Mr. Sukhvinder Atthi

Hillbrook Dental Health Centre

Inspection Report

286 Ladypool Road
Balsall Heath
Birmingham
B12 8JU
Tel:0121 449 5656
Website: www.hillbrookdental.com

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Overall summary

We carried out an announced comprehensive inspection on 8 September 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations.

Background

Hillbrook Dental Health Centre offers mainly NHS treatment to patients of all ages but also offers private dental treatments. The services provided include predominantly routine restorative and preventative dental treatment but also domiciliary visits (to a local care home), implants, orthodontics and dental treatment under conscious sedation.

There is a waiting room and one treatment room on the ground floor and a further two treatment rooms on the first floor of the premises. The practice also has a decontamination room, a waiting room, a reception area and toilet facilities.

There are currently five dentists (one of whom is the principal dentist) and one dental therapist. There are also four receptionists and five dental nurses (two are trainees). One of the dental nurses also acts as the practice manager. The principal dentist is also in the process of recruiting another two dental nurses.

The opening hours are 9am to 5pm on Monday, Tuesday, Thursday and Friday. The practice is open from 9am to 7pm on Wednesday – this provides some flexibility for working age people and families with school children. Domiciliary visits were also carried out during these

Summary of findings

hours. However, during the inspection, we were informed that the principal dentist would be subsequently carrying out domiciliary visits during the practice's lunch hour only.

The principal dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

26 patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with patients on the day of the inspection. Overall the information from patients was very positive. Patients were positive about their experience and they commented that they were treated with care, respect and dignity.

Our key findings were:

- The practice had systems in place to record accidents and complaints.
- Staff had received safeguarding training but not all staff members were aware of how to proceed in the event of a safeguarding issue.
- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available. This was available at the practice but not at the domiciliary visits (although the practice changed their policy with immediate effect so that this equipment was available on domiciliary visits too).
- Infection control procedures were in place but improvements were needed. Further training was required as not all staff members were consistently following published guidance.
- Patient care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Patients were treated with dignity and respect and confidentiality was maintained.
- The appointment system met the needs of patients.
- There was an effective complaints system.
- Staff felt involved and worked as a team.
- The practice sought feedback from patients about the services they provided.
- Governance systems were in place but improvements were required around their auditing processes.
- 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.
- Not all processes to assess, monitor and improve the quality and safety of the services were effective.

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 in the carrying on of the regulated activity.
- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others.

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:

- Consider further training for staff in safeguarding, whistleblowing and Legionella prevention.
- Review their infection control procedures for safer practice.
- Consistently follow their own recruitment policy by obtaining references for newly appointed staff.
- Have a robust process to monitor professional registration and medical indemnity of the clinical staff members.
- Review arrangements for conducting audits and learning from the results.

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.

Equipment at the practice was generally well maintained and regularly serviced. The practice had the equipment and medicine they might need to deal with medical emergencies but this was not taken with them during domiciliary visits. We discussed this with the principal dentist and they informed us they would change their policy immediately so that they were equipped on all future domiciliary visits. Staff received external and internal training in medical emergencies.

There were comprehensive staff recruitment policies and procedures to help reduce the risk of unsuitable staff being employed. However, the practice was not following their own recruitment policy by consistently obtaining references for all newly employed staff. The principal dentist told us they always sought references for newly appointed staff but they were not always successful in obtaining this information from referees.

There were detailed policies and procedures for safeguarding children and vulnerable adults. Training had been provided for all staff but some of the staff were not familiar with the safeguarding process.

Fire safety was assessed and staff took part in regular fire drills. Policies and precautions were in place to reduce the risk of infection from Legionella bacteria. However, some of the staff needed further training as they were not all following the recommended guidance on Legionella prevention. The practice needed to make improvements in the management of infection prevention and control.

Are services effective?

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

Patients' dental care records provided comprehensive information about their current dental needs and past treatment. The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits, options and costs were explained.

Dentists had a general awareness about the importance of gaining patients' consent. Not all staff members were familiar with the requirements of the Mental Capacity Act 2005 (MCA) although they were not directly involved with treating patients and obtaining consent. All staff had received training on the MCA.

Are services caring?

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

Patient feedback stated that they had very positive experiences of dental care provided at the practice. Staff behaved in a respectful, appropriate and kind manner.

