

Mr Kulwant Singh

# Cheslyn Hay Dental Practice

## Inspection Report

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### Overall summary

#### Background

Cheslyn Hay Dental Practice has three dentists, one who works full time and the other two who each work part time, a dental hygienist, two qualified dental nurses who are registered with the General Dental Council (GDC) and a trainee dental nurse. The practice's opening hours are 9am to 5.30pm Monday to Friday and 9am to 1pm on Saturdays.

Cheslyn Hay Dental Practice provides private treatment for both adults and children. The practice is situated on the ground floor of a converted residential property, the first floor is still utilised as living accommodation. The practice had two dental treatment rooms; both on the ground floor and a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and waiting area and a staff meeting room which could also be used for private discussions with patients if required.

The practice owner 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.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 30 completed cards and spoke to three patients. These provided a positive view of the services the practice provides. All of the patients commented that the quality of care was excellent.

We carried out an announced comprehensive inspection on 1 December 2015 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

#### Our key findings were:

- Staff had been trained to handle emergencies and appropriate medicines and life-saving equipment was readily available in accordance with current guidelines.
- The practice was visibly clean and well maintained.
- Infection control procedures were robust and the practice followed published guidance.
- The practice had a dedicated safeguarding lead with effective safeguarding processes in place for safeguarding adults and children living in vulnerable circumstances.
- The practice had enough staff to deliver the service.
- Staff recruitment files were well organised and complete.

# Summary of findings

- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Staff we spoke to felt well supported by the registered manager and were committed to providing a quality service to their patients.
- Information from 30 completed CQC comment cards gave us a completely positive picture of a friendly, caring and professional service.
- The practice had a rolling programme of clinical audit in place.

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

- Appropriate signage should be placed on doors of rooms where X-rays are located.
- Update the training matrix to record the up to date training details for staff.

# 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 care which was safe in accordance with the relevant regulations.

There were systems in place to help ensure the safety of staff and patients. The practice had robust arrangements for infection control, clinical waste control, maintenance of equipment and the premises and dental radiography (X-rays). Staff had received training and equipment and medicines were available to respond to medical emergencies. There were sufficient numbers of suitably qualified staff working at the practice. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. The practice followed procedures for the safe recruitment of staff, this included carrying out Disclosure Barring Service (DBS) checks, and obtaining references.

### **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. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The staff received professional training and development appropriate to their roles and learning needs. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

### **Are services caring?**

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

Feedback from patients was that they were treated with dignity and respect. We were told that all staff were friendly, professional and caring. All of the patients commented that the quality of care was very good. We observed that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

### **Are services responsive to people's needs?**

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

Patients had good access to treatment and urgent care when required. Dental treatment rooms were on the ground floor enabling ease of access into the building for patients with mobility difficulties and families with prams and pushchairs. The practice's complaints policy was available to patients in the waiting room as well as in a folder containing other practice policies which may be of interest to patients.

### **Are services well-led?**

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

There were good governance arrangements and an effective management structure in place. Regular staff meetings were held and information governance was discussed at these meetings. Staff said that they felt well supported and could raise any issues or concerns with the registered manager.

# Cheslyn Hay Dental Practice

## Detailed findings

### Background to this inspection

We carried out an announced, comprehensive inspection on 1 December 2015. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

We informed NHS England area team that we were inspecting the practice, however there were no immediate concerns from them.

During our inspection visit, we reviewed policy documents and staff records. We spoke with four members of staff, including the registered manager. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and

the computer system that supported the patient treatment records and patient dental health education programme. We reviewed comment cards completed by patients and spoke to three patients. Patients gave very positive feedback about their experience at the practice.

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

We were told about the systems in place for reporting and learning from incidents. An accident reporting book was available but there had been no accidents recorded within the previous 12 months. Staff spoken with said that there had been no accidents, including sharps injuries at the practice. A significant events file was available. This contained detailed protocols and policies to guide staff of the action to take when reporting a significant event. Significant event reporting forms and review forms were available on file. We saw that the practice had recorded one significant event. This related to a delay in checks on a piece of equipment at the practice. This equipment was on a service contract; however the contractor had not undertaken the annual service. Learning outcomes were recorded on the significant event form as well as action taken to ensure that incidents such as this did not reoccur. We saw that significant events were a routine topic of discussion at practice meetings and discussions had taken place regarding the significant event recorded.

