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Bhandal Dental Practice - 190 High Street

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 19 April 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Bhandal Dental Practice - 190 High street has 10 dentists, 13 qualified dental nurses who are registered with the General Dental Council (GDC) and two receptionists. The practice's opening hours are from 9am to 5.30pm Monday to Friday. The practice is closed between 1.30pm and 2.30pm Monday to Friday.

Bhandal Dental Practice provides NHS and private treatment for adults and children. The practice is situated in a converted property. There are dental treatment rooms on the ground floor and on the first floor; the first floor treatment rooms are rarely used. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and a main waiting area on the ground floor.

The registered manager was present during this inspection. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received feedback from 16 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

Our key findings were:

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Staff had been trained to deal with medical emergencies.
- The practice kept up to date with current guidelines when considering the care and treatment needs of patients.
- Infection prevention and control systems were in place, and audits were completed on a six monthly basis.
- Options for treatment were identified and explored and patients said they were involved in making decisions about their treatment.
- Patients' confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Health promotion advice was given to patients appropriate to their individual needs such as smoking cessation or dietary advice.
- Some staff from within the practice visited local schools to provide oral health and hygiene advice to children.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Systems were in place for recording significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

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).

Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). Emergency medical equipment was also available and documentation was available to demonstrate that checks were being made to ensure equipment was in good working order and medicines were within their expiry date. Staff had received training in responding to a medical emergency.

There were sufficient numbers of suitably qualified staff working at the practice. The practice had undertaken the relevant recruitment checks to ensure patient safety. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults.

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 up to date national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

The practice used oral screening tools to identify oral disease. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. Patients' dental care records confirmed this and it was evident that staff were following recognised professional guidelines.

Staff received professional training and development appropriate to their roles and learning needs. Qualified 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 providing caring services in accordance with the relevant regulations.

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. Feedback from patients was overwhelmingly positive. Patients praised the staff and the service and treatment received. Patients commented that staff were professional, friendly and helpful. We were told that the quality of care was good.

Are services responsive to people's needs?

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

Summary of findings

Patients had good access to treatment and urgent care when required. The practice had ground floor treatment rooms and toilet which had been adapted to meet the needs of patients with a disability. Ramped access was provided into the building for patients with mobility difficulties and families with prams and pushchairs.

The practice had an efficient appointment system in place to respond to patients' needs. There were vacant appointments slots for urgent appointments each day.Patients confirmed that they had good access to treatment and urgent care stating that urgent appointments were always available on the day that they phoned the practice.

There was a procedure in place for responding to patients' complaints The practice's complaints policy was available to patients in the waiting room.

Are services well-led?

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

There were good governance arrangements and an effective management structure in place. The practice regularly audited clinical and non-clinical areas as part of a system of continuous improvement and learning.

There were good governance arrangements and an effective management structure in place. Staff said that they felt well supported and could raise any issues or concerns with the registered manager. There were arrangements in place to share information with staff by means of monthly practice meetings which were minuted for those staff unable to attend. Staff said that they felt well supported and could raise any issues or concerns with the registered manager.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent.

Bhandal Dental Practice - 190 High Street

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection took place on 19 April 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with five members of staff including the registered manager. We 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 dental care records and patient dental health education programme.

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

Significant event, accident and incident policy documents and reporting forms were available on the practice's computer system. Information regarding reporting a 'near miss' was included in the policy. Step by step guidance was available for reporting, analysing and monitoring significant events. Staff spoken with could describe the procedure for reporting significant events. Evidence of action taken and learning points discussed with staff were recorded. We saw that policies were easily accessible to all staff via the computers in each treatment room.

Accident books demonstrated that any accidents at the practice were recorded and action taken. We saw that there had been no accidents at the practice since 2014. Significant event forms had been completed as applicable for some accidents and learning points were recorded. Accident investigation/significant event analysis and prevention forms recorded actions taken to reduce the risk of reoccurrence of accidents and significant events.

We discussed the reporting of injuries, diseases or dangerous occurrences (RIDDOR). We saw that guidance about RIDDOR regulations and reporting forms were available for staff on the computer system. There had been no incidents reported under RIDDOR regulations.

