Rodericks Limited

# Blackbrook Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 28 July 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

We found this practice was not providing safe care in accordance with the relevant regulations and requires improvement.

**Are services effective?**

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

**Are services caring?**

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

**Are services responsive?**

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

**Are services well-led?**

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

**Background**

CQC inspected the practice on 19 November 2014 and asked the provider to make improvements regarding legal requirements relating to cleanliness; infection control and monitoring the quality of the service provided. We checked these areas as part of this comprehensive inspection and found they had mostly been resolved.

The practice offers mainly NHS treatment and some private treatment services for its patient population. Blackbrook Dental Surgery has four dentists one of whom offers an orthodontic (tooth alignment) service. There is a practice manager, one dental hygienist, five trainee dental nurses and two receptionists. At the time of our inspection there were four dentists supported by trainee dental nurses on duty to meet the demands of the patient population. The practice manager was also in attendance.

The practice manager 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.

# Summary of findings

The practice is open Monday, Wednesday and Thursday 8.15am to 5.15pm, Tuesday 8.15am to 7.00pm, Friday 8.15am to 4.15pm. The service is closed at weekends but offers an Out of Hours service via the local NHS community dental services.

We spoke with eight patients who used the service on the day of our inspection and reviewed 20 Care Quality Commission (CQC) comment cards that had been completed by patients prior to the inspection. The patients we spoke with were very complimentary about the service. They told us they found the staff to be extremely friendly and welcoming and felt they were treated with dignity and respect. The comments on the CQC comment cards were also very complimentary about the staff and the service provided.

We found the practice was effective in treatments provided, caring and responsive to patients needs and well led by the practice manager. We found the provider and manager had taken action to address the areas of non-compliance found at the last inspection.

We found the practice had not carried out appropriate checks on staff for example a Disclosure and Barring check (DBS) prior to their employment at the practice. A DBS check identifies whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. All the dental nurses employed at the practice are trainee nurses who do not have the relevant training skills and knowledge of registered dental nurses. However some trainees are undertaking a dental nurse apprenticeship course with a local provider.

**Our key findings were:**

- Patients' needs were assessed and care was planned in line with best practice guidance such as that from the National Institute for Health and Care Excellence (NICE). NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure every NHS patient gets fair access to quality treatment.
- There were effective systems in place to reduce and minimise the risk and spread of infection.
- Equipment, such as the air compressor, autoclave (steriliser), fire extinguishers, and X-ray equipment had all been checked for effectiveness and had been regularly serviced.
- The practice had effective safeguarding processes in place and staff understood their responsibilities for safeguarding adults living in vulnerable circumstances and children.
- Staff reported incidents and kept records of these which the practice used for shared learning.
- The patients we spoke with and all the comment cards we reviewed indicated patients were consistently treated with kindness and respect by staff. It was reported communication with patients and their families, access to the service and to the dentists, was good. Patients reported good access to the practice with emergency appointments available the same day.
- The practice had implemented clear procedures for managing comments, concerns or complaints.

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

- Ensure records of identification checks are included in staff personnel files and use current DBS checks. Ensure risk assessments are in place to assess the need for criminal record checks for non-clinical staff or those for whom no completed DBS check has been received.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of patients using the service; by reviewing the skill mix of trained and trainee dental nurses in the practice for the safety and protection of patients.

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:

- Review the management of prescriptions issued to ensure an audit trail is available for all prescriptions issued.

# Summary of findings

- Review corporate leadership and management involvement and support to the practice; to ensure good leadership and an open, transparent culture between the location and the provider.

# 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 this practice was not providing safe care in accordance with the relevant regulations and requires improvement. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

We found the practice had not carried out appropriate checks on staff for example a Disclosure and Barring check (DBS) prior to their employment at the practice. All the dental nurses employed at the practice were trainee nurses who did not have the relevant training, skills and knowledge of registered dental nurses. However some were undertaking a dental nurse apprenticeship course with a local provider.

The practice was safe in other areas. We found they had systems and protocols which were used to minimise the risks associated with providing dental services. We found the equipment used in the practice was well maintained and checked for effectiveness.

There was a safeguarding lead person and staff understood their responsibilities in terms of identifying and reporting potential abuse.

There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The practice had policies and protocols, which staff were following, for the management of infection control, medical emergencies and dental radiography.