Guidance was also available regarding reporting of incidents, diseases and dangerous occurrences regulations (RIDDOR). Staff spoken with were aware of RIDDOR and what should be reported.

We saw that the practice had a 'being open policy. This gave guidance to staff regarding duty of candour and where appropriate apologising and telling patients when they were affected by something that had gone wrong. Staff spoken with were aware that patients and other relevant persons would be provided with information, support and an apology in the event of a patient safety incident.

The registered manager received national alerts regarding patient safety via email. These were printed and kept in a file. Discussions were held with staff as appropriate to ensure they were acted upon.

### Reliable safety systems and processes (including safeguarding)

The registered manager acted as the practice safeguarding lead. This individual acted as a point of referral should members of staff encounter a child or adult safeguarding

issue. Staff spoken with were aware who held this role. We saw training records to demonstrate that all staff had completed safeguarding vulnerable adults and children training within the last 12 months.

Information was available to guide staff regarding signs of abuse or neglect and how to raise concerns. Forms were available to enable staff to report suspicions of abuse. Detailed policies were in place in relation to safeguarding vulnerable adults and children. These policies recorded contact details of external contacts to report any suspicions of abuse, such as the local authority responsible for investigations. The practice reported that there had been no safeguarding incidents that required further investigation by appropriate authorities.

We spoke to a dental nurse and the registered manager about the prevention of needle stick injuries. We were told that the treatment of sharps and sharps waste was in accordance with the current EU directive with respect to safe sharp guidelines, thus protecting staff against blood borne viruses. The practice used a system whereby needles were not resheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist. The practice had a detailed protocol in place regarding needle stick injuries and the action to take should a needle stick injury occur. The systems and processes we observed were in line with the current EU Directive on the use of safer sharps.

We asked about the instruments which were used during root canal treatment. The registered manager explained that these instruments were single use only. We were told that root canal treatment was carried out where practically possible using a rubber dam. (A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work). Patients could be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

### Medical emergencies

Arrangements were in place to deal with medical emergencies at the practice. The practice had an oxygen cylinder and other related items such as manual breathing aids but did not have a suction device or an automated

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external defibrillator (AED). However, we saw evidence that this had been ordered and following our inspection we were told that the AED had been received at the practice. (An AED is 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 registered manager told us that they had recently disposed of the old suction device and a new one had been ordered and was confirmed for delivery on 18 December 2015.

The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The emergency drug kit was kept in a secure location but was easily available to all staff. All staff were aware of the location of the emergency medicines and equipment. All emergency medicines and oxygen were in date. The expiry dates of medicines and equipment were monitored using a daily, weekly and monthly check sheet which enabled the staff to replace out of date drugs and equipment promptly. One emergency medicine was stored in the fridge and staff were monitoring the temperature of the fridge on a daily basis. This helped to ensure that the medicines was stored within manufacturer's guidelines. The practice held training sessions for the whole team to maintain their competence in dealing with medical emergencies on an annual basis and we saw that this training was up to date.

Training records demonstrated that a number of staff at the practice had undertaken first aid training. We saw that a first aid kit was available which contained sufficient equipment which was being monitored to ensure it was within its expiry date.

## **Staff recruitment**

The practice had a recruitment policy that described the processes to follow when employing new staff. We checked the employment file of the two members of staff most recently employed at the practice. We found that appropriate employment procedures had been followed. Employment files contained details of the staff member's professional registration (where appropriate) and their training certificates. Information was available regarding the immunisation status for each member of staff. We saw that Disclosure and Barring Service checks (DBS) had been completed for all staff. These are 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 evidence that newly employed staff had a period of induction to familiarise themselves with practice procedures and complete mandatory training such as health and safety and infection control, before being allowed to work unsupervised. The dental hygienist told us that when the practice was taken over by the new registered manager in 2013 all staff were required to complete induction training to ensure that they were working in accordance with the practice's policies, protocols and systems of working. We were told that the induction was very good, provided update training and gave a detailed insight into how the practice was run.

