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Trinity Dental Surgery

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 October 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

Trinity Dental Surgery has three dentists who work part time, a part time hygienist, one qualified dental nurse who is registered with the General Dental Council (GDC) and two trainee dental nurses. The practice's opening hours are 8.30am to 5.30pm on Monday, Tuesday and Thursday, 8.30am to 1pm on Wednesday and 8.30am to 3.30pm on Friday.

Trinity Dental Surgery provides NHS dental treatment for adults and children. The practice has two dental treatment rooms on the ground floor and one dental treatment room on the first floor. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There was also a reception and waiting area on the ground floor.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission 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 19 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was good and staff were professional and knowledgeable.

Our key findings were

Summary of findings

- 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.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a three monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was 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 appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice was well-led and staff felt involved and worked as a team.
- Governance arrangements were in place for the smooth running of the practice and there was a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography.

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

- Review the recruitment procedures and protocols to ensure that all pre-employment information is obtained in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Review the practice's fire safety procedures and ensure that regular checks are made of all firefighting equipment including emergency lighting, that all staff are involved in fire drills on a regular basis and that the practice undertakes and records details regarding a robust fire risk assessment.

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?

No action

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).

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 seen demonstrated 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. Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. The practice followed procedures for the safe recruitment of staff, this included carrying out disclosure and barring service (DBS) checks, and obtaining references.

Infection control audits were being undertaken on a six monthly basis. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Are services effective?

No action

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

The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. 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. Staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

No action

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

Summary of findings

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.

Are services responsive to people's needs?

No action 

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

Patients had good access to treatment and urgent care when required. 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 developed a complaints procedure and information about how to make a complaint was available for patients to reference.

Are services well-led?

No action 

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. Regular staff meetings were held and systems were in place to ensure all staff who were unable to attend the meeting received an update about topics of discussion. Staff said that they felt well supported and could raise any issues or concerns with the principal dentist.

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. Staff told us they enjoyed working at the practice and felt part of a team.

Trinity Dental Surgery

Detailed findings

Background to this inspection

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

This inspection took place on 18 October 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 principal dentist. 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.

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.

No action

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had clear guidance for staff about how to report incidents and accidents. Accident reporting books and significant event reporting forms were available. The accident record book demonstrated that there had been 13 accidents since 2007 with the date of the last accident recorded as 13 June 2016.

The practice had reported two significant events within the last 12 months. These had been well documented. The minutes of the practice meeting of 8 January 2016 recorded discussions held regarding an incident including learning points and action taken.

All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) and forms were available to enable staff to report incidents under RIDDOR regulations if necessary. We were told that there had been no events at the practice that required reporting under RIDDOR.

The practice received national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). These were actioned if necessary and were the stored for future reference.

The practice received these alerts via email and any that were relevant were printed off and kept by the senior nurse. There was no documentary evidence to demonstrate that appropriate action had been taken regarding the MHRA alert. However, the lead nurse kept a log book of discussions held with staff during nurse and whole practice meetings and notes seen demonstrated that a safety alert had been discussed during one of these meetings.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults which had been reviewed on an annual basis with the date of last review recorded as 10 June 2016. The principal dentist had been identified as lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. We were told that there had been no safeguarding issues to report.

Details of how to report suspected abuse to the local organisations responsible for investigation of child protection issues were available including social services and the local child protection nurse. The practice did not have contact details available regarding reporting suspected adult abuse. Staff we spoke with said that they would be able to find these details if required.

We saw evidence that all staff had completed the appropriate level of safeguarding training and on-line training was available to all staff.

Practice meeting minutes seen demonstrated that child protection and adult safeguarding were discussed.

The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with each dentist.

A sharps policy was available which had been reviewed on 4 September 2016 by the lead nurse. We found that the practice was complying with the Health and Safety (Sharp instruments in healthcare) Regulations 2013. Sharps information was on display in treatment rooms and the decontamination room were sharps bins were located. Sharps bins were fixed to walls in appropriate locations which were out of the reach of children. We were told that there had been no sharps injuries at the practice since the introduction of safer sharps systems.