**Are services effective?**

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

National Institute for Health and Care Excellence (NICE) and local clinical guidelines were considered in the delivery of dental care and treatment for patients. The treatment provided for the patients was effective, evidence based and focussed on the needs of the individual. The practice monitored patients' oral health and gave appropriate health promotion advice. Staff explained the treatment options to patients to ensure they could make informed decisions.

The practice worked well with other providers and followed up on the outcomes of referrals made to other providers. Staff engaged in continuous professional development (CPD) and were meeting the training requirements of the General Dental Council.

**Are services caring?**

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

We received positive feedback from patients about the quality of the care provided at the practice. They felt the staff were patient and caring. Patients told us they were treated with dignity and respect at all times. We found patient records were stored securely and patient confidentiality was well maintained.

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

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

Patients had good access to appointments, including emergency appointments, which were available on the same day. The needs of people with disabilities had been considered and there was level access to the waiting area and treatment rooms on the ground floor. Patients were invited to provide feedback via a satisfaction survey and a feedback box situated in the waiting room.

# Summary of findings

There was a complaint policy which was displayed in the waiting room. The practice manager followed the complaint policy in terms of carrying out and recording investigations of complaints received. The clinical staff described to us how learning from complaints had been implemented to ensure issues did not recur.

**Are services well-led?**

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

The practice had clinical governance and risk management protocols in place. These were disseminated effectively to all members of staff. A system of audits was used to monitor and improve performance. Staff described an open and transparent culture at the practice location where they were comfortable raising and discussing concerns with the practice manager. Feedback from staff and patients was used to monitor and drive improvement in standards of care.

However, we noted that some records relating to staff recruitment had not been kept in line with the safer recruitment guidance and company policy. We discussed this with the practice and area manager present during the inspection. They assured us these documents would now be obtained and kept on file.

# Blackbrook Dental Practice

**Detailed findings**

## Background to this inspection

We carried out an announced, comprehensive inspection on 28 July 2015. The inspection took place over one day. The inspection was led by a Care Quality Commission (CQC) inspector. They were accompanied by a specialist advisor.

We reviewed the areas of non-compliance found at the last inspection and the information received from the provider prior to the inspection. The practice sent us their statement of purpose, staffing levels and a summary of complaints they had received in the last 12 months. We also informed the NHS England area team and the local Healthwatch we were inspecting the practice; however we did not receive any information of concern from them.

During our inspection visit, we reviewed policy documents and dental care records. We spoke with eight members of staff, including four of the dentists. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We observed dental nurses carrying out decontamination procedures of dental instruments and also observed staff interacting with patients in the waiting area.

20 people had completed CQC comment cards and provided feedback about the service. Patients we spoke with, and those who completed comment cards, were positive about the care they received from the practice. They were complimentary about the friendly and caring attitude of the dental staff.

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**

There was an effective system in place for reporting and learning from incidents. There had been no incidents recorded since our last inspection in November 2014. There was a policy for staff to follow for the reporting of these events and we heard from staff how this would be implemented when an incident happened.

Staff meetings were convened monthly and any points of learning from incidents or audits were a regular agenda item. We were told this was where the wider learning points from an incident or audit could be disseminated and any necessary change in protocol discussed and disseminated to all staff. We saw in the minutes for June 2015 meeting and the July 2015 meeting learning from the last inspection had been discussed and implemented. All staff present had signed an attendance sheet. For staff not present the manager ensured they were updated with information shared at the meeting.

We noted it was the practice policy to offer an apology when things went wrong. We saw an example of how the provider had exercised their duty of candour with a written apology that had been offered following a patient's complaint.

Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There had been no accidents or incidents which had required notification under the RIDDOR guidance.

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

The practice had policies and procedures in place for child protection and safeguarding vulnerable adults. This included contact details for the local authority safeguarding team, social services and other agencies, such as the Care Quality Commission. This information was available in folders in each surgery so staff could access the information promptly. These details were also kept with the safeguarding policy and in the manager's office.

The practice manager was the safeguarding lead person for the protection of vulnerable children and adults. At the last inspection we found some dental practitioners had not completed safeguarding training. During this inspection we saw evidence all staff had completed safeguarding training and were able to describe what might be signs of abuse or neglect and how they would raise concerns with the safeguarding lead person.

Staff were aware of the practice policy in relation to raising concerns about another member of staff's performance (a process sometimes referred to as 'whistleblowing'). Staff told us they knew they could raise such issues with one of the dentists or practice manager. They also knew they could contact the Care Quality Commission (CQC) if any concerns remained unaddressed.

