Robinson & Dicker Dental Practice

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 October 2015 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

Robinson & Dicker Dental Practice provides general dental services for NHS and private patients. The service is provided by the practice owner (principal dentist), three associate dentists, one therapist and two hygienists. They are supported by eight nurses (one of whom is a trainee) and three receptionists (two of whom are trainees). Another dentist visits the practice on an ad hoc basis to provide implants (approximately on a monthly basis). This dentist (implantologist) brings their own nurse who has received additional training to assist with implant surgery. This dentist occasionally carries out conscious sedation – this is restricted to their own patients who are undergoing implant surgery. (Conscious sedation involves techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation). The provider also carries out some adult orthodontic treatment on a private basis.

The practice is located within a converted three storey building on a busy road in Erdington. There is wheelchair access available to the premises with a designated parking bay by the entrance. There is disabled access to the ground floor waiting area and the ground floor treatment room offers access for patients with reduced

Summary of findings

mobility. The practice is located close to local amenities and bus services. One of the dentists offers domiciliary care for those patients who cannot access the practice. Opening hours are Monday to Friday 8:45am to 5pm.

The practice owner (Dr Jain) is the registered manager. Dr Jain became the practice owner in August 2015 i.e. two months prior to this inspection. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

23 patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was very positive. Patients were positive about their experience and they commented that they were treated with care, respect and dignity. They commented that the dentists were very knowledgeable and always listened to patients. Staff told us that they always interacted with them in a respectful, appropriate and kind manner.

Our key findings were:

- Systems were in place to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding and the management of medical emergencies.
- Oral health advice and treatment were provided in line with the 'Delivering Better Oral Health' toolkit.
- Patients told us they were treated with care, respect and dignity. Patients commented they felt involved in their treatment and that it was fully explained to them.
- There were clearly defined leadership roles within the practice and staff told us they felt supported and comfortable to raise concerns or make suggestions.
- Patients were able to make routine and emergency appointments when needed.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were managed.
- Audits in key areas (X-rays, dental care records and infection control) were overdue.

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

- Implement a system so that the practice conducts regular audits to help improve the quality of the service (evidence of this was provided after the inspection visit).
- Adopt a robust recruitment process so that accurate, complete and detailed records are maintained relating to employment of staff. This includes making appropriate notes of verbal references taken and ensuring recruitment checks, including references and immunisation status, are suitably obtained and recorded. Staff appraisals should be regularly conducted.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping. This includes recording consent for dental care and treatment.
- Consider a more robust process for documenting all incidents and details relating to health and safety such as testing fire alarms and decontamination equipment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

Equipment at the practice was generally well maintained and regularly serviced. The practice had the equipment and medicine they might need to deal with medical emergencies and staff received external training in medical emergencies.

The practice had systems to assess and manage risks to patients, whistleblowing, complaints, safeguarding and health and safety. The staff were suitably qualified for their roles. However, their recruitment policy needed to be more robust. Audits were overdue in infection control and X-rays at the time of inspection although an infection control audit was carried out after our visit.

Patients' medical histories were obtained before any treatment took place. There was a thorough infection control policy in place and procedures were understood and followed by staff. Some improvements were required with regard to documenting quality checks for the decontamination equipment.

Are services effective?

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

Patients' dental care records provided information about their medical history, dental treatment and oral health advice. 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, options and costs were explained.

Dentists had awareness about the importance of gaining patients' consent although this was not always documented. Staff members were familiar with the requirements of the Mental Capacity Act 2005.

The practice followed best practice guidelines when delivering dental care. The practice focused on prevention and the dentists were aware of 'The Delivering Better Oral Health Toolkit' (DBOH).

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Patient feedback was very positive about the care they received from the practice. They commented they were treated with kindness while they received treatment. Patients commented they felt involved in their treatment, it was fully explained to them and they were listened to.

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. There were vacant appointment slots for emergency appointments each day. Patients commented they could access treatment for emergency care when required. There were clear instructions for patients requiring urgent care when the practice was closed.

Summary of findings

There was an effective procedure in place for acknowledging, recording, investigating and responding to complaints made by patients. This system was used to improve the quality of care.

The practice had made reasonable adjustments to accommodate patients with a disability or limited mobility.

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 all felt supported in their own particular roles. The provider was responsible for the day to day running of the practice.