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

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support on 18 May 2016. Emergency equipment including oxygen and 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), was available and checked on a weekly basis to ensure it was in good working order.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored in a purposely designed emergency medicines storage container and were checked on a weekly basis to ensure they were within date for safe use. Records were available detailing checks made from 2008 to 14 October 2016. We saw that the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF).

Staff completed first aid training in May 2016. We saw that a first aid kit was available which contained equipment for use in treating minor injuries. Records were available to demonstrate that equipment in the first aid box was regularly checked to ensure it was available and within its expiry date.

Staff recruitment

The practice had a robust recruitment policy that described the process to follow when employing new staff. This policy included details of the pre-employment information to obtain, interview processes and equal opportunities policy to follow.

We discussed the recruitment of staff and looked at one recruitment file in order to check that recruitment procedures had been followed. We saw that this file contained pre-employment information such as proof of identity, written references details of qualifications and registration with professional bodies. However staff had not completed a pre-employment medical questionnaire. Recruitment files also contained other information such as contracts of employment, job descriptions and copies of policies and procedures such as data protection, confidentiality, health and safety, recruitment and induction. All information had been scanned and copies were kept electronically on the practice's computer system. Copies of training certificates were also available on these files.

We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. 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.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave.

There were enough staff to support dentists during patient treatment. We were told that all dentists worked with a dental nurse. The hygienist told us that they worked alone but assistance was provided by dental nurses with decontamination of used dental instruments and when six point charting was completed. We were told that staff were able to communicate with each other via the practice's computer system which also contained a panic alarm which could be activated if required.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. A health and safety poster was on display in the staff kitchen. We saw that the practice had developed a health and safety policy which had been reviewed on 19 February 2016. The principal dentist was identified as the health and safety lead and staff spoken with said that they could obtain health and safety advice from this person.

Numerous risk assessments had been completed. For example, we saw risk assessments for fire, radiation, sharps injury, hepatitis B non-immunised staff or non-responder and a general practice risk assessment. Risk assessments were reviewed on an annual basis. The fire risk assessment was completed on 1 November 2015. This was a brief standardised document which had not been adapted to meet the needs of the practice.

We discussed fire safety with staff and looked at the service and maintenance records for fire safety equipment at the practice. Records seen confirmed that fire safety equipment such as fire extinguishers; smoke alarms and fire alarms were subject to routine maintenance by external professionals. We saw that an external company had completed a check of the fire alarm system including smoke detectors and fire extinguishers on 7 October 2016. We were not shown records to demonstrate that emergency lighting had been serviced or checked.

No action

Are services safe?

The principal dentist told us that fire drills took place on a weekly basis when the fire alarm was tested. We were not shown records to demonstrate which staff were involved and other details of the fire drill. Some of the part time staff do not work at the practice on the day of the week when the fire alarm was tested and would therefore not be involved in fire drills.

Details of all substances used at the practice which may pose a risk to health were recorded in a COSHH file. An itemised list was available which had been reviewed and updated when new products were used at the practice. We saw that COSHH products were stored in a lockable cupboard. On the day of inspection this cupboard was not locked but we were told that this had been left open for inspection and was usually locked.

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. Dental nurses who worked at the practice were responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area. Patient feedback reported that the practice was always clean and tidy.

Systems were in place to reduce the risk and spread of infection within the practice. There were hand washing facilities in each treatment room and in the decontamination room. Signs were in place to identify that these sinks were only for hand wash use. Adequate supplies of liquid soaps and paper hand towels were available throughout the premises.

Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

The practice had developed an infection control folder; all of the contents of this folder were reviewed on an annual basis with the last review taking place on 12 September 2016.

Infection prevention and control audits were completed on a six monthly basis. The last audit was undertaken on 10 June 2016 and the practice achieved an assessment score of 100 %.