The practice had carried out a range of risk assessments and implemented policies and protocols with a view to keeping staff and patients safe. A practice-wide risk assessment had been carried out which covered topics such as fire safety, the safe use of X-ray equipment, disposal of waste, and the safe use of sharps (needles and sharp instruments). We spoke with one of the dentists about the sharps protocol which had been put in place following this risk assessment to check staff were aware of the outcomes of these assessments. The dentist explained the use of sharps in line with this protocol. For example, they knew the discarding of a used needle was the dentist's responsibility.

The practice also followed national guidelines about patient safety. For example, the practice used a rubber dam for root canal treatments. (A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth).

**Medical emergencies**

The practice had arrangements in place to deal with medical emergencies at the practice. Staff received annual training in using the emergency equipment. We saw the training also included responding to different scenarios, such as a patient fainting and using role-play drills. We saw staff training in the handling of medical emergencies was last undertaken in October 2014. The practice manager showed us evidence training had been booked for all staff in September 2015. The practice had trainee dental nurses and not all had received information about and training in dealing with medical emergencies as part of their induction.

The practice held emergency medicines, in line with guidance issued by the British National Formulary, for dealing with common medical emergencies in a dental

practice. These medicines were all in date and fit for use. The practice had an automated external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm). Oxygen and other related items, such as manual breathing aids, were also available. The emergency medicines and equipment were stored in a cupboard behind the reception desk. Staff were aware of this arrangement. The equipment was easily removed from the cupboard in the event of needing to respond to an emergency.

**Staff recruitment**

The practice staffing consisted of four dentists, one dental hygienist, five trainee dental nurses and a practice manager. Additionally, the company had seconded a trained dental nurse from another practice to be the dental nurse / patient care trainer in the practice.

There was a recruitment policy in place and we reviewed the recruitment files for four staff members. We saw relevant checks to ensure the individuals being recruited were suitable and competent for the role had not been fully completed.

We saw for two of the trainee dental nurses (neither of whom had yet been enrolled on a training course) the provider had obtained an application form, curriculum vitae (CV) which showed previous employment history, proof of identity from a passport and a health assessment. However they had not obtained any references or a criminal records check through the Disclosure and Barring Service (DBS) prior to commencement in the service. We were told it was the company policy to ask the new employee to make application for a DBS check on their first day in post.

We looked at the recruitment records for two new dentists at the practice. We saw the practice had obtained proof of identification, qualifications and registration with the appropriate professional body but had not obtained references or a criminal record check through the Disclosure and Barring Service (DBS).

When we discussed this with the area manager and the practice manager we were shown for one of the dentists a DBS check which had been undertaken by another employer. We advised the managers this was not a portable check and a new DBS certificate for the dentist's employment with their company should be obtained. The registered manager, area manager and the provider, (HR department at the company headquarters), were unaware of the DBS update service. (This is a service to which individuals can sign up and will enable any new employer to check on line immediately). The provider asked the dentist about this and was able to supply the evidence of a satisfactory DBS check. For the other dentist no DBS check had been undertaken and no risk assessment had been completed. The use of risk assessment for staff without a DBS check had not been included in the company policy.

In discussion with the practice and area managers we were told for new and non-clinical staff there were no risk assessments in place to demonstrate how the practice would manage the potential risks to patients as this had not been considered.

Newly employed trainee nursing staff had a period of induction to familiarise themselves with the way the practice ran, before being allowed to work unsupervised. Induction included fire safety, first aid, welfare, general safety, data security and confidentiality. This was mostly evident in discussion with the staff but had not always been consistently recorded and appropriate records completed to evidence full induction had been provided.

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

There were arrangements in place to deal with foreseeable emergencies. We saw there was a health and safety policy in place. There was a fire risk assessment that had been reviewed annually. Fire extinguishers were also serviced annually, fire alarms checked regularly and fire drills were held at regular intervals and recorded. We also saw records of regular fire evacuation drills.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise these risks. COSHH products were securely stored. The practice manager in conjunction with the area manager was responsible for maintaining the file and disseminated information about how to minimise the risks associated with new products to staff before they were used.

# Are services safe?

Alerts received were disseminated by the practice manager to practice staff. Alerts were discussed with staff and/or at practice meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

There was a business continuity plan in place. This had been kept up to date with key contacts in the local area. There was also an arrangement in place to use another practice's premises for emergency appointments in the event the practice's own premises became unfit for use.