All Medicines and Healthcare products Regulatory Agency alerts regarding patient safety (MHRA) were received at the head office. Information regarding relevant alerts was then forwarded to each practice. Staff spoken with were able to recall two recent alerts which had been received and discussed at a practice meeting. We saw that MHRA alerts were a standard agenda item for practice meetings. A log of alerts was kept and we were told that these were available for staff if required.

A 'being open' policy was available. This detailed the practice's expectation of openness and transparency towards patients and between staff members in the event of an incident.

Reliable safety systems and processes (including safeguarding)

The registered manager acted as the practice's safeguarding lead and was the point of referral should members of staff encounter a child or adult safeguarding issue. Staff we spoke with were aware of who within the practice was the safeguarding lead. A policy was in place for staff to refer to in relation to children and adults who might be the victim of abuse or neglect. Other documents available to staff on the practice's computer system included a face injury map, child protection guidance and a child protection flow chart. Staff had access to this information on each computer at the practice. Training records showed that staff had received appropriate safeguarding training for both vulnerable adults and children. Practice meeting minutes demonstrated that safeguarding was a topic for discussion at monthly practice meetings. Information was displayed for staff that contained telephone numbers of whom to contact outside of the practice if there was a need, such as the local authority responsible for investigations.

We were told that there had been no needle stick injuries at the practice recently. Accident records demonstrated that when a needle stick injury had occurred details of any action taken and recommendations given were recorded. Staff explained 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. We were told that dentists were responsible for ensuring safe recapping following administration of a local anaesthetic to a patient and for disposal of used needles into the appropriate sharps' bin.

A dentist we spoke with explained that root canal treatment and other treatment where appropriate 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 can be assured that the practice followed appropriate guidance by the British Endodontic Society in relation to the use of the rubber dam.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. There was an automated external defibrillator (AED), a portable electronic device that analyses life-threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Staff had received training in how to use this equipment with all staff receiving update training in December 2015. Daily checks were made on the AED to

Are services safe?

ensure it was in good working order and records were kept to demonstrate this. The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. These were stored in a purpose designed emergency medicine storage container which was stored in a central location known to all staff. The practice had access to oxygen along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and oxygen were all in date and records were available to demonstrate that monthly monitoring took place. Expiry dates were recorded on monitoring sheets, this enabled staff to replace out of date medicines and equipment promptly.

We saw that two first aid kits were available which contained equipment for use in treating minor injuries. Records were available to demonstrate that equipment in the first aid boxes were regularly checked to ensure they were available and within their expiry date. Seven of the dentists had completed first aid training and certificates seen demonstrated that their training was in date.

Staff recruitment

We discussed staff recruitment, looked at the recruitment policy and at six staff recruitment files. The recruitment policy which was available on the practice's computer system identified the steps to be taken when appointing staff.

We saw that staff recruitment files contained a standardised layout with a front sheet which recorded information available in each file such as written references, proof of identity, curriculum vitae and expiry dates for training completed. Information was available regarding the staff member's professional registration, immunisation status and disclosure and barring service checks (DBS). DBS checks 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. Staff signed an annual update to confirm that there had been no change to their DBS status.

Robust systems were in place to ensure that appropriate pre-employment checks were undertaken for all staff prior to employment.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. Various health and safety policies were available to staff on the practice's computer system as well as health and safety advice sheets and guidance documents. A well-maintained Control of Substances Hazardous to Health (COSHH) file was available and a number of risk assessments were carried out including fire, legionella, clinical waste and a general dental practice risk assessment. Risk assessments were available on the practice's computer system for all staff to see.

An external agency provided fire protection equipment servicing. Certificates were available to demonstrate checks undertaken, for example fire extinguisher and emergency lighting test certificates. We saw that staff had undertaken monthly fire drills with records kept detailing the names of the staff who took part. We saw that a fire risk assessment had been completed in May 2015. Action plans recorded actions taken to reduce the risk of fire. A staff meeting was held to discuss the findings of the risk assessment and actions taken. Fire exit signage was in place as appropriate throughout the practice. We saw that fire safety checks were undertaken on a weekly or monthly basis as necessary.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and toilet were visibly clean, tidy and uncluttered. Patient feedback also reported that the practice was always clean and tidy. Hand washing facilities were available including liquid soap and paper towels in each of the treatment rooms and toilets. Hand washing protocols were also displayed appropriately in various areas of the practice and bare below the elbow working was observed. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. Appropriate amounts of personal protective equipment were available in treatment rooms.