Sufficient numbers of staff were on duty to ensure that the reception area was not left unmanned at any time. Duty rotas recorded the job role of the dental nurse for the week; all dental nurses were expected to work on the reception as well as undertaking clinical duties. There were enough staff to support the dentists and hygienist during patient treatment. Two of the dental nurses supporting the dentists were qualified and registered with the General Dental Council (GDC) and there was also a trainee dental nurse.

Systems were in place to ensure that the service was uninterrupted during times of annual or unexpected leave. Staff were asked to book leave at least two months in advance to enable cover to be provided. Cover arrangements included asking part time staff to work additional hours for both dentists and dental nurses or the use of agency dental nurses. Staff confirmed that they were required to provide cover to ensure that there continued to be enough staff for the smooth running of the practice. We were also told that agency nurses had been used within the last 12 months.

## **Monitoring health & safety and responding to risks**

The practice had systems, processes and policies in place to monitor and manage risks to patients, staff and visitor to the practice. A number of audits and risk assessments were carried out including a fire and separate legionella risk assessment undertaken by an external specialist company. Other assessments included a health and safety compliance audit, a practice risk assessment control of substances hazardous to health (COSHH) and risk assessments regarding lone working, slips trips and falls and working in the sluice room. We saw that action plans were in place where necessary and some actions had been

# Are services safe?

taken to address issues raised. The practice had a detailed business continuity plan to deal with any emergencies that may occur which could disrupt the safe and smooth running of the service.

A health and safety policy was in place and a health and safety at work poster was on display in the reception area. We saw that staff had completed health and safety and fire training. Fire alarm checks were undertaken weekly. An external agency provided fire protection equipment servicing. We saw that staff had undertaken fire drills and these were carried out on a six monthly basis.

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies.

## **Infection control**

On the day of inspection the two dental treatment rooms, waiting area, reception and toilets were visibly clean, tidy and clutter free. Patient feedback reported that the practice was always clean and tidy. Environmental cleaning was carried out by a cleaner employed by the practice in accordance with the national colour coding scheme and cleaning schedules and a cleaning protocol were available for inspection.

We discussed infection prevention and control with the registered manager and we saw policies and records kept. We were told about the decontamination of the general treatment room environment following the treatment of a patient and we saw that daily checklists were completed to demonstrate that the working surfaces, dental unit and dental chair were decontaminated.

Hand washing facilities were available including wall mounted liquid soap, hand gels and paper towels in each of the treatment rooms and toilets. Personal protective equipment (PPE) such as disposable gloves and aprons was available for staff and patient use as appropriate. Staff uniforms ensured that staff were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. Hand washing protocols were also displayed appropriately in various areas of the practice including patient toilets.

Maintenance of dental water lines took place to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings). We were told about the methods

used which were in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out at the practice by a competent person in September 2014. We saw evidence that a review was due to be carried out in September 2016. Records were kept of hot and cold water temperatures which were being monitored on a monthly basis. These measures ensured that patients' and staff were protected from the risk of infection due to Legionella.

The practice utilised a separate decontamination room for instrument processing. This room was very well organised and was clean, tidy and clutter free. A dental nurse demonstrated the decontamination process to us from taking the dirty instruments through to clean and ready for use again. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. Sufficient amounts of personal protective equipment (PPE) such as gloves, aprons and eye goggles were available and the member of staff used these as appropriate throughout the decontamination process. Two separate sinks plus dedicated hand washing facilities were available in this room. Hand washing posters were on display to remind staff of the correct technique to follow for effective infection prevention and control.

Protocols were displayed on the wall to remind staff of the processes to be followed at each stage of the decontamination process. A sharps injury poster was also on display.

We saw that instruments were manually scrubbed and then inspected under an illuminated magnifier before being placed in an autoclave (a machine used to sterilise instruments). The practice used a non-vacuum autoclave. When instruments had been sterilized they were pouched and stored appropriately until required. All pouches were dated with an expiry date in accordance with current guidelines. Records were kept to monitor expiry dates. All of the instruments seen in the drawers of a dental treatment room were pouched and it was obvious which items were single use and these were clearly new.