**Infection control**

During our visit we saw the practice appeared clean and well maintained. There was a cleaning plan, schedule and checklists, which we saw were completed, and cleaning equipment was stored appropriately in line with Control of Substances Hazardous to Health Regulations 2002. The practice manager reviewed the domestic staff's work to ensure schedules were being effectively followed.

At the last inspection we found the practice had not been following appropriate guidance for the safety and wellbeing of patients. There were now systems in place to reduce the risk and spread of infection.

There was an infection control policy which included the decontamination of dental instruments, hand hygiene, use of protective equipment, and the segregation and disposal of clinical waste. One of the trainee dental nurses took the infection control lead role and demonstrated to us how the practice had made changes and implemented the appropriate guidance to ensure compliance with the regulations.

The practice had 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)'. In accordance with HTM 01-05 guidance an instrument transportation system had been implemented to ensure the safe movement of instruments between treatment rooms and the decontamination area which ensured the risk of infection spread was minimised.

We examined the facilities for cleaning and decontaminating dental instruments. There was a dedicated decontamination room for the practice. We saw there was a clear flow from 'dirty' to 'clean' around the room. One of the trainee dental nurses demonstrated how they used the room and showed a good understanding of the correct processes. The nurse wore appropriate protective equipment, such as heavy duty gloves and eye protection. Items were manually cleaned and then inspected using an illuminated magnifier to check for any debris. Items were placed in an autoclave (steriliser) after cleaning. Instruments were placed in pouches after sterilisation and a date stamp was used to indicate when the sterilisation became ineffective.

The autoclave was checked daily for its performance, for example, in terms of temperature and pressure. A log was kept of the results demonstrating the equipment was working effectively.

The practice had carried out regular infection control audits every six months. The last audit in May 2015 had found a very high level (98%) of compliance with infection control guidance.

The practice had an on-going contract with a clinical waste contractor. Waste was being appropriately stored and segregated. We saw this included clinical waste and safe disposal of sharps. We were shown the provider had taken action since the last inspection and saw the clinical waste storage bins were now appropriately secured.

Trainee dental nursing staff spoken with demonstrated they had some understanding of the guidance of HTM01-05, however they told us if weren't sure of anything they would ask another trainee dental nurse for advice. In discussion with these staff we were advised their knowledge was obtained through word of mouth from one to the other as they were unable to tell us from where the guidance came e.g.HTM01-05. They told us they knew how to dispose of single-use items appropriately.

In two of the trainee dental nurse personnel files we saw an induction document which showed the trainer providing the induction and the trainee had discussed infection control issues and guidance and referred to HTM 01-05 however the trainee was not able to demonstrate they had retained the information.

All the dentists we spoke with were conversant with HTM 01-05 guidance and told us they would advise and support the trainee dental nurses in implementing this as and when required.

The dental unit water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a

bacterium found in the environment which can contaminate water systems in buildings). The method described was in line with current HTM 01-05 guidelines. We saw an external company had tested the water in June 2015 and reported the practice actively maintained a quality water supply from the dental equipment.

A Legionella risk assessment had also been carried out by an appropriate contractor in April 2015. We saw the practice kept a monthly log of hot and cold water temperatures which demonstrated the water was within the required temperature to prevent the growth of Legionella.

Staff files showed staff regularly attended training courses about infection prevention and control. Clinical staff were also required to produce evidence to show they had been effectively vaccinated against Hepatitis B to prevent the spread of infection between staff and patients. Records seen confirmed this.

There were hand washing facilities in each treatment room and staff had access to good supplies of personal protective equipment (PPE) for patients and staff members. Staff and patients we spoke with confirmed staff wore protective aprons, gloves and masks during assessment and treatment in accordance with infection control procedures. A hand washing audit undertaken in May 2015 achieved 100%.

**Equipment and medicines**

We found the equipment used at the practice was regularly serviced and well maintained. For example, we saw documents showing the air compressor, fire equipment and X-ray equipment had all been inspected and serviced in 2015. Portable appliance testing (PAT) had been completed in July 2014, in accordance with the Electricity at Work Regulations 1989. PAT is the name of a process during which electrical appliances are routinely checked for safety.

Prescription pads were kept to the minimum necessary for the effective running of the practice. They were individually numbered and stored securely. However the number of the prescription was not recorded in the patient's notes for audit purposes.