There were effective systems in place to reduce the risk and spread of infection within the practice. A review of practice protocols showed that HTM 01 05 (national guidance for infection prevention control in dental practices') Best Practice Requirements for infection control were being met. It was observed that a current audit of infection

prevention and control processes confirmed compliance with HTM 01 05 guidelines. This was dated January 2016. We saw that infection prevention and control audits were completed on a six monthly basis.

A dental nurse described to us the end-to-end process of infection control procedures at the practice. They explained the cleaning of the general treatment room environment following the treatment of a patient. They explained how the working surfaces, dental unit and dental chair were cleaned.

Cleaning schedules were available which detailed the daily, weekly and monthly cleaning tasks to be completed. An external company completed cleaning of non-clinical areas and dental nurses were responsible for cleaning of all clinical areas. Documentary evidence was available to demonstrate that mop heads were changed at the start of each week.

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings), a dental nurse described the method they used which was in line with current HTM 01 05 guidelines. A Legionella risk assessment had been carried out by an appropriate contractor in January 2015 and documentary evidence was available for inspection. We saw that all actions identified during the assessment had been completed. Records were available showing that monthly water temperature checks were completed and weekly flushing of all water outlets. These measures ensured that patients and staff were protected from the risk of infection due to Legionella.

We looked at the procedures in place for the decontamination of used dental instruments. A decontamination room was available for instrument processing which consisted of a separate dirty and clean room with a wall hatch enabling instruments to be passed from the dirty to the clean room. Dedicated hand washing facilities were available in each room. Hand washing technique posters were on display by all hand washing sinks.

A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). Systems were in place to ensure that instruments were safely transported between treatment rooms and the decontamination room. The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. We saw evidence that the heavy duty gloves worn by staff during part of the decontamination process were disposed of on a weekly basis. Clean instruments were packaged; date stamped and stored in accordance with the latest HTM 01-05 guidelines. All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly. Services safe

The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health. We observed that sharps' containers, clinical waste bags and municipal waste were properly maintained and stored in accordance with current guidelines. The practice used an appropriate contractor to remove dental waste from the practice and this was stored in a separate locked location prior to collection by the waste contractor. Waste consignment notices were available for inspection. Patients could be assured that they were protected from the risk of infection from contaminated dental waste.

Equipment and medicines

Maintenance contracts were in place for essential equipment such as X-ray sets, autoclaves and dental chairs. Records were available to demonstrate that equipment checks had been carried out in line with the manufacturer's recommendations. For example, the autoclaves had been serviced and calibrated in February 2016, compressor vessel checks had been completed in March 2016 and an electrical installation condition report in June 2013 (to be completed again in June 2018). Annual portable appliance testing (PAT) had been completed on electrical equipment at the practice to ensure it was safe to use.

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. We were told that this practice did not dispense medicine.

Are services safe?

We found that the practice stored prescription pads securely to prevent loss due to theft. We observed that the practice had equipment to deal with body fluid and mercury spillage.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine could be stored at room temperature with a shortened expiry date. However, the practice's preference was to store this medicine in the fridge. We saw that records were kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. Staff completed and signed records every day to demonstrate the fridge temperature.

Radiography (X-rays)

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 (IRMER). A well-maintained radiation protection file in line with these regulations was observed. Included in the file were the critical examination packs for each of the X-ray sets along with the three yearly maintenance logs and a copy of the local rules. The file also contained the X-ray set inventory, risk assessment, quality assurance process and notification to the Health and Safety Executive.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. We saw a recent X-ray audit completed in January 2016. Audits help to ensure that best practice is being followed and highlight improvements needed to address shortfalls in the delivery of care.