There were several systems in place to monitor the quality of the service. Several audits had been undertaken but they were overdue in infection control, X-rays and record keeping. The provider sent us evidence after the inspection and this demonstrated a clear action plan to ensure that pending governance issues were addressed. The practice carried out the NHS Family and Friends Test (FFT) to get feedback on the quality of the service they provided but this did not apply to their private patients.

Regular practice meetings were held and minuted. We were told that informal meetings took place on a daily basis in addition to the formal monthly meetings. These provided staff the opportunity to discuss concerns and make any suggestions.

Robinson & Dicker 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 Robinson & Dicker Dental Practice on 5 October 2015. The inspection team consisted of two CQC inspectors and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them. 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 principal dentist (who was the registered manager), two dentists and three nurses and one receptionist. We also spoke with patients and reviewed CQC comment cards which patients had completed. We reviewed a range of practice policies and protocols and other records relating to the management of the service.

Approximately 30% of dental care provided at this practice was NHS. The remainder was private (both private scheme insurance and fee per item).

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 clear guidance for staff about how to report incidents and accidents. We saw evidence they were documented and investigated by the practice. The last entry in the Incident book was in 2013. An incident had taken place recently involving the temporary loss of a patient's denture. We were told this was discussed with staff members for learning purposes but not documented.

Staff members we spoke with all understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). No RIDDOR reports had been made in the last 12 months.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with MHRA (Medicines and Healthcare products Regulatory Agency). The receptionists were responsible for printing off relevant emails and distributing copies to each surgery so that all dentists and nurses could review them.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult procedures in place. These provided staff with information about reporting and dealing with suspected abuse. Staff had access to contact details for both child protection and adult safeguarding teams. There was not a named safeguarding lead professional at the practice although staff told us they would approach the provider or senior nurse in the event of any safeguarding queries. The provider had undertaken Level Two safeguarding training for children and vulnerable adults in September 2015. (Level Two training would be appropriate for those dentists and other team members who have greater involvement with children and for whom child protection is a regular feature of their work, for example the child protection lead person within a practice). There had not been any safeguarding referrals to the local safeguarding team; however staff were confident about when to do so.

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 and operating field and airway. Rubber dam kits were available in two treatment rooms i.e. the other two treatment rooms did not have this kit. Not all of the dentists were using a rubber dam for all stages of the root canal treatment. We were told that alternative actions were used to reduce the risk to patients whenever rubber dams were not used.

The practice had clear processes to make sure they did not make avoidable mistakes such as extracting the wrong tooth. The provider told us they always checked and re-checked the treatment plan and tooth charting. They also checked with the nurse and with the patient and would have the X-ray displayed (if relevant).

Staff we spoke with were aware of the whistleblowing process. GDC guidance states that all dental professionals have a professional responsibility to raise concerns if they witness treatment or behaviour which poses a risk to patients or colleagues.

Medical emergencies

Within the practice, the arrangements for dealing with medical emergencies was 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.

We were told that staff received annual training in the management of medical emergencies and first aid training although the certificates were not kept on site. This took place in October 2014 and the next training session was booked for October 2015. Staff we spoke with were all aware of the location of the emergency equipment and drugs.

The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was not stored in the fridge and this does reduce its expiry date to 18 months after the date of purchase. This medicine was in date and the expiry date was discussed with the provider.

Staff recruitment

The provider informed us their systems for staff recruitment were under review. As the provider had taken over less than

Are services safe?

two months ago, they admitted their recruitment policy needed to be more robust. The policy was not sufficiently detailed and the provider informed us they were planning to include further requirements such as details of the number of references required and interview notes. We viewed five staff files and found they all had Disclosure and Barring Service (DBS checks) and identity checks. The staff files were not consistent as some of them contained information such as immunisation status, qualification certificates and employment contracts but others did not.

The provider informed us they would be utilising an agency to carry out new DBS checks on all staff members as some of the existing ones were carried out several years ago.

The practice monitored professional registration and indemnity of its staff and registration certificates were on display on the walls for patients to view. Staff commented they were asked to bring in updated certificates after renewal with the GDC. Staff were also asked to bring in a log of their completed Continuous Professional Development (CPD) and indemnity certificates. The provider recently changed practice policy so that all dental nurses and dentists were now responsible for their own indemnity and GDC registration.

Monitoring health & safety and responding to risks

We saw evidence of a comprehensive 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. There was a list of essential contact numbers, such as staff members, a plumber and a dental engineer. The plan was sufficiently detailed although it did not have the telephone number of the new dental software package provider. This system was installed one week prior to the inspection and the plan had not been updated to reflect this recent change.

