Short Heath Dental Practice Partnership

Short Heath Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 27 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

Short Heath Dental Practice is a dental practice providing general dental services on a NHS and private basis. The service is provided by two dentists. They are supported by five dental nurses (two of whom are trainees) and a practice manager. All of the dental nurses also carry out reception duties.

The practice is located in a residential area. The practice offers access to patients with limited mobility as it is situated on the ground floor; however, it cannot accommodate wheelchair users. There are car parking facilities outside the practice. The premises consist of a waiting room, a reception area, an office, kitchen, decontamination room, toilet facilities and two treatment rooms. The practice's opening hours were from 8:30am to 5pm on Monday to Friday.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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.

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

Summary of findings

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

Our key findings were:

- The practice appeared clean and tidy on the day of our visit. 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 although we identified some improvements were required.
- 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 necessary improvements were required.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- Practice meetings were used for shared learning.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review availability of medicines to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review stocks of equipment and the system for identifying and disposing of expired stock.
- Review the practice's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.
- Review the training, learning and development needs of individual staff members and have an effective process established for the on-going assessment and supervision of all staff.
- Review staff awareness of the requirements of the Mental Capacity Act (MCA) 2005 and Gillick competency and ensure all staff are aware of their responsibilities as it relates to their role.
- 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.
- Review the legionella risk assessment upon completion 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'.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

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 mostly in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. We identified some missing items and these were ordered immediately.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit which centred around the prevention of Legionella.

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?

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) although some improvements were required.

The dentists followed some national guidelines when delivering dental care but updates were required in some areas. The practice responded promptly and relevant staff members carried out verifiable training within a few days of our visit. 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.

Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was generally positive about the care they received from the practice. Patients described staff as friendly and caring. 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 professional and polite.

Are services responsive to people's needs?

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

Summary of findings

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

The practice had an effective complaints process.

The practice offered access for patients with limited mobility but not for wheelchair users. Patients requiring wheelchair access were able to receive dental care at the owners' other practice which was local.

Are services well-led?

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

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

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

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. Improvements were required to ensure, where applicable, audits had documented learning points with action plans.

Short Heath 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 Short Heath Dental Practice on 27 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 practice manager (who has been the CQC registered manager since 2014), the area manager, one dentist and two 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. The last accident was recorded in November 2015. Records of accidents we saw were generally completed with sufficient details about what happened and any actions subsequently taken.

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.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We saw that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The practice manager was responsible for obtaining information from relevant emails and forwarding this information to the rest of the team. All team members were registered with a social media site which they logged on to regularly. Information was sent to them via this medium. Staff we spoke with were aware of the practice's arrangements to report any adverse drug reactions. There was also a written policy with information about this.

Staff we spoke with were 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. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and protection of vulnerable adult policies and procedures in place. These policies were readily available and provided staff with information about identifying, reporting and dealing with suspected abuse. Staff had access to contact details for local safeguarding teams. The practice manager was the safeguarding lead in the practice. They had not carried out the appropriate training since November 2012 but they responded promptly and subsequently completed the training soon after (on the same day as our visit).

Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. Training records were not available for all staff but we reviewed some that confirmed that staff had completed appropriate training in October 2016. We were told that some of the staff were due to have safeguarding training shortly.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. We saw a rubber dam kit at the practice but were told that not all dentists routinely used it when carrying out root canal treatment. Staff described alternative measures that they used to protect the patient's airway. The practice manager informed us that this would be discussed at the next staff meeting. [A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured].

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, such as extracting the wrong tooth. Some staff members we spoke with were not aware of 'never events'. The practice did not have written processes to follow to prevent these happening, however, we saw evidence that a draft version was present. The practice manager told us they were awaiting authorisation from their senior before disseminating this information to the practice staff.

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

Medical emergencies

Are services safe?

Within the practice, the arrangements for dealing with medical emergencies in the practice were mostly in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). However, we identified some necessary improvements.