Records demonstrated that the lead dental nurse had provided training to all other dental nurses in September 2016 regarding the principles of infection control. The principal dentist had undertaken separate training on 13 October 2016.

We looked at the procedures in place for the decontamination of used dental instruments. A separate decontamination room was available for instrument processing. A dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments 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 decontamination room had appropriate dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified. There was a clear flow of instruments through the dirty to the clean area. A visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with current 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.

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) they described the method they used which was in line with current HTM 01 05 guidelines. A risk assessment regarding Legionella had been carried out by

No action

Are services safe?

an external agency in February 2015. There were no recommendations for action. The practice were completing monthly routine temperature monitoring checks and records were available to demonstrate temperatures.

We discussed clinical waste with the principal dentist; we looked at waste transfer notices and the storage area for clinical and municipal waste. Clinical waste was stored in a suitable locked container which was not accessible to members of the public. We were told that clinical waste was collected every week. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, dental chairs, autoclaves, fire safety equipment, the ultra-sonic cleaner and the compressor. Records seen demonstrated the dates on which the equipment had recently been serviced.

All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in April 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that one of the emergency medicines (Glucagon) was being stored in the emergency medicines kit. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine could be stored in a refrigerator or at room temperature with a shortened expiry date. Although staff were aware that the expiry date should be shorted this had not been done. Following the inspection we received confirmation from the principal dentist that they had amended the expiry date of the medicine as appropriate.

Prescription pads were securely stored and a log of each prescription issued was kept. This recorded details of the date, prescription number and patient code.

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.

Radiography (X-rays)

The principal dentist told us that a Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure equipment was operated safely and by qualified staff only. The principal dentist was the RPS and an external company had been contracted to provide RPA services.

We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety.

The practice had three intra –oral X-ray machines that can take an X-ray of one or a few teeth at a time. The machines had been appropriately serviced and tested. Local rules were available in each of the treatment rooms were X-ray machines were located for all staff to reference if needed.

We saw that the practice had notified the Health and Safety Executive on 10 October 2016 that they were planning to carry out work with ionising radiation.

Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the current recommended interval of three years.

Dental care records where X-rays had been taken showed that dental X-rays were justified and reported on every time. The decision to take an X-ray was made according to clinical need and in line with recognised general professional guidelines.

We saw a recent X-ray audit completed in November 2015. Action plans were recorded and the next audit was due in November 2016.Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

Wediscussed patient care with the dentist and checked dental care records to confirm the findings. The practice kept up to date detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. We were told that medical history records were updated at every visit to the dental practice and we were shown evidence to confirm this.

Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE) and NICE guidance was also used to determine recall intervals for patients. Each dentist took risk factors such as diet, oral cancer, tooth wear, dental decay, gum disease and patient motivation to maintain oral health into consideration to determine the likelihood of patients experiencing dental disease. Patient care records demonstrated that risk factors had been documented and discussed with patients.

Patient dental care records that we were shown demonstrated that the dentist was following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping. The practice used a proforma on their computer to record details of their assessment of soft tissues. Records were comprehensive and included details of the condition of the teeth, soft tissues lining the mouth and the gums using the basic periodontal examination (BPE) scores. (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).

Health promotion & prevention

The practice had a strong focus on preventative care and supporting patients to ensure better oral health in line with the 'Delivering Better Oral Health' toolkit (DBOH). DBOH is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the dentist applied fluoride varnish to children who attended for an examination. Fissure sealants were also applied to children at high risk of dental decay. High fluoride toothpastes were prescribed for patients at high risk of dental decay.

Medical history forms completed by patients included questions about smoking and alcohol consumption. Patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice. Patients with a high rate of dental caries were requested to complete a record of their dietary intake for a short period of time. Staff were then able to review this information and give advice about hidden sugars in foods which may affect oral health. We saw that a leaflet about smoking cessation was available for patients in the reception and this information was offered to patients who smoked.