The practice had arrangements in place to monitor health and safety. Risk management policies were in place. For example, we viewed a fire safety risk assessment undertaken by a Fire Prevention Officer in March 2015. An action plan was formulated with a recommendation – this was discussed with the provider and they told us it had been actioned but not documented. We saw that the health and safety law poster was displayed where all staff could easily refer to it.

We were told that fire drills took place every six months. The last fire drill took place on 29 September 2015 and this was documented. We viewed a Fire Record Book and this showed the last fire alarm test was documented was on 27 August 2015. We were told these were carried out weekly but they had not been documented every time. Monthly checks also took place to check the emergency lighting – the last test that was documented was also on 27 August 2015. Fire safety training was carried out in July 2015. Fire extinguishers were present and were serviced in November 2014. The provider sent us information after the inspection and this confirmed that the practice was documenting tests of the fire alarms and emergency lighting more regularly (on a weekly to fortnightly basis).

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. The COSHH file was comprehensive and graded materials and substances as low, medium or high risk. There were review dates present and all entries were divided into alphabetical order to allow easy reference. The practice identified how they managed hazardous substances in their health and safety and infection control policies, for example in their blood spillage procedure.

Infection control

There was an infection control policy and procedures to keep patients and staff safe; this policy was thorough and personalised to this practice. Staff members 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 who was responsible for ensuring infection prevention and control measures were followed.

We were told that all staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff. However, evidence of this was not kept on site.

Decontamination procedures were carried out in a dedicated decontamination room. We observed the treatment rooms and the decontamination room to be generally clean and hygienic. Several patients commented that the practice was clean and hygienic. Work surfaces and drawers were clean and free from clutter. We saw that there were clearly designated dirty and clean areas in the

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

Sharps bins were located appropriately. We observed waste was separated into safe and lockable containers for disposal by a registered waste carrier and appropriate documentation retained. We reviewed consignment notes which showed that waste was collected on a weekly basis. White bags were used in the treatment rooms to collect clinical waste. These were then placed in large orange bags and subsequently placed into the large yellow clinical waste bin. This procedure was discussed with the provider as placing clinical waste into white bags could cause confusion amongst staff as they may inadvertently place this into general waste bins. The clinical waste bin outside was locked but not chained to the wall for additional security. However, the car park was secure as it was a gated area.

Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. These instruments were checked on a monthly basis and re-sterilised if the storage date had expired. Discussions with staff members confirmed they were aware of items that were single use and that they were being disposed of in accordance with the manufacturer's instructions.

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.

The practice had systems in place for daily quality testing the decontamination equipment and we saw records which confirmed these had taken place. We were told the relevant tests took place on a daily basis but some days were not documented in the records. There appeared to be sufficient instruments available to ensure the services provided to patients were uninterrupted. Staff also confirmed this with us.

The provider informed us that all general cleaning such as treatment room floors and other rooms in the building was currently carried out by their own nurses. An external cleaning company was previously utilised but they were dismissed because the provider was not satisfied with their standard of cleaning. On the day of the inspection, the treatment rooms were visibly clean.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw that the most recent audit was undertaken in November 2014 so the next audit should have taken place in May 2015. The results from the previous audit demonstrated 100% overall compliance with the guidance. Another audit was undertaken after the audit and the provider sent us evidence of this subsequent to the inspection. This showed that the practice achieved a score of 94%. There was a limited action plan in place with recommendations for improvement but this needed to be more comprehensive.

We reviewed risk assessments for Legionella and saw that these were carried out in 2010 and March 2015. Legionella is a term for particular bacteria which can contaminate water systems in buildings. The risk assessment from 2015 had limited details but the 2010 assessment contained some recommendations and these had been carried out. There was a written waterline management scheme in place. Staff we spoke with were following the guidelines on running the water lines in the treatment rooms to prevent Legionella. Each treatment room had a certificate which showed that the water lines were being treated. We saw evidence that the practice was recording the water temperature to check that Legionella was not developing. However, the risk assessment recommended checking the water temperature every six months and the last documented check was in November 2014. The provider sent us some documents after the inspection visit and these showed that the water temperature had been re-checked and recorded in November 2015.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, autoclaves, dental chairs and the compressor. Portable appliance testing (PAT) was completed in July 2014 and it was recommended that this testing was repeated in 12 months. It had not been completed at the time of the inspection even though it was three months overdue. (PAT confirms that electrical appliances are routinely checked for safety).

Are services safe?