Some products, were being stored in a fridge in line with the manufacturer's guidance. We saw routine checking of the fridge temperature ensured storage of these items remained within the recommended range.

**Radiography (X-rays)**

Radiography equipment was available in all of the four treatment rooms.

The practice had in place a Radiation Protection Adviser and a Radiation Protection Supervisor in accordance with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). There was a well-maintained radiation protection file, in line with these regulations. Included in the file were the critical examination pack for the X-ray set, the three-yearly maintenance log, a copy of the local rules and appropriate notification to the Health and Safety Executive.

We saw evidence staff had either completed radiation training, or were booked on to an appropriate course to renew their training in 2015. We reviewed a sample of dental care records where X-rays had been taken. These records showed dental X-rays were justified, reported on and quality assured every time. The practice had also carried out an audit of their X-ray performance in March 2015 which demonstrated X-rays were being taken to an appropriate standard. These findings showed the practice was acting in accordance with national radiological guidelines so patients and staff were protected from unnecessary exposure to radiation.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

Patient's needs were assessed and dental care and treatment was planned and delivered in line with their individual treatment plans. We looked at a sample of computerised patient record cards. The records contained details of the condition of the gums and soft tissues lining the mouth. These examinations were carried out at each dental health assessment. Patients were made aware of changes in their oral condition following these assessments. Where patients were diagnosed with more aggressive forms of gum disease, a more detailed assessment of the gums was carried out by individual pocket depth charting. Patients would then be provided with a more complex plan of care by the dentists.

Details of the treatments carried out were also documented; local anaesthetic details including type, site of administration, batch number and expiry date were recorded. However we noted where a patient was given a prescription for antibiotics the prescription number had not been recorded in the notes for audit purposes. Patients were given a copy of their treatment plan, including any fees involved. Treatment plans were signed before treatment began.

The reception staff gave all new patients a medical history form to complete prior to seeing the dentist for the first time. Medical history checks were updated at every visit. This included an update about patients' health conditions, current medicines being taken and whether they had any allergies.

Patients' dental recall intervals were determined by the dentist using a risk based approach based on current National Institute for Health and Care Excellence (NICE) guidelines.

The recall interval for each patient was set following discussion of these risks with them. The dentists worked according to the NICE guidelines in relation to deciding antibiotic prescribing and wisdom teeth extraction The dentists were also aware of the 'Delivering Better Oral Health Toolkit' when considering care and advice for patients. 'Delivering better oral health' is an evidence-based toolkit to support dental teams in improving their patients' oral and general health.

The dentists were informed by guidance from the Faculty of General Dental Practice (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 and these were reviewed in the practice's programme of audits.

**Health promotion & prevention**

The reception area contained leaflets which explained the services offered at the practice. This included information about effective dental hygiene and how to reduce the risk of poor dental health. The practice had a range of products patients could purchase that were suitable for both adults and children.

Our discussions with the dentists together with our review of the dental care records showed that, where relevant, preventative dental information was given in order to improve outcomes for patients. This included advice around smoking cessation, alcohol consumption and diet. Additionally, all the dentists carried out checks to look for the signs of oral cancer.

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 patients in a way they understood. Oral hygiene and dietary advice had been discussed with the use of appropriate demonstrations.

**Staffing**

Staff told us they received appropriate professional development and training. We reviewed staff files and saw this was the case for the dentists. The training covered all of the mandatory requirements for registration issued by the General Dental Council. This included responding to emergencies and infection control. There was an induction programme for new staff to follow to ensure they understood the protocols and systems in place at the practice.

The trainee dental nurses working at the practice were provided with an induction and five weeks of training which included shadowing another trainee, or occasionally a newly qualified dental nurse. During this time they were shown the basic role of the dental nurse and provided with a majority of mandatory training information.

After five weeks the trainee was assessed as competent by a newly qualified dental nurse and was then left to work on

# Are services effective?

## (for example, treatment is effective)

their own with a dentist. In two personnel records seen this assessment had not been consistently or fully completed. In a third record seen the induction record was incomplete with two weeks of the five week training not being signed as completed. When we spoke with the trainee dental nurses they told us they had gaps in their knowledge when they started working on their own with the dentist. However they told us it was good to learn by doing. The dentists told us they would support and guide the trainee dental nurse as much as possible.