We saw entries in dental care records that detailed patients' oral health, discussions that had taken place with patients regarding improving oral health. A dental nurse spoken with told us that during appointments tooth brushing and interdental cleaning techniques were explained to patients in a way they understood. The hygienist told us that patients were also shown oral hygiene using a model or the patient undertook the task with assistance from the hygienist.

Free samples of toothpaste and toothbrushes were available in treatment rooms. The practice had a selection of dental products on sale in the reception area to assist patients with their oral health.

Staffing

Practice staff included a principal dentist, an associate dentist and a foundation dentist, a part time hygienist, one qualified dental nurse who is registered with the General Dental Council (GDC) and two trainee dental nurses.

We discussed staff training with the principal dentist and with a dental nurse. Training was provided to staff via attendance at courses, in-house and on-line training. Staff told us that they were encouraged to attend training courses and supported to develop their skills. The dental nurse said that regular weekly meetings were held with trainee dental nurses to provide update training. Staff spoken with said that they received all necessary training to enable them to perform their job confidently and were able to ask for help and advice as required.

The principal dentist confirmed that they monitored staff continuing professional development (CPD) to ensure staff

No action

Are services effective?

(for example, treatment is effective)

met their CPD requirements. CPD is a compulsory requirement of registration as a general dental professional. We were told that discussions were held with staff about CPD and training during appraisal meetings.

The principal dentist had a system in place to ensure that all GDC registrations were up to date. Records showed professional registration with the GDC was up to date for all relevant staff.

We saw evidence in staff recruitment files that staff had undertaken safeguarding, mental capacity, fire safety, infection control and basic life support training. We also saw that some staff had received training in other specific dental topics such as advanced preventative dentistry, decontamination and dental radiography.

Appraisal systems were in place. Staff said that appraisal meetings were held on an annual basis. We saw that personal development plans were available for staff. Staff were able to record feedback on appraisal forms and we were told that the appraisal system enabled them to discuss job satisfaction, training needs and any issues or problems.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves.

A written referral log was set up for each patient, a copy of the referral letter was kept and patients could have a copy of this letter if requested. Staff checked the referral log on a monthly basis to ensure that patients had received their referral appointments. The referral log remained 'open' until the dentist had confirmed that the referral had been received and treatment completed.

Referrals made for suspicious pathology were sent by letter to the hospital and followed up with a telephone call to ensure that the referral had been received.

Consent to care and treatment

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. The practice had developed a consent policy which had been reviewed on an annual basis with the date of last review recorded as 20 May 2016; reference was made to the Mental Capacity Act 2005 (MCA) in this policy. The 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 had recently received in-house training regarding the MCA

There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.

We were shown entries in dental care records where treatment options were discussed with patients. Any risks involved in treatment were also recorded and there was evidence in records that consent was obtained.

A written treatment plan with estimated costs was produced for all patients to consider before starting treatment. This was used to assist patients to understand the agreed treatment. Patients were also given verbal information to support them to make decisions about treatment. We were told that patients were able to go away and consider their options and obtain further information before any agreement was reached to proceed with a treatment.

We saw that consent was reviewed as part of a recent record card audit by the principal dentist on 24 November 2015.

No action

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed privacy and confidentiality were maintained for patients who used the service on the day of inspection. Treatment room 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. Dental care records were not visible to patients and computer screens at the reception desks were not overlooked which helped to maintain confidential information at reception. Staff spoken with told us that if computers were ever left unattended then they would be logged off to ensure confidential details remained secure.

Music was played in the waiting area and in treatment rooms, 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 or in the treatment room.

Patients provided positive feedback about the practice on comment cards which were completed prior to our inspection. Feedback from patients spoken with on the day of inspection was positive and they commented that they were treated with care, respect and dignity. We observed staff to be friendly and respectful towards patients during interactions at the reception desk and over the telephone.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Posters detailing both NHS and private costs were on display in the reception area.