The batch numbers for local anaesthetics were not routinely recorded in patient dental care records. Prescriptions were stamped at the point of issue and stored securely in a locked cupboard. The practice also dispensed four different types of antibiotics. Prescription numbers and medicines were logged in the patient's clinical care record and on a separate log sheet to provide an audit trail of their use. However, they did not record the amount taken or the amount left. The provider sent us evidence of an updated logging sheet after the inspection visit. This recorded all relevant details that were previously not included.

Radiography (X-rays)

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

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 treatment rooms next to the X-ray machines for all staff to reference if required.

Those authorised to carry out X-ray procedures had all attended the relevant training and this was recorded (although the certificates were not kept on site). This protected patients who required X-rays to be taken as part of their treatment.

We reviewed an X-ray audit which had been carried out over 12 months previously. Regular audits are needed to assess the quality of the X-ray and check they have been justified and reported on. This is needed in order to meet the required standards to reduce the risk of patients being subjected to unnecessary X-rays.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date electronic dental care records. The patient records were converted to electronic format one week before the inspection. The dentists used NICE guidance to determine a suitable recall interval for their NHS patients. (National Institute for Health and Care Excellence – this is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment) This takes into account the likelihood of the patient experiencing dental disease. This was documented and also discussed with the patient.

We spoke with the provider about patient care records and they told us they documented clinical details such as oral health advice and any signs of mouth cancer; this was corroborated by looking at patient care records. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies. We saw that one patient's care record lacked information about their X-rays, such as an X-ray report of the patient's tooth/teeth and grading of the X-ray (for quality and improvement purposes).

We viewed a policy and risk assessment for domiciliary visits. The provider told us that only one of the dentists carried out domiciliary visits and they always took a dental nurse with them to assist and to act as a chaperone. They told us the dentist always carried out a risk assessment before carrying out any dental treatment; this helped to ensure that the patient was treated in a safe environment to meet their needs. If the dentist felt the treatment was inappropriate, they would arrange a referral to the Community Dental Services (CDS). We were told that the CDS usually had the capacity to see the patients within one month.

We were told that conscious sedation was occasionally provided at the practice for patients receiving implants by the visiting dentist. This dentist brought their own dental nurse as we were told they had received additional training in implant surgery and sedation. We were told this dentist brought their own sedation equipment and drugs to facilitate safe sedation in line with current guidance.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentists we spoke with and the patient records showed 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 to look after their health. The provider informed us they were in the process of investing in a television screen in the waiting area to provide information for patients such as health promotion.

The practice had a focus on 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). Patients were given advice regarding the maintenance of good oral health.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. Staff we spoke with confirmed they had been fully supported during their induction programme and we reviewed induction policies in staff files.

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff were registered with the GDC (apart from the trainee nurse as only qualified staff can register) and registration certificates were displayed in the practice.

The provider monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that locum nurses were utilised whenever they were

Are services effective?

(for example, treatment is effective)

short-staffed. During our visit, we were also informed they were looking to recruit one more nurse to further reduce any inconvenience caused by multiple staff being off work simultaneously.

The provider contacted us after the inspection and told us that they had successfully recruited a new full-time staff member who would be specifically assisting with governance duties. The provider explained that the new employee would assist the practice with the implementation of a practical governance model to ensure that they were maintaining the highest standards. The provider told us that an additional person would be joining the practice early next year to also assist with this and better use of audits.

Dental nurses were supervised by the dentists and supported on a day to day basis by the provider. Staff told us the provider was readily available to speak to at all times for support and advice.

Most of the nurses had additional training which allowed them to take dental X-rays – we saw certificates as evidence. We were told that two of the nurses were currently undergoing additional training in sedation and implant surgery so they could assist the specialist dentist that occasionally visited the practice for these procedures.

Staff told us they were encouraged to develop their skills and they discussed their professional development informally. We saw some CPD certificates of the staff as evidence that they had completed training in areas such as radiography (X-rays), medical emergencies and safeguarding. However, there was no system in place to record and monitor staff training needs and professional development and several staff members kept their own CPD certificates at home. The provider contacted us after the inspection and provided an action plan which demonstrated the early implementation of staff appraisals.

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 hospitals and specialist dental services for further investigations or specialist treatment. We viewed one referral letter and noted it was sufficiently detailed to ensure the specialist service had all the relevant information required.

Consent to care and treatment

Patients were given appropriate verbal and written information to support them to make decisions about the treatment they received – this was corroborated by patients. Staff ensured patients gave their consent before treatment began.