Are services responsive to people's needs?

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

The practice provided friendly, personalised dental care. Consultations were carried out in line with best practice guidance. Patients could access routine and emergency treatment when required. Patients using a wheelchair could access the service.

Summary of findings

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 Notice section).

Although the practice had a number of policies, systems and processes, they were not all being consistently followed by all staff members. 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.

Staff members were not consistently following systems and processes with regard to safe practice. Improvements were required in relation to infection control; recommended guidance was not being adhered to in relation to Legionella prevention. Not all of the staff members were familiar with the safeguarding process or the Mental Capacity Act 2005. The practice was not consistently following its own recruitment policy as references were not always obtained (although the principal dentist told us they always sought references). Audit results were not always analysed and reported upon.

The culture of the practice encouraged candour, openness and honesty. Improvement was required with the audit process as not all of the audits had been completed.

Staff were supported to maintain their professional development and skills. The practice sought the views of patients both formally and informally.

Hillbrook Dental Health Centre

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 8 September 2015 by two CQC inspectors and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources such as NHS England and the provider's own website. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the principal dentist (who was the registered manager), one dentist, two dental nurses and the receptionist. 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 responded to national patient safety and medicines alerts that affected the dental profession. The principal dentist told us they reviewed all alerts and spoke with staff to ensure they were acted upon. This was usually discussed at practice meetings – we were informed that practice meetings would be brought forward if there were urgent safety alerts. We were told that adverse incidents would be discussed at staff meetings to provide opportunities for shared learning.

The practice had an accident book and staff were aware of guidance surrounding this. The principal dentist understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR) and provided guidance to staff within the practice's health and safety policy. No RIDDOR reports had been made in the last 12 months.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adults policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff and they all had access to contact details for safeguarding teams. The principal dentist was the safeguarding lead in the practice and had completed Level 1 Safeguarding training in May 2015. Level 1 training would be appropriate for all members of the dental team who have contact with children in the course of their work.

We viewed a risk assessment for domiciliary visits. The principal dentist was following the guidance recommended by the BSDH (British Society for Disability and Oral Health). The dentist told us they always took a dental nurse with them on domiciliary visits to assist and to act as a chaperone.

Safeguarding training was provided within the practice in August 2015 and July 2014 but not all staff were present. All staff members had read and signed the safeguarding policy. We spoke with several staff members about the safeguarding process but not all staff members were aware of how to proceed in the event of a safeguarding issue. There had not been any safeguarding referrals to the local safeguarding team in the last 12 months.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal and operating field and airway. Rubber dam kits were available in all of the treatment rooms. Not all of the dentists were using a rubber dam for all stages of the root canal treatment. Alternative actions were used to reduce the risk to patients where rubber dam were not being used.

The practice had clear processes to make sure they did not make avoidable mistakes such as extracting the wrong tooth. The principal dentist told us they always checked and re-checked the treatment plan and tooth charting.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. However, these did not extend to domiciliary dental visits (visits made by the dentist to the patient's home). The dentist undertaking the domiciliary visits was not taking any emergency equipment or drugs with them. We discussed this with the principal dentist and they informed us this would change with immediate effect.

Within the practice, the arrangements for dealing with medical emergencies was in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. The principal dentist carried out intra-venous sedation at the practice and we saw that the emergency drugs included the reversal agent for the sedative medicine. There was an Automated External defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff received annual training in the management of medical emergencies. Medical emergencies were also discussed at practice meetings. Staff we spoke with were all aware of the location of the emergency equipment and drugs. They were stored in a secure area.

Are services safe?

Records showed regular checks were carried out to ensure the equipment and emergency medicines were safe to use. The emergency medicines were all in date and stored securely.

Staff recruitment

The practice had a policy for the safe recruitment of staff. This included Disclosure and Barring Service (DBS checks), professional registration, employment contracts, identity checks, references and the immunisation status for staff. We viewed three staff files but we saw no evidence that references had been obtained. The practice was not following their own recruitment policy as they did not always obtain references for newly appointed staff. This was discussed with the principal dentist and they told us they always sought references but did not always successfully obtain them due to various reasons. All other required information was present in the three staff files we viewed.