We saw that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively. These included the automatic control test and steam penetration test. Maintenance records were kept which demonstrated that equipment was serviced and maintained on a regular basis. Records seen were up to date.

# Are services safe?

We observed that sharps containers, clinical waste bags and municipal waste were properly maintained and the segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. Policies were in place regarding waste management and all waste was stored in accordance with this policy in a separate locked room within the practice. An appropriate contractor was used to remove dental waste and we saw waste consignment notices which demonstrated that waste was collected from the practice on a regular basis. Patients could be assured that they were protected from the risk of infection from contaminated dental waste.

There were effective systems in place to reduce the risk and spread of infection within the practice. The registered manager was the infection control lead. It was demonstrated through a description of the end to end process and a review of practice protocols that HTM 01 05 Essential Quality Requirements for infection control was being exceeded. (HTM 01 05 is national guidance for infection prevention control in dental practices) It was observed that a current audit of infection control processes confirmed compliance with HTM 01 05 guidelines.

## **Equipment and medicines**

Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example the autoclave had been serviced and calibrated in November 2015. The practices' X-ray machines had been serviced and calibrated in January and April 2015. Portable appliance testing (PAT) for all electrical appliances had been carried out in February 2015 and compressor vessel checks undertaken in January and November 2015.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients. Antibiotics were dispensed from the practice. These were securely stored and stock records were kept which included the dosage given and patient details. All antibiotics seen were within their expiry date.

The practice carried out occasional conscious sedation - (these are techniques in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained). We saw that medicines used for sedation were securely stored.

Some essential equipment was available for this procedure for example a pulse oximeter (a finger probe that measures the amount of oxygen in the blood through the nail bed) and a blood pressure machine (sphygmomanometer). Others were missing, for example a portable suction device and the automated external defibrillator (AED) the registered manager confirmed that they would not do any more sedation procedures until these pieces of equipment, which had been ordered, were available at the practice.

## **Radiography (X-rays)**

We were shown a well maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER). This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. At this location two of the dentists acted as the Radiation Protection Supervisor for their dental treatment room. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

Dental care records seen where X-rays had been taken showed that when dental X-rays were taken they were justified, reported on and quality assured. These findings showed that the practice was acting in accordance with national radiological guidelines and patients and staff were protected from unnecessary exposure to radiation.

The surgery doors did not display notices conforming to legal requirements to inform patients that X-ray machines were located in the room. The registered manager confirmed that this would be actioned immediately.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

Discussions with the registered manager showed they were aware of NICE guidelines, particularly in respect of recalls of patients and antibiotic prescribing. Consultations, assessments and treatment was carried out in line with recognised general professional guidelines. We reviewed patient records including one for a patient who had received emergency treatment. We saw that a new computer system was introduced in July 2015 and all dentists now worked with computerised records which were found to be detailed and up to date.

The registered manager described to us how they carried out their assessment of a patient. The assessment began with the patient completing a medical history questionnaire disclosing any health conditions, medicines being taken and any allergies suffered. We saw evidence that the medical history was updated at subsequent visits. This was followed by an examination covering the condition of a patient's teeth, gums and soft tissues and any signs of mouth cancer. Dental care records seen showed that the findings of the assessment and details of the treatment carried out were recorded appropriately. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. We were told that fluoride varnish was applied to the teeth of all children aged three to 18 and to adults with a high dental caries risk.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice, details of smoking cessation and general dental hygiene procedures such as brushing techniques. Patients were shown information regarding treatment options on the practice's computer system. The patient dental care record was updated with the proposed treatment after discussing options with the patient. A treatment plan was then given to each patient and this

included the cost involved and a copy was kept on patient records. Patients were monitored through follow-up appointments and these were scheduled in line with their individual requirements.

The practice regularly undertook a three monthly audit of the clinical record keeping, which served to ensure that accurate contemporaneous records were maintained for all patients at the practice.

### Health promotion & prevention

The waiting room at the practice contained literature in leaflet form that explained how to reduce the risk of poor dental health.

Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Tooth brushing techniques were explained to them in a way they understood and dietary, smoking and alcohol advice was also given to them. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. The dental care records we observed demonstrated that dentists had given oral health advice to patients.

### Staffing

Practice staff included the registered manager, and two part time dentists; one of whom worked only two Saturdays per month at the practice but would also provide cover at times of annual leave. A dental hygienist also worked part time and two qualified and one trainee dental nurses provided support. A cleaner was also employed by the practice. Staff spoken with said that they enjoyed their work and said that all staff worked together well as a team.

The practice had a training policy which recorded the annual training that staff must undertake for example safeguarding, fire safety and basic life support. The training file contained guidance documents for staff, for example; day to day reception duties, start of the day and end of the day procedures. We were told that these were available as a reminder for staff if required. We saw that the registered manager had sent memos to all staff informing them that they were required to attend training. Staff confirmed that they received regular training including training in cardio pulmonary resuscitation (CPR), infection control, child protection and adult safeguarding and other specific dental topics. Dental nurses and the hygienist received an

# Are services effective?

(for example, treatment is effective)

annual appraisal in which training requirements were discussed. We saw that staff kept records to ensure that they met their continuing professional development (CPD) requirements. CPD is a compulsory requirement of registration as a general dental professional.

The practice had developed a training matrix which recorded details of training courses undertaken by all staff. Staff said that this could be used to ensure that staff had attended the necessary training and updates. We saw that this document was not up to date and did not record details of all training undertaken by staff, for example mental capacity act and radiography training.

Staff told us that they were supported to attend training courses appropriate to the work they performed and to develop their skills. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Records showed professional registration with the GDC was up to date for all relevant staff.

## **Working with other services**

The practice had suitable arrangements in place for working with other health professionals to ensure quality of care for their patients. Referrals were made when required to other dental specialists. Patients were given the choice of a private or NHS referral. For example those patients who required specialist oral medicine or surgery were referred to a local hospital or a specialist practice in Walsall. Referrals were made by telephone for those patients with

suspected oral cancer and monitoring was undertaken to ensure appointments were attended. Internal referrals were also made to the dental hygienist and notes made in patients' records. The practice kept a copy of all referral letters and patients were offered a copy of any correspondence.

## **Consent to care and treatment**

We spoke to the registered manager on the day of our visit who had a clear understanding of consent issues. They explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. We saw that consent forms were signed before each treatment. Patients spoken with confirmed that the dentists took great care when explaining care and treatment to ensure they had an understanding of their treatment options. We saw that information leaflets were available for patients regarding all complex treatments. This helped them to make an informed decision before agreeing to any treatment.

We discussed the mental capacity act with the registered manager. We saw records to confirm that staff had completed training regarding this. The registered manager was aware of the mental capacity act and explained how they would obtain consent from a patient who suffered with any mental impairment which may mean that they might be unable to fully understand the implications of their treatment. We saw that as well as the practice's own policy regarding mental capacity, British Dental Association (BDA) and other guidance was available for staff.

# Are services caring?

## Our findings

### **Respect, dignity, compassion & empathy**

The waiting area was situated away from the reception area which helped to ensure that conversations held at the reception desk could not be heard by patients waiting to be seen. Staff spoken with said that they had all signed a confidentiality agreement and were aware of the steps to take to keep personal information confidential. We observed staff greeting patients in a friendly and helpful manner. Feedback from patients confirmed that they were treated with respect and privacy and dignity was always maintained. We saw copies of data protection leaflets available in the waiting room for patients, these gave information regarding patients' rights to access their personal information and how to access them. There was also a folder in the waiting area which contained some of the practice's procedures for patients to view. The practice's confidentiality policy was available in this folder.

Treatment rooms were situated away from the main waiting area and we saw that doors were able to be closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy. Patients' clinical records were stored electronically as a new computer system had recently been installed. Some paper records were available but these were securely stored in lockable cabinets. Computers were password protected and regularly backed up to secure storage. Practice computer screens at reception were not overlooked which ensured patients' confidential information could not be viewed at reception.