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 and delivers an electrical shock to attempt to restore a normal heart rhythm.

Staff received annual training in the management of medical emergencies and this took place in May 2016. 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.

Current guidance recommends that dental practices keep oropharyngeal airways in four sizes. This airway is a medical device that is used to maintain or open a patient's airway. We found that the practice only held airways in two sizes. The practice also did not have a self-inflating bag (with face masks) for paediatric patients. Staff ordered the missing items on the same day as our visit.

Staff undertook regular checks of the emergency oxygen and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and monthly checks of the emergency medicines. However, they did not check the AED as they were told that this would exhaust the battery. We discussed the importance of checking this regularly to ensure it was fit for purpose. The practice manager told us they would begin implementing this immediately.

The emergency medicines were all in date and stored securely. A glucagon injection kit is used to treat episodes of severe hypoglycemia which is defined as having low blood glucose levels that requires assistance from another person to treat. The practice had glucagon and this was not stored in the fridge - this is acceptable as long as the reduced expiry date is taken into consideration. The reduced expiry date was recorded on the glucagon injection kit but we found that the log sheets did not have this information documented. This could have resulted in the accidental use of expired glucagon or the non-availability of suitable glucagon in a hypoglycaemic emergency - this was discussed with the practice manager who told us the dates would be amended on the log sheet.

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 employment contracts and staff identity verification. Where relevant, the files contained copies of staff's dental indemnity and General Dental Council (GDC) registration certificates. Some of the records contained evidence of curricula vitae, written references and induction plans.

There were also Disclosure and Barring Service (DBS) checks present for all 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 practice had a system in place to monitor the professional registration and dental indemnity of its clinical staff members.

The practice had a recruitment policy for the safe recruitment of staff, however, this did not have specific information about the acceptance of historical DBS checks or the number of references required for each potential post. Within two working days, the practice manager informed us that this policy had been amended and contained all of the relevant information.

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 and manage risks to patients, staff and visitors to the practice. We reviewed several risk management policies.

The practice had measures in place to manage the risk of fire on the premises. We saw evidence that the fire

extinguishers had been serviced in March 2016 and the smoke alarms were checked monthly. Fire drills took place every month to ensure staff were rehearsed in evacuation procedures. There were three fire exits and there was clear signage to show where the evacuation point was. A fire risk assessment took place in October 2015 and this was reviewed annually. The practice manager informed us that staff would consider fire marshal training to further increase their knowledge about fire safety.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them. This file was updated annually and whenever a new substance was introduced to the practice.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The policy was reviewed in July 2016 and was dedicated to the practice. The practice followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. 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 the treatment rooms and the decontamination room to be visually clean. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were free from clutter. Clinical areas had sealed flooring which was in good condition.

In one treatment room, there were small defects in the upholstery of the dental chairs which would make effective cleaning difficult. These defects had been temporarily covered with an additional barrier until the repairs could be carried out. The work surface in one treatment room also had a defect and this would hinder effective cleaning. Patient dental care records were computerised and the keyboards in the treatment rooms were all water-proof, sealed and wipeable in line with HTM 01-05.

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

Decontamination procedures were carried out in a dedicated decontamination room. 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 a washer-disinfector to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. A washer-disinfector is the preferred method of cleaning instruments as the process is fully automated. 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 quality testing the decontamination equipment daily. 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

Are services safe?

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 staff at the practice.

The practice had a dedicated area for the storage of their cleaning equipment. the practice had been given advice by a visiting infection control nurse regarding the storage of wet mopheads: they should be stored heads down suspended over the corresponding upright bucket. This conflicts with popular protocol which is that the wet mopheads should be stored upright so that they splay open allowing for complete air drying – contention was that this method could potentially lead to recontamination of the mop handle as water could drip down it and to avoid this it was deemed better that the mopheads be stored as advised even though they would be likely to retain moisture, thereby harbouring bacteria. However re-usable mopheads should be suitably decontaminated after each use and wrung dry as much as possible (rendering them damp) before inverting for completion of drying – if this protocol is followed, the issue of contamination of the mop handle would be eliminated. Also there was no visible ventilation in the storage area to aid drying. Further, we observed that the practice was using the same mop and bucket for the reception and waiting areas and also the kitchen. According to NPSA Guidance, a separate colour coded mop and bucket (green) should be reserved for use only in the kitchen area.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out in line with current guidance. We reviewed the audit from October 2016. There was no summary of the audit findings and no subsequent action plan. By following action plans, the practice would have been able to assure themselves that they had made improvements as a direct result of the audit findings. We discussed this with the practice manager and they told us they will implement this with immediate effect.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We did not see any evidence of a Legionella risk assessment. We were told that this was carried out by an external contractor two years ago under the previous practice ownership. The practice manager told us that there were no outstanding actions or recommendations but the staff were unable to produce a copy of this. We were told that the solicitor held this risk assessment. As part of their risk management processes, the practice had a certificate from November 2015 which certified that the water quality was within safe levels. This check was repeated annually. However, the practice could not assure themselves that they were taking all appropriate actions without a current Legionella risk assessment. A new assessment would have been required due to changes within the practice's plumbing system. Under the current ownership, the decontamination room was extended and the plumbing was modified. Within two working days, the practice manager informed us that a risk assessment would be carried out the following month by an external contractor.

Equipment and medicines

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

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 October 2015.

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

The practice needed to adopt a more robust system when checking the expiry dates of stock as we found some dental materials that had expired. These were disposed of immediately. Within two working days, the practice manager informed us that this would be discussed at the next staff meeting.

Are services safe?

Radiography (X-rays)

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

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

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. This was removable and was shared between the two treatment rooms.

We saw evidence that one dentist was up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The practice did not hold this evidence for the second dentist.

We saw evidence that the practice carried out X-ray audits every three months. 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.

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. 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). However, we identified some necessary improvements.

We spoke with one dentist about the oral health assessments they carried out for 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 not consistently recording the BPE for all adults and children aged 7 and above (as per guidelines).

Our discussion with the dentist found that they were not fully up to date with other current guidelines and research. This is required in order to develop and improve their system of clinical risk management. For example, the dentist was not aware of the most recent guidance relating to antibiotic prophylaxis for patients at risk of infective endocarditis. However, they 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. Within two working days, the practice manager informed us that the dentist had completed verifiable CPD since our visit in topics such as consent, RIDDOR, COSHH and safeguarding. The practice manager also informed the dentist to update their knowledge about antibiotic prescribing.

Following clinical assessment, the dentist 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. However, this information was not always documented by the dentist in the records.

Health promotion & prevention

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

Patients were requested to complete a questionnaire which included details about their smoking status, tooth brushing habits, use of mouthwash, etc. This gave the dentists comprehensive written details about their patients' oral health habits.

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.

The practice promoted oral health in the local schools. One of the dental nurses had visited a local school to increase awareness of the importance of oral health. Tooth brushing techniques were demonstrated and dietary advice given to young children.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran.

Staff told us they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC (apart from the trainee dental nurses as only qualified staff can register). We reviewed a selection of CPD records for staff and found that training had been completed in topics such as consent, infection control and confidentiality.

The practice manager monitored staffing levels and planned for staff absences to ensure the service was

Are services effective?

(for example, treatment is effective)

uninterrupted. We were told that dental nurses were often transferred from the providers' other local practices and staff were happy to travel between the two locations if required. We were told that this arrangement worked well because the practice would arrange travel and the other practices were larger and employed more staff so there was a lot of flexibility.

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. Several dental nurses had completed additional training which enabled them to take dental X-rays and place fluoride applications on teeth. One dental nurse had qualifications in customer service.

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 and orthodontic treatment. We viewed four referral letters and noted that not all were sufficiently detailed to ensure the specialist services had all the relevant information required. The letters lacked details about medical status of the patient and whether the dentist had taken any relevant X-rays. The practice manager informed us that this topic had been added to the agenda for the next staff meeting so that all staff were aware of the information required in referral letters. Patients were given the option of receiving a copy of their referral letter.