Staff 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). There were no recent examples of patients where a mental capacity assessment or best interest decision was needed. 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.

We reviewed a consent policy but it was brief and not in line with GDC requirements. There was a dedicated and thorough consent process when patients were involved in implant treatment. However, consent was not routinely recorded for routine dental treatment.

We were told that all patients were always given a written treatment plan after discussions about treatment options, costs and alternatives.

We viewed a patient care record who had received treatment via the practice's domiciliary services. We saw that the patient's treatment plan was signed by a representative of the patient. There was no evidence in this record to explain why the patient did not sign their own treatment plan. If the patient was unable to consent, there were no details recorded of any capacity assessments. The provider told us they were assessing patients and their capacity and acting in accordance with the MCA whenever patients were unable to consent.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

23 patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was very positive. Patients were positive about their experience and they commented that they were treated with care, respect and dignity. They commented that the dentists were very knowledgeable and always listened to patients. Staff told us that they always interacted with patients in a respectful, appropriate and kind manner.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to treatment rooms were closed during appointments. We observed staff were helpful, discreet and respectful to patients. Staff we spoke with were aware of the importance of providing patients with privacy. We were told there was always at least one staff member in the reception area (usually three) as this was where confidential patient information was stored. Staff said if a patient wished to speak in private an empty room would be found to speak with them. Patients often used the back office to complete application forms for private dental plan insurance.

Confidential patient information was kept out of sight behind the reception area. The provider had recently invested in hand-held electronic devices for patients to record/update their personal and medical details. This information was backed up to prevent loss of data. All information was automatically deleted as soon as the dentist transferred this information to the patient's clinical record. This system prevented any other patients accessing confidential information relating to somebody else. The provider told us patient feedback was positive and approximately 90% of patients embraced this new system. Some patients required assistance with the device and we were told that these patients were able to update their details once they were in the treatment room.

We were told that the practice managed anxious patients using various methods. They would book patients in with the same dentist whenever possible in order to maintain or build professional relationships between them. Most staff members were longstanding at the practice and knew the patients well. The patients were encouraged to bring a friend or family member for them for support if they wished. Reception staff would try to book appointments at a time when it was less likely that the dentist would run late – this would hopefully alleviate any additional anxiety for the patient. The dentists would also try to use certain clinical techniques in anxious patients, such as using topical anaesthetic prior to administering local anaesthetic; this was used to numb the surface of the gums to make the subsequent needle placement more comfortable.

Involvement in decisions about care and treatment

We were told that the dentists 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. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. Patients were also informed of the range of treatments available.

A list of NHS treatment fees was clearly displayed on the wall in the waiting area. However, information about the costs of private dental examinations and treatments were limited in the waiting area. This information was not available in the form of leaflets and there was not a practice website to refer to.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties had access to the practice via a ramp and there was a designated parking bay near the entrance for wheelchair access. There was a treatment room on the ground floor and the other dentists/ hygienists could swap rooms so that patients could have dental treatment on the ground floor if required. There were toilet facilities on the ground floor but these were predominantly for staff members. We were told that patients with mobility difficulties could use these facilities if required.

An audit on the Disability and Discrimination Act was carried out in 2012. Some issues were identified as a result of the audit such as no toilet facilities for the disabled and no Braille signs or leaflets in large print. The provider was considering implementing these changes to make the service more accessible to all. The provider was also considering having electric doors at the entrance to the building to make it more convenient for patients arriving at and departing the premises.

We found the practice had an efficient appointment system in place to respond to patients' needs. There were dedicated appointment slots every morning and afternoon to accommodate urgent bookings. Patient feedback confirmed they had sufficient time during their appointment and didn't feel rushed. We observed that appointments ran smoothly on the day of the inspection and patients were not kept waiting. The provider told us they tried to avoid double-booking appointments to minimise any inconvenience to patients and staff.

The provider informed us that they were considering improving access for patients by opening late evenings during the week. They were aware that a lot of their patients worked full-time and/or had young children so this would particularly benefit those patients. The provider told us they occasionally opened on a Saturday to accommodate patients, particularly if there were few remaining appointments during the week.