The trainee dental nurses told us they would be enrolled for a dental nurse training course at some point in their employment. In one record we saw the trainee dental nurse had been working at the practice for seven months before being offered and accepted to undertake the apprenticeship dental nurse training course being offered by a local provider. For two other trainees we saw they had been employed at the practice for more than four months and had not yet been enrolled on the apprenticeship training course. In discussion with the registered manager she told us she did not have the authority to manage the skill mix of staff but escalated it to the area manager as representative for the provider. The registered manager also told us the enrolment of trainee staff on a dental nurse apprenticeship training was outside of her control and was managed by the provider.

Staff told us they had an annual appraisal which identified their training and development needs. We saw notes were kept from these meetings. This led to changes which reflected their career development goals. For example, one of the dentists wanted to undertake some training in surgical dentistry and this was being facilitated. We did not see any supervision records or personal development plans for the trainee dental nurses.

**Working with other services**

The practice was working towards providing a range of specialist services to reduce the need to refer patients elsewhere. For example, there was a specialist in orthodontics (tooth alignment) working at the practice.

Two of the dentists explained how they currently worked with other services. Dentists were able to refer patients to a range of specialists in primary and secondary care if the treatment required was not provided by the practice. The practice held copies of relevant referral criteria for secondary and tertiary care providers in order to guide their referring practices.

A referral letter was prepared and sent to the hospital with full details of the dentists findings and a copy was stored in the practices' records system. When the patient had received their treatment they were discharged back to the practice. Their treatment was monitored after referral back to the practice to ensure patients received a satisfactory outcome and appropriate post-procedure care.

**Consent to care and treatment**

The practice ensured valid consent was obtained for all care and treatment. Staff discussed treatment options, including risks and benefits, as well as costs, with each patient. Notes of these discussions were recorded in the clinical records. Formal written consent was also obtained using standard treatment plan forms. Patients were asked to read and sign these before starting a course of treatment.

We saw evidence the requirements of the Mental Capacity Act 2005 (MCA) had been considered by the practice. The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

The clinical staff could accurately explain the meaning of the term mental capacity and described to us their responsibilities to act in patients' best interests, if patients lacked some decision-making abilities.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

We collected feedback from 20 patient comment cards and spoke with eight patients during the course of the inspection. They described a positive view of the service provided.

We observed all staff treated patients with dignity and respect. The patients we spoke with were positive about the care and treatment they had received from the practice. They told us they were given choices and options with respect to their dental treatment in language they could understand. They said they were treated with respect and dignity at all times.

Staff were clear about the importance of emotional support needed when delivering care to patients who were very nervous or phobic of dental treatment. Staff were sensitive to the needs of their patients and there was a strong focus on reducing anxiety and supporting people to feel comfortable in the surroundings.

Maintaining patient confidentiality was high on the agenda at this practice. This was captured as part of the practice patient questionnaire. We observed staff were careful to follow the practice's confidentiality policy when discussing patient's treatments so that confidential information was kept private.

Staff and patients told us all consultations and treatments were carried out in the privacy of a treatment room and we observed this to be the case. We observed the treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. These would then be investigated and any learning identified would be shared with staff individually or at practice meetings if necessary.

**Involvement in decisions about care and treatment**

The practice displayed information in the waiting area which gave details of the NHS and private dental charges and fees. We saw the practice had displayed information about dental care and treatments and opening times. There was also information and contact details displayed regarding how patients could access emergency dental care if required. This information was also available in the patient information leaflet.

Patients were routinely given copies of their treatment plans which included useful information about the proposed treatments, any risks involved, and associated costs. We reviewed a sample of dental care records and saw examples where notes had been kept of discussions with patients around treatment options, as well as the risks and benefits of the proposed treatments.

The dentists and trainee dental nursing staff we spoke with confirmed treatment options, risks and benefits were discussed with each patient to ensure the patient understood what treatment was available so they were able to make an informed choice. During appointments the dentist asked questions about each patient's current oral hygiene practice and gave suggestions how this could be improved to prevent oral health problems.

Where a patient's carer attended an appointment with the patient they ensured the carer was involved in the discussion. Patients who had received treatment were given explanations about what to do to minimise any discomfort and prevent problems.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

We found the practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

We observed appointments ran smoothly on the day of the inspection and patients were not kept waiting. Patients commented they had sufficient time during their appointment and were seen promptly. Staff told us if appointments were running late they would speak with the patient waiting to ensure they were kept informed and were able to continue to wait.