Records seen showed that all dentists had up to date training regarding Ionising Radiation (medical Exposure) Regulations 2000 (IRMER).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

The dentist described how they carried out their assessment of patients for routine care. 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 reviewed and 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. Basic periodontal examination (BPE) scores were recorded. (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 and any costs explained in detail.

Where relevant, preventative dental information was given in order to improve the outcome for the patient. This included dietary advice and general dental hygiene procedures such as tooth brushing techniques or recommended tooth care products. Fluoride varnish was applied to those with a high dental caries risk and high concentration fluoride was prescribed for adults as required. 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. Dental care records we saw showed that the findings of the assessment and details of the treatment carried out were recorded appropriately.

Health promotion & prevention

We discussed 'The Delivering Better Oral Health Toolkit' with the registered manager. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. The practice placed a high emphasis on preventative care. High concentration fluoride toothpastes were prescribed when required and fluoride varnish applied. Medical history forms completed by patients included questions about smoking and alcohol consumption. The dentists explained tooth brushing and interdental cleaning techniques to patients in a way they understood and dietary, smoking and alcohol advice was given to them. Dental care records we observed demonstrated that the dentist had given oral health advice to patients.

We saw that free samples of toothpaste were available to patients who requested them.

We were told that nurses from Bhandal head office visited schools wherever Bhandal dental practices were located. These staff provided an activity to groups of children. During this activity, they provided oral hygiene instruction and advice on healthy eating. At the end of each session, they provided a dental pack to each child that included a brushing chart and toothpaste and a certificate of attendance.

Staffing

Practice staff included a registered manager, 10 dentists (seven part time), 13 dental nurses (1 part time), two receptionists and a cleaner.

We discussed staff training and looked at training and appraisal records. We saw that staff recruitment files contained details of training that staff who work at Bhandal dental practices must complete. The expiry date of the training was recorded and we were told that a member of staff from head office booked staff on training courses to ensure they were up to date with their training. We saw that some dental nurses had undertaken courses to enable them to undertake extended duties such as impression taking, radiography and oral health education. The development of extended duty dental nurses showed effective use of skill mix in the practice.

We saw that staff had complete training in cardio pulmonary resuscitation infection control, child protection and adult safeguarding, dental radiography (X-rays) and

Are services effective?

(for example, treatment is effective)

other specific dental topics. Training was provided to staff via attendance at courses, in-house and on-line training. All staff had access to the provider's website which contained e-learning. Staff recruitment files contained copies of continuous professional development (CPD) logs. These record details of training undertaken by staff. CPD is a compulsory requirement of registration as a general dental professional. Records showed professional registration with the GDC was up to date for all relevant staff.

Staff told us that they were supported to attend training courses appropriate to the work they performed and to develop their skills. Staff said they received all necessary training to enable them to perform their job confidently.

We were told that annual appraisal took place for all staff and we saw some records to confirm this. We saw that there was an appraisal policy on the computer which detailed how often and who would conduct appraisal meetings. Staff confirmed that they had an annual appraisal and were able to raise issues or concerns during these meetings and request training.

The practice planned for staff absences to ensure the service was uninterrupted. Dental nurses supported each dentist during patient treatment and we were told that there were enough staff to provide cover during times of annual leave or unexpected sick leave. Staff said that they had to book annual leave in advance and this and any unplanned absences were covered by part time staff working additional hours. We were told that managers were flexible and always tried to grant leave at short notice if possible. A policy regarding annual leave was available for all staff to review. Sufficient numbers of staff were on duty to ensure that the reception area was not left unstaffed at any time.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required sedation or oral surgery. A referral policy was in place that reflected the process to follow. When the patient had received their treatment, they would be discharged back to the practice for further follow-up and monitoring. A copy of the referral letter was always available to the patient if they wanted this for their records. Systems were in place to ensure referrals were received in a timely manner; the dentist we spoke with confirmed that they always followed up their referrals with a telephone call to the patient to ensure they had received their appointment.

Consent to care and treatment

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. Staff spoken with were aware of the MCA and best interest decisions. The dentist explained how they would obtain consent from a patient who suffered with any mental impairment that may mean that they might be unable to fully understand the implications of their treatment. All staff had completed training regarding the Mental Capacity Act within the last 12 months. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. A consent policy had been implemented and reference was made to the MCA in this policy. A patient leaflet regarding consent could be printed off and given to patients as required.