The practice did not have a robust system in place to monitor professional registration and medical indemnity of the clinical staff members. We noted that certificates were present but not all were updated to reflect the current year's membership. The principal dentist told us they had requested this information from staff but not all of the staff had provided the updated certificates. This issue was resolved during the inspection and the principal dentist assured us they would adopt a more robust system.

Monitoring health & safety and responding to risk

We saw evidence of a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire.

The practice had arrangements in place to monitor health and safety. Risk management policies were in place. For example, we viewed a fire safety risk assessment undertaken by an external agency in April 2015. In this case, we saw that the principal dentist followed the recommendations wherever possible. There was written justification where it was not possible to complete the specific recommendation. We also saw a health and safety compliance audit from April 2015.

We were told that fire drills took place every six months. There was a certificate stating that fire safety equipment was valid until November 2015 – this included fire blankets and fire alarms. Fire training was carried out in November 2014.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. The practice identified how they managed hazardous substances in their health and safety and infection control policies, for example in their blood spillage procedure.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. 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 who was responsible for ensuring infection prevention and control measures were followed.

We saw evidence that staff were immunised against blood borne viruses (Hepatitis B) to ensure the safety of patients and staff.

We observed the treatment rooms and the decontamination room to be visually clean and hygienic. Several patients commented that the practice was clean and hygienic. We were told that there were some recent leaks in the decontamination rooms but these were being addressed and repaired. In one surgery, there was a small tear in the dental chair which would make effective cleaning difficult. This was brought to the attention of the principal dentist. This chair was re-upholstered two days after the inspection and we saw evidence that this had been carried out. Work surfaces and drawers were clean and free from clutter. We saw that there were clearly designated dirty and clean areas in the treatment rooms. There were handwashing facilities in each treatment room and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. The treatment rooms had portable fans and these have the potential to spread contamination due to the rapid uncontrolled air circulation. This was discussed with the principal dentist and they said they would be removed.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM

Are services safe?

01-05 guidance an instrument transportation system was in place to ensure the safe movement of instruments between treatment rooms and the decontamination room. The practice owner had invested in a specially designed system which used pneumatic tubes to transport contaminated instruments from the treatment rooms to the decontamination rooms. This system negated the need for the nurse to leave the treatment room.

Not all sharps bins were located appropriately as some were positioned almost at ground level. Sharps bins should be kept above floor level, out of the reach of children. This was discussed with the principal dentist and they informed us the bins would be moved to a safer location. We observed waste was separated into safe and lockable containers for disposal by a registered waste carrier and appropriate documentation retained.

Two dental nurses discussed 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. Discussions with staff members confirmed they were aware of items that were single use and that they were being disposed of in accordance with the manufacturer's instructions. This included disposable safety syringes.

The practice was using an ultrasonic cleaning bath to clean the used instruments; they were examined visually with an illuminated magnifying glass and then sterilised in an autoclave. 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 heavy duty gloves, disposable gloves, aprons and protective eye wear. Household heavy duty gloves are recommended during the manual cleaning process and should be replaced on a weekly basis. We were told they were being replaced less frequently – the principal dentist assured us they would be changing them weekly with immediate effect.

We noticed that some of the burrs in the treatment rooms were rusty. A dental burr is a type of burr (cutter) used in a dental handpiece (drill). They are used during dental procedures, usually to remove decay and shape tooth structure prior to the insertion of a filling or crown. These burrs should be discarded and checks should be in place to ensure that rusty equipment is not used when treating patients. This was discussed with the principal dentist and they informed us this would be closely monitored in future.

The practice had systems in place for daily quality testing the decontamination equipment and we saw records which confirmed these had taken place. There appeared to be sufficient instruments available to ensure the services provided to patients were uninterrupted. Staff also confirmed this with us.

The principal dentist informed us that all general cleaning such as treatment room floors and other rooms in the building was carried out by an external cleaning company. They informed us the cleaner kept cleaning records to confirm the cleaning they had done. We were told that the cleaning records were regularly checked by an assigned staff member. On the day of the inspection, the treatment rooms were visibly clean. Cleaning products were stored in the cupboard adjacent to the compressor. There was also a methylated spirit bottle present – these were brought to the attention of the principal dentist and moved immediately due to their flammable qualities.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw audits were undertaken in 2014 and 2015 but the results were not analysed and reported upon. Without any outcomes or analysis, the practice could not assure themselves that they were fulfilling the requirements of HTM 01-05.