Each patient contact with a dentist was recorded in the patient's computerised record. New patients were asked to complete a comprehensive medical history and a dental questionnaire. This questionnaire enabled the practice to gather important information about their previous dental, medical and relevant social history. They also aimed to capture details of the patient's expectations in relation to their needs and concerns. This helped to direct the dentists in providing the most effective form of care and treatment for them.

The practice ensured there were appointments available for emergencies each day. The practice supported patients to attend their forthcoming appointment by having a text reminder system in place. Patients who commented on this service reported it was helpful.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its service. Staff told us they treated everybody equally and welcomed patients from a range of different backgrounds, cultures and religions. The practice had recognised the needs of different groups in the planning of its services which included access to translation services for patients whose first language was not English. The practice logged when a translator was required including for a recall.

The premises had been adapted to meet the needs of patients with disabilities. The building had easy access for patients in wheelchairs at the front of the building and also a disabled access toilet. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and these arrangements allowed for easy access to the ground floor treatment rooms.

Staff described to us how they had supported patients with additional needs such as a learning disability. They ensured patients were supported by their carer or a relative and that there was sufficient time to explain fully the care and treatment they were providing in a way patients understood**.**

**Access to the service**

Comprehensive information was available to patients about appointments and was displayed in the practice. Patients were very satisfied with the appointments system. Comments received from patients showed that those in need of emergency treatment had been able to make appointments on the same day of contacting the practice.

The opening hours for the practice at the time of our inspection were Monday, Wednesday and Thursday 8.15am to 5.15pm, Tuesday 8.15am to 7pm and Friday 8.15am to 4.15pm. Patients could book appointments in person or via the phone.

**Concerns & complaints**

We arranged for a Care Quality Commission (CQC) comments box to be placed in the waiting area of the practice several days before our visit and 20 patients chose to comment. All of the comment cards completed were very complimentary about the service provided, telling us the staff and practice is very family friendly.

The practice had a system in place for handling complaints and concerns. There was a designated responsible person, the practice manager, who handled all complaints in the practice. Most patients we spoke with knew how to raise concerns or make a complaint. Although patients were aware how to complain, the patients we spoke with said they never felt the need to complain. Information about how to complain was displayed in the waiting area and included the timeframes of when the complainant might expect to receive a response.

There was also a suggestions box in the waiting area which was checked regularly by the practice manager. We

# Are services responsive to people's needs?

## (for example, to feedback?)

reviewed practice patient questionnaires and they were all favourable about the service provided. We looked at complaints received and found they had been handled appropriately and dealt with in a timely manner.

We saw in the file of historical complaints patients routinely received a written response, including an apology, when anything had not been managed appropriately. We also noted the practice responded to comments posted on the NHS Choices website.

# Are services well-led?

## Our findings

At the last inspection we found the provider was not meeting the regulations because they did not have a registered manager and they were not effectively monitoring the quality of service provision. We saw steps had been taken to address these shortfalls.

Since the last inspection the practice manager was registered with the Care Quality Commission as the registered manager. The practice had also put good governance arrangements in place with an effective management structure.

**Governance Arrangements**

The practice and area managers took the lead role in the practice for the individual aspects of governance such as responding to complaints and managing risks. The wider aspects of governance relating to safe recruitment in line with the latest guidance (Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document. Third edition: March 2014) requires attention to ensure recruitment practices follow company policy. Staff we spoke with were clear about their roles and responsibilities within the practice and about the lines of accountability both in the practice and through the company.

The practice manager undertook quality checks at the practice. The practice had a proactive approach for identifying where quality or safety was being affected and addressing any issues. Health and safety and risk management policies were in place and we saw a risk management process to ensure the safety of patients and staff members. For example, we saw risk assessments relating to fire, exposure to hazardous substances and medical emergencies.

We noted one instance where practice policies had not been strictly followed. This was in relation to the recruitment policy and the keeping of up-to-date staff files. There were some documents missing from the staff files we reviewed including employment histories, references and a Disclosure and Barring Service (DBS) check. We discussed this with the practice manager at the time of the inspection. The managers were not aware of the DBS update service and acknowledged it was company policy that DBS checks were not applied for until the member of staff commenced employment in the practice.

Practice staff were clear about what decisions they were required to make, knew what they were responsible for as well as being clear about the limits of their authority. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

It was clear who was responsible for making specific decisions, especially decisions about the provision, safety and adequacy of the dental care provided at the practice and this was aligned to risk.