Patients who were anxious about dental treatment told us that the dentist always put them at their ease. Comment cards received also recorded that the dentist and all staff were professional, caring and patients had trust in the staff. Dental nurses we spoke with explained the steps they took to ensure that patients felt at ease and were not anxious about receiving dental treatment. This included inviting anxious patients to wait in a separate room prior to their treatment and explaining the treatment to patients in detail, giving them the option to stop the process at any time if they felt uncomfortable.

### **Involvement in decisions about care and treatment**

The practice provided clear treatment plans to their patients which detailed possible management options and indicative costs. A poster detailing private treatment costs was displayed in the reception area and was available in the patient folder in the waiting area. Feedback from patients confirmed that they were involved in all decisions about care and treatment and we were told that the dentists were very good at giving detailed information in a way that patients could understand to help them make decisions. Patient notes we saw recorded information given to patients about treatment options and costs. The registered manager told us that when needed patients were given written information and were able to consider their treatment options at home before making a decision.

We spoke with the registered manager about the Gillick competency test. The test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions about their care and treatment. The registered manager demonstrated a good understanding of Gillick principles.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

A patient information folder was available in the waiting area. This contained some of the practice's policies which were relevant to patients such as complaints and confidentiality. Information regarding costs and opening times was also available. A variety of information leaflets were on display in the waiting room and we were told that dentists could print off more detailed information for patients if required.

We looked at the appointment schedules and found that adequate time slots were given for appointments of varying complexity of treatment. Feedback from patients was positive. We were told that the dentist took their time to explain treatments in detail and also made time to exchange polite conversation which patients said made them feel relaxed and at ease.

Patients we spoke with said that they found it easy to get a routine appointment and were generally seen within a few minutes of their appointment time. Waiting time audits had been completed on a six monthly basis. We saw that patients were generally seen within five minutes of their allocated appointment.

The feedback we received from patient comment cards was positive. Patients described their care as excellent; we were told that the dentist and all staff were professional, thorough and offered flexibility for appointments to meet people's needs.

### Tackling inequity and promoting equality

The practice was located in the ground floor of a converted residential property. Dental treatment rooms were located on the ground floor which enabled access for patients with mobility difficulties. There was no disabled toilet facility at this practice.

Staff told us that all patients registered at the practice were able to speak English and there was currently no need for an interpretation service. However, we saw that details of interpretation services were on display in the waiting room and patients were advised to inform reception staff if interpreters were required. We also saw that the practice leaflet recorded a statement that the leaflet could be translated into other languages on request. Staff confirmed that an interpretation service was available if required.

There was no hearing loop at the practice. Staff told us that currently there were no patients who had severe hearing difficulties and who would need special support or equipment. We saw that the need for a hearing loop had been identified in the disability discrimination act audit that had recently been completed. A best practice action plan had been developed by the practice which recorded that a hearing loop would be purchased in the near future.

### Access to the service

The practice is open Monday to Friday between the hours of 9am to 5.30pm and on a Saturday from 9am to 1pm. The routine opening hours were on display within the practice and were available on the website and practice leaflet. When treatment was urgent, patients would be seen on the same day. Patients spoken with during the inspection confirmed this. Appointments could be made in person or by telephone. The patient information leaflet and practice website gave details of arrangements to ensure patients received urgent assistance when the practice was closed.

Feedback received demonstrated that patients had satisfactory access to the service and did not have difficulty getting through to the practice on the telephone. We were told that the practice was flexible and tried to ensure that appointments were made at a time to suit patient need.

We were told that when the new computer system was introduced patients with mobile telephones were able to receive a text message reminder. Reception staff also telephoned patients who did not have mobile phones to remind them of their appointments.

### Concerns & complaints

Information for patients about how to complain was on display and also available in the folder in the waiting area. This gave details of who to speak to within the practice and the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example the General Dental Council and Dental complaints service for complaints about private treatment. The practice leaflet also requested patients to speak with the practice if they had any concerns or complaints.