A risk assessment process for Legionella was carried out in April 2015 by an external agency. We saw evidence that the practice was recording the water temperature and undertaking regular assessment of the water quality to check that Legionella was not developing. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). However, not all of the practice staff were following the guidelines on running the water lines in the treatment rooms to prevent Legionella. We spoke with two nurses and neither were following the guidance.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as X-ray sets, autoclaves and the ultrasonic cleaning baths. There was a separate fridge for

Are services safe?

the storage of medicines and dental materials. We saw evidence that the temperature was being monitored appropriately. Portable appliance testing (PAT) was completed (PAT confirms that electrical appliances are routinely checked for safety).

The batch numbers for local anaesthetics were recorded in patient dental care records. Prescriptions were stamped at the point of issue but were not stored securely. We saw a prescription pad placed on the counter in one of the treatment rooms. Following the inspection the practice confirmed that the prescription pads are stored out of sight whenever the treatment room is not in use. They also told us that the pads were always locked in a secure location at the end of the day. Prescription numbers were recorded in patient dental care records. The last prescription audit was in 2011.

Radiography (X-rays)

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

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

Those authorised to carry out X-ray procedures had all attended the relevant training. This protected patients who required X-rays to be taken as part of their treatment.

We saw an X-ray audit from 2014 and this showed a percentage of X-rays were not rated. Regular audits are needed to assess the quality of the X-ray and check they have been justified and reported on. The results of this audit confirmed they must record the quality of every X-ray taken. This is needed in order to meet the required standards to reduce the risk of patients being subjected to further unnecessary X-rays.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out an assessment in line with recognised guidance from the Faculty of General Dental Practice (FGDP). This was repeated at each examination in order to monitor any changes in the patient's oral health. The dentists used NICE (National Institute for Health and Care Excellence – this is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment) guidance to determine a suitable recall interval for patients. This takes into account the likelihood of the patient experiencing dental disease. This was documented and also discussed with the patient.

We talked to the principal dentist about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient care records. Clinical records were comprehensive and included details of the condition of the teeth, soft tissue lining the mouth, gums and any signs of mouth cancer. Medical history checks were updated by each patient every time they attended for treatment and entered in to their electronic dental care record. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

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 following the recommended guidance in adults but not currently in children. The dentists were not always recording the patient's individual risk to dental disease. The practice did use other guidelines and research to improve their system of clinical risk management. For example, following clinical assessment, the dentists 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 in the patient's care record. Records showed that treatment options and costs (where applicable) were discussed with the patient.

The principal dentist carried out intra-venous (IV) and inhalation sedation at the practice for patients who were very nervous of dental treatment. We found that the principal dentist had put into place robust systems to underpin the safe provision of conscious sedation. They told us they were acting in accordance with the guidelines published by the Department of Health (Conscious Sedation In The Provision of Dental Care – 2003).

The systems supporting sedation included pre and post sedation treatment checks, monitoring of the patient during treatment, discharge and post-operative instructions and staff training. We were told that all of the nurses had in-house sedation training in January 2015. We were told this training occurred on an annual basis. We were told the dentist carrying out sedation was always supported by one appropriately trained nurse and another dentist on each occasion.

We were told that patients were always assessed for suitability for IV sedation at a preceding appointment. We were told that all patients undergoing IV sedation had important checks made prior to sedation; this included a detailed medical history, blood pressure and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines. We were told that during the sedation procedure important checks were recorded at regular intervals; these included pulse and the oxygen saturation of the blood. This was carried out using specialised equipment including a pulse oximeter which measures the patient's heart rate and oxygen saturation of the blood. Blood pressure was measured using a separate blood pressure monitor. We were told the blood pressure monitor was calibrated and tested every year. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practice.

Health promotion & prevention

The medical history form patients completed included questions about smoking and alcohol consumption. The dentists we spoke with and the patient records showed that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice. There were posters and oral health promotion leaflets available in the practice to support patients look after their health.

Are services effective?