Patient feedback confirmed that the practice was providing a service that met their needs. The practice offered patients a choice of treatment options to enable them to receive care and treatment to suit them. The practice was not undertaking their own patient survey and there was no suggestion box available. They did say that patients made suggestions verbally which could be acted on and this was corroborated when we spoke with patients.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. We saw that they had made adjustments to enable patients to receive their care or treatment, including an audio loop system for patients with a hearing impairment. The practice had treatment rooms on the ground and first floor of the premises. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. Wheelchair access and ramps were available.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

Access to the service

Patients 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 on the telephone answering machine. Information was also displayed clearly in the waiting room. Patients who were registered for private treatment could access emergency treatment by contacting a local practice in the event of a dental emergency during the evening or weekend.

Concerns & complaints

Two complaints had been received by the practice in the last 12 months. We looked at both complaints and found that they had been recorded, analysed and investigated. We found that complainants had been responded to in a timely manner. Both complaints were resolved efficiently and appropriate action was taken to ensure the patients were satisfied. We saw evidence that learning from complaints was shared with the rest of the team in subsequent staff meetings.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had an effective complaints policy which provided staff with clear guidance about how to handle a complaint. Information for patients about how to make a complaint was available at the practice.

We also looked at entries made by patients on the NHS choices website. Comments made by patients were overwhelmingly positive and complimentary. The practice had not yet responded to these entries (both positive and negative).

Are services well-led?

Our findings

Governance arrangements

The provider had recently taken over the practice and was aware of the areas that required attention. We identified several areas that required improvement during the inspection and the provider told us they were in the process of adopting new systems and processes to ensure these were addressed. We contacted the provider after the inspection and asked them to send us an action plan to demonstrate the changes that had been implemented since the inspection. The provider subsequently sent us a comprehensive plan which included changes and improvements that had already taken place since the inspection. They provided an explanation of difficulties they had encountered whilst undertaking some of the improvements. They had completed some audits since the inspection. The provider had sent a detailed action plan of how and when they would be making the remaining improvements.

The provider contacted us after the inspection and told us that they had successfully recruited a new full-time staff member who would be specifically assisting with governance duties. The provider explained that the new employee would assist the practice with the implementation of a practical governance model to ensure that they were maintaining the highest standards. The provider told us that an additional person would be joining the practice early next year to also assist with this and better use of audits.

The provider was in charge of the day to day running of the service. 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.

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). The provider told us they were actively communicating with private dental plan providers to increase staff awareness of practice governance.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty. This was evident when we looked at the complaints they had received in the last 12 months and the actions that had been taken as a result.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant. All staff 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 clinical leads and infection control leads. However, they did need to introduce a safeguarding lead. The practice did not have a dedicated practice manager, however, duties were shared amongst senior staff and the whole team were aware of these senior members' duties.

Learning and improvement

Staff told us they had good access to training and the provider paid for staff to access online CPD to ensure essential staff training was completed each year. Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Staff also had access to online training which recorded their CPD.

We saw evidence of several recent audits as part of a system of continuous improvement and learning. These included audits of patients' medical history details (June 2015) and NICE guidelines (June 2015). Audits had also been completed in record keeping, infection control and radiography (X-rays) but none of these were recent at the time of the inspection. The provider sent us completed audits in infection control and record keeping post-inspection.

The practice held monthly staff meetings where learning was disseminated. We saw evidence of this and all staff meetings were minuted. Staff meeting and training dates

Are services well-led?

were displayed on a board in the office which was accessible to all staff members. Staff also had informal meetings every morning to discuss the day ahead. Any concerns or queries were addressed during these meetings.

The provider was aware that staff had not had regular appraisals. Appraisals offer an opportunity to discuss learning needs, concerns and aspirations. We saw evidence that they had not been carried out since 2012. The provider told us they would be arranging for appraisals to be carried out on an annual basis. Subsequent to the inspection visit, the provider sent us evidence which demonstrated the early implementation of staff appraisals.

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

The practice did not undertake their own patient satisfaction survey or have a suggestion box. However, the provider told us they were in the process of implementing feedback questionnaires for patients. The practice undertook the NHS Family and Friends Test (this captures feedback from patients undergoing NHS dental care but not the practice's private patients). We discussed this with the provider and they were considering capturing patient feedback via the new hand-held electronic devices within the practice. They said the device had a feature on it which would allow patients to complete a survey and the devices would capture and collate this feedback and produce an electronic log. This feature had not yet been activated (as the devices were only introduced one week prior to the inspection).

The practice did not have a robust system of capturing feedback from staff. However, staff members we spoke with told us they were able to share their views with senior staff informally. We saw that many staff members were longstanding and there was a low turnover of staff; the provider told us this was a reflection of staff satisfaction in their roles at the practice.