The dentist we spoken with explained how individual treatment options, risks, benefits and costs were discussed with each patient and then documented in a written treatment plan. We were told that patients were given verbal and written information to support them to make decisions about treatment. We were told that both verbal and written consent was obtained and patient care records seen demonstrated this.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. Music was played in the waiting area, this helped to distract anxious patients and also aided confidentiality as people in the waiting room would be less likely to be able to hear conversations held at the reception desk. There was a poster in the waiting area advising patients that they could ask to speak with dental staff in private and a room would be made available.

Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. The computer screens at the reception desks were not overlooked which helped to maintain confidential information at reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times.

We observed staff were friendly, helpful and accommodating when talking with patients on the telephone and in the reception area. We observed reception staff dealing with issues of confidentiality; information had been requested from a representative of the patient, staff followed their confidentiality policy and only gave information to the patient following confirmation of their identity. 14 patients provided positive feedback about the practice on comment cards which were completed prior to our inspection. Patients commented that staff were professional, friendly, helpful and caring.

Policies were available for staff regarding confidentiality and information governance and we saw that staff had undertaken training in these areas.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Information leaflets could be printed off the computer and given to patients. For example information leaflets were available regarding gum disease, dentures, guide to good oral health and tooth decay. Clear treatment plans were given to patients which detailed possible treatment and costs. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. This included information recorded on the standard NHS treatment-planning forms for dentistry where applicable. Posters detailing both NHS and private costs were on display in the reception area. Patients commented that the dentists listened to them, they felt involved in their treatment and it was fully explained to them.

The dentist spoken with was familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We discussed appointment times and scheduling of appointments. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment. We observed the clinics ran smoothly on the day of our inspection and patients were not kept waiting.

The practice's website described the range of services offered to patients which included general dentistry and cosmetic dentistry. The practice provided NHS and private treatment. NHS treatment costs were clearly displayed in the waiting area.

Tackling inequity and promoting equality

The practice was located on the ground and first floor of a converted building. There was no car park and patients used roadside parking or one of the nearby pay and display car park if required.

The practice had an equality, diversity and human rights policy which was available to all staff on the practice's computer system. Staff had completed equality and diversity training. We saw that contact details for a translation service were available to staff. Patient's care records detail whether a translator would be required. We were told that the translation service was used on a regular basis and had been used on the morning of our inspection. Staff also had access to British Sign Language for people who were hard of hearing.

The practice had carried out a disability discrimination audit in October 2014 which had been reviewed in October 2015. Documentation was available for a re-audit to be completed if any changes were made at the practice. There was a hearing loop at the reception area and the practice was suitable for wheelchair users. Four of the treatment rooms were on the ground floor with level access to the front of the building, and a disabled toilet. There were also two treatment rooms on the first floor but we were told that these were rarely used.

Access to the service

The practice was open from 9am to 5.30pm on Monday to Friday (closed between 1.30pm to 2.30pm). When the practice was closed patients were directed to call NHS 111.

Appointments were booked by telephoning the practice or in person by attending the practice. Staff told us that patients were usually able to get an appointment within a day or two of their phone request. However emergency appointments were available on the same day that patients telephoned the practice. The practice also provided a walk in service from 6pm to 9pm each day for patients in dental pain who required urgent treatment. This service was open to patients who were not registered at the practice. Patients we spoke with were aware of how to access appointments both during opening hours and outside of opening hours. Patients told us that they could get an appointment at a time to suit them and said that they did not have difficulty getting through to the practice on the telephone. Staff told us that they provided a reminder by text, email or letter. Patients were asked for their preference of how they were to receive their appointment reminder. This helped to reduce the number of patients who did not attend their appointment.

Patients we spoke with told us that they were generally seen within a few minutes of their appointment time. We saw that a waiting time audit had been completed on an annual basis. The results from the survey demonstrated that average waiting times had reduced over the previous three years.

