complaints were documented too. We found that complainants had been responded to in a professional manner.

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. 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. One example was their risk assessment of injuries from sharp instruments. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments. The practice also had risk assessments for areas such as the plug sockets, gases released during sedation and display screen equipment.

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.

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.

Staff meetings took place on an irregular basis. We were told that the practice planned to hold these on a weekly basis. Within two working days, the provider sent us an agenda of the next practice meeting (to be held the week after our visit). The agenda included topics such as safeguarding, duty of candour and safe prescribing. The minutes of the previous 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.

All staff (including the dentists) received appraisals in September 2016 but these were only recently introduced at the practice. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed. We reviewed three appraisals and were told these would be carried out on an annual basis. They would be carried out more frequently if staff wished to have a formal discussion sooner.

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. Examples included extending the opening hours and redecorating the waiting room in response to suggestions made by patients. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. Prior to the FFT, the practice invited patients to complete satisfaction surveys.

No comments had been made on the NHS choices website.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires.