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JD Dental Surgery

Inspection Report

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Date of inspection visit: 18 June 2015
Date of publication: 03/09/2015

Overall summary

We carried out an announced comprehensive inspection on 18 July 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 respects 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 not providing well-led care in accordance with the relevant regulations.

JD Dental Surgery provides mainly NHS dental treatment although staff told us they also carry out a small amount of private treatment. The practice is situated in a residential area of Birmingham with a mixed population where some people are living in deprived circumstances whilst others are more affluent. The area has a diverse population of people from different ethnic origins and a high student population.

JD dental practice has one dentist, one dental hygienist, one dental nurse and a practice manager. Two other members of the practice team were on maternity leave. The practice has three dental treatment rooms (one of which was out of use) and a decontamination room for the cleaning, sterilising and packing of dental instruments. The reception area and waiting room are on the ground floor.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 17 completed cards. These provided a positive view of the service the practice provides. Patients told us the practice was welcoming and that the dentist was understanding, thorough and helpful. Several patients specifically commented that the dentist put them at ease. The dentist provided dental care to people living in eight care homes in the area. We spoke with senior staff from those

Summary of findings

homes. They were generally very positive about the service people received and highlighted that the dentist was particularly good at understanding the needs of people living with dementia illnesses.

Our key findings were:

- The practice had no records of significant events or accidents to ensure they investigated these and took remedial action. There was no evidence of learning when adverse incidents happened.
- The practice was visibly clean but some areas of the building needed to be improved.
- The practice had systems to assess and manage risks to patients for infection prevention and control (IPC) and the management of medical emergencies but was not carrying out IPC audits to test the effectiveness of infection control procedures.
- The practice had safeguarding processes and staff understood their responsibilities for safeguarding adults and children.
- Recruitment policies and procedures did not ensure that all of the required checks for new staff were completed.
- The content of clinical records was brief, but included the essential information expected about patients' care and treatment.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- The practice did not have an established effective system for handling and responding to complaints made by patients.
- Patients who completed Care Quality Commission comment cards were pleased with the care and treatment they received and complimentary about the dentist and the practice team.
- Patients were able to make routine and emergency appointments when needed.
- The practice did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided.
- The practice did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.

We identified regulations that were not being met and the provider must:

- Establish an effective system to assess, monitor and improve the quality and safety of the services provided.
- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.

You can see full details of the regulations not being met at the end of this report.

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

- Introduce effective systems for recording accidents and other significant events to ensure that remedial action and learning takes place when adverse incidents occur.
- Provide separate protective face visors in the decontamination room from those used in the treatment rooms to avoid the potential for cross contamination.
- Establish a process to audit and monitor infection prevention and control arrangements at the practice.
- Routinely use a rubber dam (or suitable alternative) during root canal work. 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.
- Update their policies and procedures for the safe use of dental sharps to reflect the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and the EU Directive on the safer use of sharps which came into force in 2013
- Consistently apply recruitment procedures which fully reflect the requirements of Regulation 19(3) and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Review and update their Disability Discrimination Act 2005 assessment of the building and make firm plans to improve the facilities based on the findings of this.
- Review the suitability of the decontamination room and staff kitchen facilities.

Summary of findings

- Make more detailed records of the care and treatment provided to patients.
- Establish an effective procedure for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.
- Improve the staff induction process to include a structured assessment of the competence of new staff for their role and responsibilities.

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 effective systems for control, clinical waste control, management of medical emergencies, maintenance and testing of equipment and dental radiography (X-rays) and child and adult safeguarding, medical emergencies.

Are services effective?

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

The dental care provided was evidence based and focussed on the needs of the patients. Patient records contained adequate information but would benefit from being more detailed. Staff, who were registered with the General Dental Council (GDC), had completed continuing professional development (CPD) and were meeting the requirements of their professional registration. Staff understood the importance of obtaining informed consent and of working in accordance with relevant legislation when treating patients who may lack capacity to make decisions.

Are services caring?

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

We gathered patients' views from 17 completed Care Quality Commission comment cards. We did not have the opportunity to speak with patients at the practice. Patients told us the practice was welcoming and that the dentist was understanding, thorough and helpful. Several patients specifically commented that the dentist put them at ease. The dentist provided dental care to people living in eight care homes in the area. We spoke with senior staff from those homes. They were generally very positive about the service people received and highlighted that the dentist was particularly good at understanding the needs of people living with dementia illnesses. Results from the NHS Friends and Family test and the practice's own surveys echoed this positive view.

Are services responsive to people's needs?

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

The dentist and staff were friendly and welcoming. Patients, including those living in care homes could access treatment and urgent and emergency care when required. The practice website did not provide information about opening times, appointment arrangements and emergency treatment when the practice was closed. The practice had decided to open until 8pm one evening a week to provide flexibility for patients unable to arrange appointments during the m ain part of the day.

Although there was a complaints procedure, the practice did not have a fully established effective system in place for acknowledging, recording, investigating and responding to complaints, concerns and suggestions made by patients.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices).

Although the practice had a number of policies, systems and processes some of these had not been reviewed for up to four years and were not necessarily live and working tools.

Summary of findings

During the course of the inspection we identified a number of issues where improvements were needed and which the practice's own systems had not identified. The new practice manager had been in post for less than two months and was aware that work was needed to establish effective governance processes.

Although the practice managed the use of sharps safely in practice, their policy and procedure for the safe use of dental sharps did not reflect the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 or the EU Directive on the safer use of sharps which came into force in 2013.

The practice was not completing six monthly audits of infection prevention and control arrangements to ensure these were maintained in accordance with guidance from the Department of Health.

The practice had a serious untoward incident policy but this was not supported by suitable systems for recording accidents and other significant events to ensure that remedial action and learning took place when adverse incidents happened.

We were not assured that the dentist was routinely using a rubber dam (or suitable alternative) during root canal work. 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.

The practice's recruitment policy referred to Disclosure and Barring Service (DBS) checks but did not contain clear information about this or other checks the practice would carry out when appointing new staff. The Disclosure and Barring Service 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 adults who may be vulnerable. We saw that the practice had accepted DBS checks from previous employers for some recently appointed staff. We saw that the practice had written forms for existing staff to confirm that the information in their DBS check was still correct; this was good practice.

JD Dental Surgery

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.

The inspection was carried out on 18 July 2015 by a CQC inspector and a dentist specialist advisor.

Before the inspection we reviewed information we held about the provider and information that we asked them to send us in advance of the inspection.

During the inspection we spoke with the dentist, dental nurse and practice manager. We looked around the premises including the treatment rooms. We reviewed a range of policies and procedures and other documents including dental care records.

We viewed the comments made by 17 patients on comment cards provided by CQC before the inspection and spoke with senior staff from eight care homes the dentist visited to provide treatment to people.

We informed the local NHS England area team that we were inspecting the practice. They provided information about improvements they had told the practice they needed to make in respect of the quality of recording in patient records.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

Although the practice had a 'serious untoward incident' policy dated 2015 and blank reporting forms the practice had no records of significant events. The new practice manager told us there had been no relevant incidents since they had worked at the practice but did not know whether there had been any before that. The dentists told us they could not recall any incidents that should have been recorded as significant events.

The practice had an accident record book. This was new and did not contain any entries. We asked staff if there was a previous accident book which had been completed. Staff told us that as far as they knew there was no previous book. The dentist told us they could not recall any accidents which should have been recorded.

We were not assured that the practice had suitable systems for recording accidents and other significant events to ensure that remedial action and learning took place when adverse incidents happened.

Reliable safety systems and processes (including safeguarding)

We discussed child and adult safeguarding with the dentist. They were aware of how to recognise potential concerns about the safety and well-being of children, young people and vulnerable adults including older patients living with dementia. The practice had a safeguarding policy for staff to refer to and contact details for the relevant safeguarding professionals in Birmingham. This information was kept on the practice computer system together with a flow chart which was displayed behind the reception desk where staff could refer to it easily. The dentist reported that there had been no safeguarding incidents. We saw documentary evidence that all staff had undertaken safeguarding training.

We asked the dental nurse if the dentist routinely used a rubber dam during root canal work. 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. They told us the dentist used one in situations that involved the back teeth. Although a rubber dam kit was available in the stock cupboard, it was not kept with the dentist's root canal kit in his surgery and we were not assured that the dentist was routinely using this or a suitable alternative.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies at the practice. The practice had an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. The practice had the emergency medicines set out in the British National Formulary guidance. Oxygen and other related items such as face masks were available in line with the Resuscitation Council UK guidelines. The emergency medicines were all in date and stored securely with emergency oxygen in central locations known to all staff.

The expiry dates of medicines and equipment were monitored using a daily and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly.

The practice held in-house training sessions for the whole team to maintain their competence in dealing with medical emergencies using an outside provider. The last training session was on the 1st June 2015.

Staff recruitment

We looked at the staff files for all of the current employees including the two who were on maternity leave and the practice's recruitment policy and procedure. We saw that in general the practice held the required information for each member of staff employed. This included evidence of conduct in previous health or care related employment and photographic proof of identity.

The practice's recruitment policy referred to Disclosure and Barring Service (DBS) checks but did not contain clear information about this or other checks the practice would carry out when appointing new staff. 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 adults who may be vulnerable. We saw that the practice had accepted DBS checks from previous employers for two recently appointed staff one of whom was the new practice manager. We saw that the practice had written forms for

Are services safe?

new and existing staff to confirm that the information in their DBS check was still correct; this was good practice. The practice manager confirmed that they had already begun the process of obtaining a new DBS check for themselves. The DBS check for the other new member of staff was two years old. That member of staff had signed a declaration that there were no changes that would affect the content of this. A new receptionist had been appointed but the practice was waiting for their DBS check to arrive before they started work.

The practice manager said they would review the recruitment policy to make sure it fully reflected the requirements of Regulation 19(3) and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. They also said they would look into using the DBS online service which allows employers to check up to date information for employees at any time.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which was due for review in April 2016. This stated that the dentist did inspections of the practice and kept records of this. However, the practice did not have records of these checks. There were a number of health and safety related policies. These included manual handling, sharps, use of the autoclave, display screen equipment, electrical safety and slips, trips and falls. Several of these were dated October 2010 and had not been reviewed or updated.

We saw that there were fire safety records showing that the practice had carried out weekly checks of the fire alarm system and fire extinguishers since January 2015. We did not see fire safety records earlier than these. The records also showed that staff had taken part in fire drills during 2015.

Infection control

The practice had an infection control policy dated April 2015 and additional guidance including an advice sheet from the British Dental Association. Staff told us that the dentist was currently the named lead for infection prevention and control (IPC).

The dental nurse told us that they did all of the cleaning at the practice and that other members also helped so that this was a team effort. We saw that dental treatment areas, decontamination room, reception and waiting area were visibly clean, tidy and clutter free.

The 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices' (HTM01-05) published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We observed the practice's processes for the cleaning, sterilising and storage of dental instruments and reviewed their policies and procedures. This assured us that the practice was meeting the HTM01-05 essential requirements for decontamination in dental practices.

The practice had not completed six monthly audits of its overall infection prevention and control arrangements to ensure these were maintained in accordance with guidance from the Department of Health. Such a process would include the Infection Prevention Societies audit tool which according to current guidelines should be carried out every six months.

Decontamination of dental instruments was carried out in a separate decontamination room on the first floor. The room was small with limited space for the equipment in the room, for example the illuminated magnifier was situated on the worktop in the 'clean' area of the room due to lack of space in the 'dirty' area. There was no separate hand wash basin in the decontamination room and staff had to go through the room to reach the staff kitchen. The practice had not completed risk assessments about these issues.

The practice had a washer disinfector but this was not working on the day of the inspection. From discussions with staff and examination of records we found that this was rarely used. Staff explained that this was because it leaked. We highlighted to the dentist that it was not an effective use of already limited space to have this machine in place if it was not working.

A dental nurse demonstrated the decontamination process to us. We saw that this followed a system which separated dirty instruments from clean ones. We also saw clear separation of dirty and clean areas in the treatment rooms. Because the washer disinfector was not working the practice used a system of manual scrubbing using a sink and separate bowl system as part of the initial cleaning process. We saw there were heavy duty gloves for the dental nurse to wear to protect them from injury from sharp instruments.

When staff had cleaned and sterilised instruments they packed them and stored them in a cupboard in the clean

area of the decontamination room until they were needed. The storage cupboard was clean, tidy and well organised. We saw that the packs were dated with an expiry date in accordance with current HTM01-05 guidelines. The nurse showed us how the practice checked that the autoclave (equipment used to sterilise dental instruments), was working effectively. They showed us the paperwork they used to record the essential daily checks of the sterilisation cycles. We observed maintenance information showing that the autoclaves were maintained to the standards set out in current guidelines. We saw that some of this paperwork was loose in a cupboard which would make finding historical records more difficult.

We inspected the drawers in the two treatment rooms which were in use. These were visibly clean and tidy. All of the instruments were in dated packs and it was clear which items were single use.

The practice had personal protective equipment (PPE) such as disposable gloves, aprons and eye protection available for staff and patient use. However, we established that there was no protective face visor in the decontamination room and that the dental nurse wore the same one they used in the treatment rooms. This creates the potential for cross infection. The treatment rooms all had designated hand wash basins for hand hygiene and a range of liquid soaps and hand gels.

The dentist provided dental care to people living in eight local care homes. We spoke with senior staff at all of those homes. Staff from some of the homes specifically mentioned that the dentist and dental nurse followed good infection control measures and brought their own personal protective equipment with them.

Legionella is a bacterium which can contaminate water systems. We saw evidence that the practice had arranged for an appropriate contractor to carry out a legionella risk assessment. The practice used a biocide to prevent a build-up of legionella biofilm in the dental waterlines. The dental nurse described how they carried out regular flushing of the water lines in accordance with current guidelines.

The practice had a record of staff immunisation status in respect of Hepatitis B, a serious illness that is transmitted by bodily fluids including blood. The nurse we spoke with understood what to do if they injured themselves with a needle or other sharp dental instrument. This included contacting the local occupational health department and recording in the practice's accident book. The practice had an inoculation injury policy. The review date on the document was 6 January 2014 and there was no record to show this had been done. The practice manager was aware than many of the practice's policies and procedures needed to be updated and told us this was work she planned to address in the next few months.

Although the practice managed the use of sharps safely in practice, their policy and procedure for the safe use of dental sharps was last updated in 2010. This did not reflect the requirements of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 or the EU Directive on the safer use of sharps which came into force in 2013. Part of this directive requires the practice to develop a risk assessment and protocol about the recapping of needles following use if single use syringes are not used in the practice. At the time of our visit the practice had not carried out such an assessment or produced a protocol relating to safer sharps use.

The segregation and storage of dental waste was in line with current guidelines from the Department of Health. We observed that sharps containers were well maintained and correctly labelled. The practice used an appropriate contractor to remove dental waste from the practice and we saw the necessary waste consignment notices.

Equipment and medicines

The outside of the building and some internal areas showed visible signs of wear and tear such as flaking paintwork. The dentist told us that they had plans to extend the practice and that work would include general refurbishment where this was needed.

We looked at the maintenance schedules for the equipment used in the practice. This showed that equipment was maintained in accordance with the manufacturers' instructions using appropriate dental engineers. This included the equipment used to sterilise instruments, X-ray equipment and equipment for dealing with medical emergencies. Portable electrical appliances had been tested by an electrical contractor in October 2014. The washer disinfector in the decontamination room was out of use because it leaked.

The practice had a system in place to monitor medicines in use at the practice. We found that there was sufficient stock and they were all in date. Staff checked the medicines

regularly and kept records of this. We saw from a sample of clinical records that the dentist recorded the name of the medicines they prescribed together with the dose and timing. The batch numbers and expiry dates for local anaesthetics were recorded in the clinical notes we saw.

Radiography (X-rays)

We were shown records relating to the Ionising Radiation Regulations 1999 (IRR99) and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).The records included the local rules and the names of the Radiation Protection Advisor and the Radiation Protection Supervisor along with the necessary documentation relating to the maintenance of the X-ray equipment. The maintenance logs were within the current recommended interval of 3 years.

We looked at the dentist's continuous professional development (CPD) training records in relation to IRMER requirements; these were within the recommended five year renewal period. We saw a copy of the most recent radiological audit completed in April 2015. This demonstrated that a high percentage of radiographs were of grade 1 standard. We looked at a sample of dental care records where X-rays had been taken on the day of our visit. These showed that the dentist had recorded their justification for taking these X-rays. The practice recorded the quality assurance scores for each X-ray in a notebook. These findings showed that practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice carried out consultations, assessments and treatment in line with recognised general professional guidelines and General Dental Council (GDC) guidelines. The dentist described how they assessed patients using a typical patient journey example. They told us they asked patients to complete a medical history questionnaire to provide the practice with details of health conditions, medicines being taken and any allergies suffered. The dentist provided dental care to people living in eight local care homes. We spoke with senior staff at all of those homes who confirmed that the dentist took medical history forms to be filled in.

The dentist described a typical examination which covered the condition of a patient's teeth, gums and soft tissues and detecting the signs of mouth cancer. They explained that they made patients aware of the condition of their oral health and whether it had changed since the last appointment. They gave each patient a treatment plan which included the cost involved.

We looked at a sample of dental treatment records for patients who attended the practice on the day of the inspection. These confirmed that the findings of the dentist's assessment and details of the treatment carried out were recorded although the notes were brief. We saw details of the condition of patients' gums were recorded using the basic periodontal examination (BPE) scores The BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums. The records also confirmed that the dentist had checked the soft tissues lining the mouth which can help to detect early signs of cancer.

The records confirmed that each dental X-rays taken was justified, reported on and quality assured and contained treatment plans and details of associated costs.

When treatment had been completed, the dentist had incorporated a risk based approach to determining the dental recall interval based on the National Institute for Health and Care Excellence (NICE) dental recall guidelines.

Health promotion & prevention

The waiting room at the practice contained literature in leaflet form that explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health.

The dentist and dental therapist advised adults and children of steps to take to maintain healthy teeth. They explained tooth brushing techniques and gave advice on diet, smoking, and alcohol consumption. The dentist explained that when they identified children at high risk of tooth decay they offered fluoride varnish applications to help keep their teeth in a healthy condition. A dental therapist was employed at the practice when patients needed more extensive treatment for their gums. The practice provided this privately, not as NHS treatment. The practice provided information about this, including the cost, on a poster in the waiting room.

Some care home staff specifically mentioned that the dentist gave guidance to care staff about providing oral health care. Staff from one care home gave us an example of how the dentist had persevered to provide dentures for a person who had lost weight and needed these to help improve their nutrition. One told us that on their most recent visit to the home the dentist took a supply of toothbrushes, toothpaste and mouthwashes for the people living there.

Staffing

The practice team consisted of one dentist, one dental hygienist, a dental nurse and a newly appointed practice manager. The dental nurse and practice manager had joined the practice within the last three months as had the dental hygienist. Two more established staff, a dental nurse and the previous practice manager were on maternity leave.

The dental nurse had been at the practice for two months. We saw a checklist which covered topics the practice had covered with them in their induction period. This included a wide range of important and appropriate topics such as emergency medicines arrangements and fire safety. The practice had not recorded details of the dates information or training was provided and had not assessed their competence in a structured way.

We saw evidence that members of the clinical team had completed appropriate training to maintain the continued professional development required for their registration

Are services effective?

(for example, treatment is effective)

with the General Dental Council. This included medical emergencies in dental practices, infection control, child and adult safeguarding, dental radiography (X-rays), and varied dental topics.

The individual staff records contained details of confirmation of current General Dental Council (GDC) registration, current professional indemnity cover and immunisation status. However, there was no system to help the practice monitor this on an ongoing basis.

Working with other services

We saw examples of referral letters which demonstrated that the dentist referred patients who required any specialised treatment to other dental specialists as necessary.

The dentist provided dental care to people living in eight local care homes. We spoke with senior staff at all of those homes. They confirmed that the dentist and dental nurse who visited worked in partnership with them to help ensure that people received the dental care they needed. Staff from some of the homes highlighted that the practice worked with them well as a team and communicated with them clearly before and after they had treated people. They were very positive about the service people living in the homes received. Some mentioned that people's dentures had not always been well fitting but that the dentist did their best to remedy this.

Consent to care and treatment

The dentist had a clear understanding of consent issues. They stressed the importance of communication skills when explaining care and treatment to patients. They understood that consent was an ongoing process and a patient could withdraw consent at any time. The dentist explained that they gave patients a detailed verbal explanation of the type of treatment required, including the risks, benefits and options.

The Mental Capacity Act 2005 (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. The practice had a consent policy and a folder containing Department of Health guidance about the MCA.

The dentist explained how they would approach the issue of consent with patients who may not fully understand the implications of their treatment. The dentist assured us that if there was any doubt about their ability to understand or consent to the treatment, then they would postpone treatment. They said they would involve relatives and carers in discussions to ensure that the best interests of the patient were served as part of the process.

Staff at the care homes confirmed that the dentist appeared to be knowledgeable about the MCA and took account of patients' ability to consent during consultations and treatment. They added that the dentist involved relatives and care home staff in decisions where appropriate to help ensure these were made in people's best interests.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to use to tell us about their experience of the practice. We collected 17 completed cards. These provided a positive view of the service the practice provides. Patients told us the practice was welcoming and that the dentist was understanding, thorough and helpful. Several patients specifically commented that the dentist put them at ease and that this had helped them overcome their fear of going to the dentist.

The practice had started to use the NHS Friends and Family test to gather patients' views. The April results for the practice included the views of six patients. Five of those patients said they were extremely likely to use the practice again and one said they were likely to do so. Several of the patients had made additional comments all of which were positive. The comments echoed those in the CQC comment cards in that patients described the dentist as patient, gentle and reassuring.

The dentist provided dental care to people living in eight care homes in the area. We spoke with senior staff from those homes. They were very positive about the service people received and highlighted that the dentist was particularly good at understanding the needs of people living with dementia illnesses.

During the inspection we saw the dentist go to collect patients from the waiting room. We noted that they had a welcoming and friendly approach and that patients responded to this in a relaxed way.

All of the staff files contained a signed confidentiality statement.

Involvement in decisions about care and treatment

When we looked at dental care records we saw that the dentists recorded information about the explanations they had provided to patients about the care and treatment they needed. Staff from the care homes gave us several examples of ways the dentist showed patience and explained what they were doing to help people understand their care and treatment. In a patient survey carried out by the practice in February 2015 19 out of 20 patients who responded said that the dentist explained things well enough.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The dentist provided dental treatment to people living in eight local care homes. They carried out regular visits to the homes to do check-ups and denture work. Staff at the homes told us that the practice arranged regular visits for check-ups and specific appointments to repair or make new dentures of to treat people with toothache.

The local area had a high student population and the practice told us they had a large number of patients who were students.

A number of patients we had comments from told us they were very nervous patients. They said that the dentist was supportive and put them at their ease. Several mentioned that this had enabled them to overcome their fear of going to the dentist.

Tackling inequity and promoting equality

The practice provided mainly NHS dental treatment although staff told us they also carried out a small amount of private treatment. The practice was situated in a residential area of Birmingham with a mixed population where some people were living in deprived circumstances whilst others were affluent. There was also a diverse population of people from different ethnic origins and a high student population. The dentist told us that the mixed practice population brought with it some challenges in respect of the variety of languages used by patients. The dentist and new practice manager told us that between them they spoke five languages used in the local area. When necessary the practice had access to local interpreting services to assist with communication.

The dentist told us they would never discriminate against a patient for any reason. They gave us an example of a patient whose particular needs had been taken into account in a non-judgemental way. The practice was occasionally approached for dental care by people seeking asylum in the United Kingdom. The practice said they checked people's eligibility for treatment with NHS England if they were unsure what to do but would not turn people away.

The practice building was a converted house in a mainly residential street. The reception, waiting room, toilet and one treatment room were on the ground floor. The other treatment room in use was on the first floor as was the decontamination room and another treatment room which was not in use. The stairs to the first floor were very steep. We saw that in October 2012 the practice had completed an assessment of the access to the building in accordance with the Disability Discrimination Act 2005. This identified that the practice needed improved access and facilities for patients with disabilities, including a properly equipped toilet. This work had not taken place. The dentist told us that they were exploring options for improving and extending the building to address these issues and to create improved facilities for people with disabilities and a more suitable decontamination room.

The practice did not have an induction hearing loop to assist patients who used hearing aids.

Access to the service

The practice was open Monday to Friday from 9am to 5pm and had just introduced late opening until 8pm on Thursdays to provide flexibility for patients unable to go to the surgery during the daytime. The practice was also open on Saturday mornings between 9am and 12pm. The practice provided dental care to people living in eight local care homes to provide them with access to dental treatment.

Information in CQC comment cards and the practice's April 2015 Friends and Family test results described a responsive service where patients found it easy to get appointments, particularly when experiencing pain.

Information we reviewed before the inspection suggested that there was a conflict between the dentist's visits to patients in care homes and the timing of appointments for patients at the practice. None of the 17 patients who filled in comment cards mentioned this as a concern. The practice had also conducted a waiting time audit covering the period January to March 2015. This showed an average waiting time of 13 minutes based on responses from 1,438 patients. They were repeating this exercise between June and August 2015. We looked at a random selection of dates on the practice's computerised appointment system and identified days where the dentist visited patients in care homes. These were booked appointments with travel time taken into account. We looked more generally at appointments on the system and saw no evidence of 'double booking'. We saw that the lengths of appointments varied according to the type of treatment being provided.