(for example, treatment is effective)

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). For example, the practice recalled patients, as appropriate, to receive fluoride applications to their teeth. Patients were given advice regarding the maintenance of good oral health and, if appropriate, were recalled at earlier intervals for hygiene treatment and support regarding general dental hygiene procedures. Where required, toothpastes containing high fluoride were prescribed.

In October 2014, the principal dentist visited a local primary school to promote good oral health. Healthy eating, decay and gum disease were discussed during this visit and we saw evidence to confirm this.

Staffing

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

Staff told us they had good access to ongoing training to support their skill level and they were encouraged to maintain the Continuous Professional Development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff were registered with the GDC, however, the practice did not hold current GDC certificates for all staff. The principal dentist had requested these from all relevant staff members but the process was not robust enough to ensure that all of these were up to date. This issue was resolved during the inspection and the principal dentist assured us they would implement a more robust system to prevent a recurrence of this.

The principal dentist monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. The principal dentist previously identified that the practice was under-staffed and this was causing difficulties within the practice. As a result, the practice recruited another staff member (in July 2015) to allow for staff shortages during sickness and holidays. We were told that locum dental nurses were utilised whenever they were short-staffed. We were also informed they were looking to recruit another two dental nurses to further reduce any inconvenience caused by multiple staff being off work simultaneously.

Dental nurses were supervised by the dentists and supported on a day to day basis by the principal dentist. Staff told us the principal dentist was readily available to speak to at all times for support and advice. We saw evidence that the staff were receiving annual appraisals and reviews of their professional development.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to hospitals and specialist dental services for further investigations or specialist treatment. We viewed three separate referral letters and noted they were all comprehensive to ensure the specialist service had all the relevant information required. The dentists handed the completed referral to the patient so it was the patient's responsiblity to ensure the letter was sent. This was in response to patient feedback as the patients wanted to be more involved in the referral process.

Consent to care and treatment

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

Not all of the staff we spoke with had an understanding of the principles of the Mental Capacity Act 2005 (MCA) and how it was relevant to ensuring patients had the capacity to consent to dental treatment. We saw evidence of internal MCA training in May 2015 although not all of the staff were aware of its relevance in practice. (Not all staff members were directly involved with treating patients and obtaining consent).

There was no evidence of recording capacity assessments for patients who lacked the capacity to consent. The principal dentist regularly undertook domiciliary visits and we were told that several of these patients lacked mental capacity. However, the dental care records did not contain any clear capacity assessments. We spoke with the dentist and they said they were assessing patients and their capacity and acting in accordance with the MCA whenever

Are services effective?

(for example, treatment is effective)

patients were unable to consent, although they were not documenting this. The dentist informed us they would be introducing a policy so that these assessments were always recorded.

Staff we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Staff confirmed individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan.

Patients were given time to consider and make informed decisions about which option they preferred. We saw evidence of this documented in the dental care records.

Not all of the staff were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to treatment rooms were closed during appointments.

We observed staff were helpful, discreet and respectful to patients. Staff said that if a patient wished to speak in private an empty room would be available to speak with them. They said they had previously used the staffroom upstairs when a patient had requested a discussion in private.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Staff described to us how they involved patients' relatives or carers when required and ensured there was sufficient time to explain fully the care and treatment they were providing in a way patients understood. The practice displayed information in the waiting area that gave details of NHS dental charges.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided patients with information about the services they offered in leaflets and on their website. The services provided include predominantly routine restorative and preventative dental treatment but also domiciliary visits, implants, orthodontics and dental treatment under conscious sedation. Many of the patients' first language was not English so the practice responded by the provision of leaflets in different languages. This included leaflets in Arabic, Punjabi, Bengali and French.

Staff told us the practice asked the patients to "sit and wait" for an emergency appointment. Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. Staff informed us they kept patients informed if any of the dentists were running late – this gave the patient the option of rebooking the appointment.

Patient feedback confirmed they had flexibility to arrange appointments in line with other commitments. Patients also commented that they were offered a cancellation appointment if this was available.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. We saw that they had carried out an audit on the Disability Discrimination Act. We saw that they had made adjustments to enable patients to receive their care or treatment, including an audio loop system for patients with a hearing impairment. We were also told they had signs in Braille for patients who were visually impaired.