There were weekly informal practice meetings, as well as more formal staff meetings to discuss key governance issues. For example, we saw minutes from the monthly staff meetings where issues such as complaints, incidents, infection control and patient care had been discussed. This facilitated an environment where improvement and continuous learning were supported.

The practice had a number of policies and procedures in place to govern activity and these were available to all staff. These included how to report adverse incidents, information governance, access to records, confidentiality and complaints. We reviewed information about risk assessments covering all aspects of health and safety and clinical governance. These were well maintained and up to date.

**Leadership, openness and transparency**

The ethos of the practice was to provide quality dental care to their patient population, and to offer them clear and helpful advice about their oral health needs and choice in the range of treatments appropriate to their patient's needs.

The staff we spoke with described a transparent culture which encouraged candour, openness and honesty. Staff said they felt comfortable about raising concerns with one of the dentists or the practice manager. They felt they were listened to and had received a response when they had commented or raised issues about the practice. Staff told us they did not feel there was the same transparent culture within the company and were not so comfortable in raising concerns at a more senior level.

We saw from minutes of team meetings they were held regularly. Each meeting had an agenda that was variable but included updates and information about subjects such

# Are services well-led?

as infection prevention and control, clinical audits and health and safety. We saw completed audits which included aspects of health and safety, radiography and infection control.

There were clearly defined leadership roles within the practice. The practice manager and area manager ensured human resource and clinical policies and procedures were reviewed and updated to support the safe running of the service. These included guidance about confidentiality, record keeping, incident reporting and consent to treatment. We reviewed a number of policies which were in place to support staff. We were shown the information that was available to all staff, which included equal opportunities, confidentiality and staff employment policies. For example whistleblowing, harassment and bullying at work. Staff we spoke with knew where to find these policies if required. Staff we spoke with were aware of the whistleblowing policy and what to do if they were concerned about any matters.

**Management lead through learning and improvement**

Staff told us the practice supported them to maintain and develop through training and mentoring. We saw regular staff performance reviews (appraisal) took place for the dentists. These included duties and responsibilities, what has gone well, what has required improvement and what changes were to be made. Staff we spoke with told us the appraisal process was a two way communication process with the practice manager and clinical director who supported their development.

All dentists who worked at the practice were registered with the General Dental Council (GDC). The GDC registers all dental care professionals to make sure they are appropriately qualified and competent to work in the United Kingdom. Five of the six dental nurses in the practice on the day of inspection were trainee dental nurses and not registered with the GDC which potentially puts patients at risk from unqualified staff. Some of them were currently undertaking an apprenticeship dental nurse training course, while two of them were not yet registered for any training programme. Staff were encouraged and supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC).

Staff we spoke with told us the practice was very supportive of training and provided them with eLearning. The practice offered a range of on-site, hands-on learning and development opportunities for dentists and all other staff.

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

Patients expressed their views and were involved in making decisions about their care and treatment. The practice used a patient feedback questionnaire to capture information about how the patients viewed the quality of dental care they received. It included sections about appointments, reception, staff and cleanliness. The questionnaire also asked for patients' individual comments.

We saw the results obtained showed patients were satisfied with the quality of service provided. Patients who used the service said the service was very professional, friendly and welcoming. There were several comments which demonstrated the practice was family friendly and that patients were at the heart of the practice.

The eight patients we spoke with were very happy with the standard of care they had received. They described the practice staff as helpful and friendly. Patients were satisfied with appointment waiting times and the cleanliness of the practice. This was further supported by observing the results and comments contained in the patient feedback questionnaires, on the practice generated comment cards and on the Care Quality Commission comment cards.

The practice had gathered feedback from staff through staff meetings, appraisal and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff.

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**Regulation 18.**<br>**How the regulation was not being met:**<br>**There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the service.**<br>**The provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to ensure they can meet the care and treatment needs of patients using the service.**<br>**The provider must ensure all trainee staff are appropriately supervised and provided with training to meet their development needs for the safety of service provision.** |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**Regulation 19.3.**<br>**How the regulation was not being met:**<br>**People who use services and others were not protected against the risks associated with recruitment processes as identified in schedule 3 of this regulation.**<br>**The provider must evidence they employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role and to enable them to provide the regulated activity.** |

This section is primarily information for the provider

# Enforcement actions

## 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.