Concerns & complaints

The practice had received three verbal complaints within the last 12 months. We were not shown a copy of a complaint log or details of any complaints received. Staff told us that all complaints were handled by the complaints manager based at head office. Complaints would also be forwarded to Mr Bhandal for review. We were told that verbal complaints would be acted upon immediately and information forwarded to the complaint manager. There was no documentary evidence on the premises to demonstrate that an audit of complaints had taken place. We were told that this would be completed by head office and the results forwarded to the practice. There was no evidence at the practice of a system to monitor complaints to identify trends and learn from issues identified.

We saw that complaints was a standard agenda item for practice meetings and we were told that they would also be discussed at informal meetings as and when they were received at the practice.

Are services responsive to people's needs?

(for example, to feedback?)

The practice's complaint policy was available on the computer system. We saw that the complaint information was available in seven languages other than English. For example Chinese, Polish, Hindi and Arabic. Information for patients about how to complain was on display in the reception and waiting area. This gave the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example NHS England, the Independent Complaints Advocacy Service or the Parliamentary and Health Service Ombudsman).

Are services well-led?

Our findings

Governance arrangements

Systems were in place for monitoring and improving the quality of services provided for patients. Comprehensive risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, health and safety and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

The registered manager was responsible for the day-to-day running of the practice. We saw that the practice had in place a well-developed system of policies, procedures and risk assessments covering all aspects of clinical governance in dental practice. For example, infection control, health and safety and radiation. We found that policies and processes were regularly review by a member of the management team at head office. Staff were aware that all policies were available on the computer system and confirmed that they had access to them at all times.

The practice held staff meetings every month which were minuted to ensure that any staff not present could be made aware of topics which had been discussed.

Leadership, openness and transparency

Staff told us that the registered manager was approachable and helpful. They said that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately.

The culture of the practice was open and supportive. Staff we spoke with told us they enjoyed working at the practice and received the support they needed. Staff said that they worked well as a team. Staff were aware who held lead roles within the practice and who should be contacted at head office regarding other areas such as complaints. Staff were aware of their responsibilities regarding duty of candour and said that there was a duty of candour policy available on the computer system.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern. We discussed the whistleblowing policy with a dental nurse who was able to give a clear account of what the procedures were for, and when and how to use them. The policy was available on any computer in the practice.

Learning and improvement

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period. Staff said that support was provided to enable them to complete training required. Annual appraisal meetings were held and personal development plans were available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

Regular practice meetings were held where learning was disseminated. These meetings were minuted. Staff said that they found these meetings useful, they were kept up to date with any changes at the practice and felt that they were well informed. Staff also told us that the registered manager was always on hand to provide help and advice. Staff said that the management team were approachable and supportive.

We saw there was a schedule of audits completed throughout the year. Dentists completed a record card and radiography audit with the last audits being completed in January 2016. Infection control audits were also completed on a six monthly basis. Other audits included a disability discrimination act access audit and a waiting time audit. The audits identified both areas for improvement, and where quality had been achieved, particularly in respect of the clinical areas.

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

We spoke with staff about the methods used to obtain feedback from patients and from staff who worked at the practice. We saw that there was a comments/compliments folder on the reception desk which contained some positive feedback recorded by patients. The Friends and Family Test (FFT) had been introduced .The friends and family test is a national programme to allow patients to provide feedback on the services provided. The results of the FFT were forwarded to head office for them to send off to be included on the NHS Choices website.

Are services well-led?

We discussed the systems in place to feedback or receive feedback from staff. We were told that practice meetings were held on a monthly basis. Staff said that they were able to speak with any of the management team or Mr Bhandal at any time if they had any concerns.

An annual satisfaction survey was conducted at the practice and we saw the results of the May 2015 survey. We saw that the majority of the results were positive with a few patients responding that they didn't know the answer to the question. We were told that the results of the satisfaction survey were correlated and reviewed by head office and the results forwarded to the practice.

We saw the results of the December 'vital signs' NHS England survey regarding waiting times and satisfaction with dentistry received. We saw that 92.9% of patients who responded to the survey were satisfied with the time they had to wait for an appointment which was higher than the area team standard of 90.3%. The practice also achieved 100% satisfaction with the dentistry provided which was also higher than the area team standard of 93%.