The practice had treatment rooms on the ground and first floor of the premises. The practice had made reasonable adjustments to accommodate patients with a disability or lack of mobility. Wheelchair access and ramps were available. There were disabled toilet facilities on the ground floor.

The steps from the ground floor to the first floor treatment rooms were very steep and narrow. Sedation was carried out only on the first floor. The dentist informed us the patients were only discharged once they were comfortable that they had passed specific discharge tests. There was a handrail on both sides of the steps and they said there was always one staff member in front and one behind the patient as they were walking down to the ground floor. This was discussed and the principal dentist stated they would offer patients undergoing sedation the choice of being treated in the ground floor surgery if they were uncomfortable walking up and down the stairs.

Access to the service

The practice displayed its opening hours in the premises and on the practice website. Patients could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service on the telephone answering machine.

Concerns & complaints

The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint. Staff told us they raised any formal or informal comments or concerns with the practice manager to ensure responses were made in a timely manner. Information for patients about how to make a complaint was available at the practice.

We looked at the complaints that the practice had received in the last 12 months and found that they had been recorded, analysed, investigated and learning had been identified. We found that complainants had been responded to in a timely manner. The practice had identified a theme regarding communication from some of these complaints and taken steps to address that issue. One example was when the principal dentist recommended that staff attend a course on improving communication skills. Any learning identified was cascaded to staff at team meetings or personally to individual team members if relevant.

We also looked at entries made by patients on the NHS choices website. The practice had responded to all of these entries (both positive and negative). It was evident from the records that the practice had been open and transparent with the patient.

Are services well-led?

Our findings

Governance arrangements

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, effective recruitment procedures and staff knowledge surrounding safeguarding.

We saw risk assessments and the control measures in place to manage those risks, for example fire risk assessment. Regular audits are imperative for identifying any compromise in quality and/or safety. Subsequently, it is important to identify any areas of improvement and then take steps in response. We saw several audits but some were incomplete or lacking in detail. For example, the X-ray audits did not all have gradings for the relevant X-ray images. Another example was the infection control audit – we saw the results but there were no outcomes or improvements identified. In contrast, the record keeping audits were very thorough and complete. The principal denttist said they intended to start undertaking regular and completed audits to ensure that high quality and safe care was being provided to patients.

The practice manager was in charge of the day to day running of the practice. We saw there were some systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had some governance arrangements in place to ensure that those risks were identified, understood and managed appropriately. The practice was a member of the BDA (British Dental Association) Good Practice scheme. (This is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities).

There were a range of policies and procedures in use at the practice. The practice held monthly staff meetings involving all staff where governance was discussed. We saw evidence that the staff meetings were minuted so that staff on leave could update themselves on latest developments.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff we spoke with told us that they felt supported and were clear about their roles and responsibilities. Staff told us they felt valued and were able to contribute ideas. Staff members described a good working relationship with each other.

Leadership, openness and transparency

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

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant. All staff members were encouraged to complete evaluation and this was an effective method of obtaining feedback. All staff were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead and medical emergencies lead.

Learning and improvement

Staff told us they had good access to training and the principal dentist monitored staff training to ensure essential staff training was completed each year. This included emergency resuscitation and immediate life support and infection control.

Staff working at the practice were supported to maintain their Continuous Professional Development (CPD) as required by the General Dental Council (GDC). Staff also had access to online training which recorded their CPD.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography – both the quality of X-ray images and compliance with the FGDP regarding appropriate selection criteria, patient records and consent.

The audits included the actions arising from them to ensure improvements were made. The practice held monthly staff meetings where learning was disseminated.

All staff had annual appraisals where learning needs, concerns and aspirations could be discussed.

Are services well-led?

We saw evidence that the principal dentist carried out reflection logs for every patient that had been sedated. This was to encourage continuous improvement.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice. Staff we spoke with told us their views were sought and listened to. The practice had systems in place to involve, seek and act upon feedback from people using the service. This included a comments book, patient surveys and a suggestions box. The most recent patient survey questionnaire was in April 2015. The practice said there was a very low uptake so they had reverted to comments placed in the suggestions box. The practice undertook a questionnaire about communication within the practice. Many of the patients commented that English was not their first language so the practice responded by providing patient information leaflets in various languages. The practice also undertook the NHS Family and Friends Test.

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 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)