There was a designated complaints lead and staff were aware who held this role. Staff told us that any formal comments or complaints received were forwarded to the registered manager for action and to ensure that these

# Are services responsive to people's needs?

(for example, to feedback?)

were responded to. Staff told us that they would try and respond to verbal complaints as and when they occurred. All details would be forwarded to the registered manager and patients who remained unsatisfied would be offered a meeting with the registered manager. The practice had a complaint folder in which any formal complaints would be logged. The practice had not received any formal complaints within the past 24 months. Detailed protocols

and policies were available to guide staff of the action to take if complaints were received. Staff told us that complaints would be discussed at practice meetings if relevant and we saw that complaints were a standard agenda item for each practice meeting. This helped to ensure that staff learned and took appropriate action to ensure similar issues did not arise in the future.

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## Our findings

### **Governance arrangements**

The practice had governance arrangements in place such as various policies and procedures for monitoring and improving the services provided for patients and systems to ensure risks were identified and managed appropriately. For example, there was a recruitment health and safety, infection prevention and control policy and child and adult safeguarding policies. Staff were aware of the location of the policy folders which were stored in the back of the reception area. Staff were aware of their roles and responsibilities within the practice and were also aware who held lead roles within the practice. Information governance was a standard agenda item on each practice meeting.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. These included six monthly infection prevention and control audit, three monthly clinical record keeping, and six monthly waiting time audits. We saw evidence to demonstrate that all audits and risk assessments were reported on and action plans completed. This practice undertook sedation and we saw that an audit had been undertaken regarding sedation in October 2015.

### **Leadership, openness and transparency**

There was an effective management structure in place to ensure that responsibilities of staff were clear. The registered manager was in charge of the day to day running of the service. Staff we spoke with were aware of their roles and responsibilities and who within the practice held any delegated lead roles, such as complaints, infection control and safeguarding. Staff told us that the registered manager was approachable and helpful. We were told that staff worked well as a team and all helped each other. We saw minutes of the practice meetings held in 2015. Staff told us that they were confident to raise issues during staff meetings and at appraisal meetings. Staff told us that the registered manager listened to them and was always willing to try new methods which improved services provided to patients. We saw that memos were sent to update staff regarding any changes at the practice. For example we saw a memo regarding the new computer system which was implemented. There was an open culture at the practice which encouraged candour and

honesty. We saw that the practice had a being open policy which encouraged staff to discuss mistakes with patients and others involved in order to make improvements to services.

### **Learning and improvement**

We found that the practice had developed a best practice action plan which recorded actions to be taken which had been identified during various audits undertaken at the practice. For example the disability discrimination audit identified the need for a hearing loop. There was a rolling programme of clinical and non-clinical audits taking place. We saw evidence of action plans detailing action taken to address issues identified as necessary.

The practice had developed a training matrix which recorded some of the training undertaken by staff. This document required updating to record all training undertaken. Staff kept copies of training certificates which demonstrated that staff were up to date with their training. Staff confirmed that they were given opportunities to undertake training and training was discussed during their appraisal meeting. We saw the CPD logs for the registered manager and two dental nurses. We saw that staff were up to date with their CPD. CPD must be completed for continued registration with the General Dental Council (GDC).

Three formal practice meetings had been held during 2015. We were told that informal 'get together' meetings were held as needed to discuss key issues. The registered manager also sent memos to staff to provide any updates as required. Staff confirmed that discussions were held as needed and they would not wait until the next planned staff meeting to discuss issues or concerns.

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

Staff we spoke with told us that they felt involved at the practice and were encouraged to speak out. Staff said that they felt confident to raise issues at practice meetings or approach the registered manager. We were told that the registered manager listened to staff and always looked into suggestions made.

Patients spoken with said that staff were friendly and approachable. None of the patients had ever made a complaint but all felt confident to do so if required. We saw

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that a copy of the complaint procedure was on display in the waiting room and also in the patient information folder available in the waiting room. Patients reported having a good relationship with all staff.

A patient satisfaction survey was undertaken in April 2015. Staff confirmed that this was the first survey that had been completed within the past 24 months. We were told that satisfaction surveys would be undertaken on an annual

basis. A suggestions box with paper and pens was available in the waiting room. Staff said that any comments made were passed on to the registered manager. Details were reviewed and discussed at staff meetings if relevant. A comments book was available on reception and we saw that patients had recorded note of praise and thanks for the services provided. Quality assurance policies were in place.