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 but this was not always recorded in the dental care records.

We spoke to one dentist and found they were not sufficiently knowledgeable about the Mental Capacity Act 2005 (MCA). 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 also found that the dentist was not 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. Within two working days, the practice manager informed us that the dentists had competed verifiable training in these topics.

Staff members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. We saw evidence 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

Thirteen patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with four patients during our visit. Patient feedback was mostly positive about the care they received from the practice. They described staff as friendly and caring. Patients commented they felt involved in their treatment and it was fully explained to them. Several patients commented that they had attended this practice for many years and many said they had recommended this practice to others. Some patients commented that they had to wait beyond their allocated appointment time.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. Staff had individual passwords for the computers where confidential patient information was stored. There was a room available for patients to have private discussions with staff and this information was clearly displayed for patients. 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 had the choice of seeing different dentists at the practice. Patients could also request a referral for dental treatment under sedation. The computer system at the practice had a feature that enabled nervous patients to be identified quickly by all staff. This would enable staff to adapt their approach, if deemed appropriate and necessary.

Involvement in decisions about care and treatment

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

NHS examination and treatment fees were displayed in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as the premises were on the ground floor; however, the practice was unable to accommodate wheelchair-users. The providers owned another NHS practice that was located nearby and any patients requiring wheelchair access were directed to their other practice. There was ample car parking for patients with limited mobility near the main entrance to the practice. There were toilet facilities on the ground floor but these were not wheelchair-accessible.

The practice had an appointment system in place to respond to patients' needs. Most patients that communicated with us confirmed 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

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

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. Also, the practice had access to sign language interpreters, if required.

The practice had access to an interpreting service for patients that were unable to speak fluent English but the practice did not need to use this service very often.

Access to the service

Feedback from patients generally 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.

We reviewed the appointment book and found that the dentists were often double-booked. We spoke with staff and found that many patients each day failed to attend their appointments so this system mostly worked well and waiting times were minimal.

The practice opened between 8:30am and 5pm on Monday to Friday.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and accessible to patients. This was not sufficiently comprehensive as it did not contain the details of several external organisations that patients could contact if they were dissatisfied with the practice's response. Within two working days, the practice manager informed us that this policy had been updated and now included the appropriate information.

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. We were told that

Are services responsive to people's needs?

(for example, to feedback?)

any learning identified was cascaded personally to team members and also discussed in staff meetings. We saw examples of changes and improvements that were made as a result of concerns raised by patients.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. They were at the practice for one or two days every week but had telephone availability on all other 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 autoclaves, hazardous waste and radiation.

Leadership, openness and transparency

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

The provider had systems in place to support communication about the quality and safety of services. Staff told us they were aware of the need to be open, honest and apologetic to patients if mistakes in their care were made. This was in line with the Duty of Candour regulation.

Learning and improvement

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

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. The practice carried out several audits each month but there was not always a clear summary of actions needed (if relevant). This was discussed with the practice manager and they arranged a staff meeting to discuss this further with all staff. They also told us that they planned to produce written summary sheets for all staff with immediate effect.

Staff meetings took place on a monthly basis. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as infection control, fire safety and referrals had been discussed in the last six months. The agenda for the next staff meeting was displayed in the reception area so that staff could easily add any topics that they wished to discuss.

We reviewed two appraisals and found that all staff (apart from the dentists) received these annually. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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

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

The practice had systems in place to involve, seek and act upon feedback from people using the service. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care.

No comments had been made on the NHS Choices website. However, we noticed that the practice details had not been updated on NHS Choices to reflect the current partnership. The opening hours also needed to be updated. The practice manager told us they would arrange for this to enable current and prospective patients to access current information about the practice. There was a notice displayed in the waiting room inviting patients to leave feedback 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.