Are services responsive to people's needs?

(for example, to feedback?)

The practice's patient leaflet provided information about opening times and how patients could access emergency dental treatment through NHS 111 when the practice was closed. The information was not included on the practice website. The dentist told us they were planning to have a more up to date and informative website built.

Concerns & complaints

The practice had a complaints policy which contained the contact details for NHS England if a person was not satisfied with how the practice dealt with their complaint.

The practice had no records of complaints. The new practice manager told us there had been no complaints direct to the practice since they started working there and they did not know if there were any before that. The dentist told us they had not received any complaints. We noted that the NHS Choices website page for the practice contained a number of negative comments from patients who were not been satisfied with the service they received. The practice manager told us they were aware of these comments and recognised that it would be beneficial to acknowledge these and ask people to contact them so their concerns could be dealt with directly.

We found information about historical complaints in a policy folder available to all staff. The information included personal information including the names and addresses of patients. The practice manager told us they would remove this information and file it appropriately.

Are services well-led?

Our findings

Governance arrangements

The practice did not have structured arrangements for regularly reviewing and improving the quality of the service or to monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors.

During the course of the inspection we identified a number of issues where improvements were needed and which the practice's own systems had not identified. These included some safety related matters including some aspects of infection control, safe use of dental sharps, the lack of assurance that the dentist used a rubber dam (or suitable alternative) for root canal treatments and effective recruitment procedures.

Although the practice had a number of policies, systems and processes some of these had not been reviewed for up to four years and were not live working tools. There was a clinical governance policy but this was not signed or dated. The practice had a number of risk assessments but many of these had not been reviewed or updated since 2010.

The practice had not been recording significant events, accidents or complaints (although there were some historical complaints records in a policy file). Staff told us there had not been any but we considered this was unlikely over the seven year period the dentist had operated the practice.

Staff meeting minutes did not contain any information about shared learning within the practice or demonstrate that discussions included improving and developing the service. The new practice manager had been in post for less than two month and was aware that work was needed to establish effective governance processes.

Leadership, openness and transparency

The practice had a dignity at work procedure and action pack sourced from a trade union which set out staff rights in respect of raising concerns about their place of work under whistleblowing legislation. We saw that the practice had a whistleblowing policy but this needed to be reviewed and updated because it referred to the primary care trust, a body which no longer exists.

The staff group at the practice was very small and on the day of the inspection we observed that the team worked together well. The new practice manager told us they had discussed the improvements that they needed to make with the dentist who they felt was open to their advice and suggestions.

Management lead through learning and improvement

We found that the practice was carrying out some clinical audits. These included clinical record keeping and X-ray quality. We looked at a sample of these. The X-ray audit was carried out on a sample of the dentist's X-rays in April 2015; this involved grading the quality of the X-rays to ensure they had been taken correctly.

We also saw a dental care record keeping audit carried out in May 2015. Areas for improvement had been identified by the dentist including the addition of criteria for the assessment of the patient. However the dental care records we used to corroborate our evidence were very brief in comparison with the dentist's detailed verbal descriptions of the assessment and consent process.

The new practice manager told us they intended to identify and address all of the areas where the practice needed to improve.

We saw notes of staff meetings that the practice had held in March, April and May 2015. These included a list of topics for discussion which were the same for each meeting. The notes of the meetings did not reflect all of the topics on the agenda and were very brief.

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

The practice had started to use the NHS Friends and Family test to gather patients' views. The April results for the practice only included the views of six patients. Five of those patients said they were extremely likely to use the practice again and one said they were likely to do so. Several of the patients had made additional comments all of which were positive.

The practice also carried out their own patient survey in February 2015 and planned to repeat this in August 2015. The February survey had identified that the majority of patients were satisfied with the practice. For example, all 20 who responded said they were confident about the quality of treatment they received. Half of the patients indicated

Are services well-led?

that they would welcome evening and weekend appointments and the practice had just introduced one late evening surgery in response and were already open on Saturday mornings.

The practice had also conducted a waiting time audit covering the period January to March 2015. This showed an average waiting time of 13 minutes based on responses from 1,438 patients. They were repeating this exercise between June and August 2015.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The practice did not have effective systems in place to - · Assess, monitor and improve the quality and safety of the services provided. · Assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. Regulation 17 (1)(2)(a)(b)