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. Clear treatment plans were given to patients which also detailed possible treatment and costs. Patients commented they felt involved in their treatment and it was fully explained to them. We were told that staff spent their time explaining treatment options, risks and benefits. Staff told us that patients were given details of websites to enable them to conduct further research regarding treatments.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS treatment and treatment costs were clearly displayed in the waiting area. Private treatment upgrades were available if requested and the cost of private treatment was also on display in the waiting area.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment. There were vacant appointment slots to accommodate urgent appointments.

Staff told us that patients were usually able to get an appointment on the day that they telephoned and were always able to get an appointment if they were in dental pain. The practice sent appointment reminders via text message and also via telephone and letter if required.

Tackling inequity and promoting equality

The practice had a policy on equal opportunities to support staff in understanding and meeting the needs of patients. This policy was last reviewed on 10 June 2016.

The practice appeared to recognise the needs of different groups in the planning of its services. A disability access audit was completed on 27 November 2015 and various adaptations had been made to the practice. There was a hearing induction loop for use by people who were hard of hearing and the practice was suitable for wheelchair users, having level access to enter the premises, ground floor treatment rooms and a ground floor disabled access toilet.

We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

We asked about communication with patients for whom English was not a first language. We were told that staff contacted Birmingham City Council translation services and then a three way conversation could be held over the telephone whenever needed.

Access to the service

The practice was open from 8.30am to 5.30pm Monday Tuesday, and Thursday, 8.30am to 1pm on Wednesday and 8.30am to 3.30pm on Friday. The opening hours were displayed in the practice and on the practice information leaflet.

Patients could access care and treatment in a timely way and the appointment system met their needs. Emergency appointments were set aside for each dentist every day; and we were told that patients in pain would always be seen within 24 hours of calling the practice. Patients commented that they were able to see a dentist easily in an emergency. A telephone answering machine signposted patients to the NHS 111 service when the practice was closed during the evening, weekends and bank holidays. This information was also available in the practice information leaflet.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding.

The policy also recorded contact details such as NHS England and the Birmingham Primary Care Shared Services Agency. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice.

Staff told us that they would take details of any complaints received, initially offer an apology and pass details of the concerns to the principal dentist. Guidance was available regarding the action to take when a complaint was received, for example completion of a complaint log. We saw that a complaint log pad was available to record details of any complaints received. The practice had not received any complaints since 2013.

Patients were given information on how to make a complaint. We saw that a copy of the complaints policy was on display in the waiting area and the practice leaflet also gave patients information on how to make a complaint.

Staff we spoke with were aware of their responsibilities regarding 'Duty of Candour'. Staff said that patients would be informed of any incident that affected them; they would

No action

Are services responsive to people's needs?

(for example, to feedback?)

be given feedback and an apology. Staff spoken with felt that by being open and honest, offering an initial apology and immediate assistance to sort out any problems mitigated the risk of receiving complaints.

No action

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of the service. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice such as complaints management, safeguarding and infection control.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. These included health and safety, complaints,

safeguarding, and infection control policies. These policies were available in the practice manual which was available to all staff. Staff we spoke with told us that during their induction period they had been given time to read the practice manual and we saw that staff had signed documentation to confirm this.

Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, sharps, infection prevention and control, radiography and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately. The practice had completed a risk management strategy for dental records. This recorded actions to take to mitigate the risk of insufficient information recorded in dental records. For example update medical history at every visit, record all advice given and treatment options.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. These included six monthly infection prevention and control audits, audits regarding clinical record keeping and radiography.

Leadership, openness and transparency

The culture of the practice encouraged candour, openness and honesty to promote the delivery of high quality care and to challenge poor practice. Staff confirmed that the culture was open and supportive; staff told us that they worked well as a team, provided support for each other and were praised by the management team for a job well done. We were told that everyone at the practice was friendly and helpful.

There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff were aware of who held lead roles within the practice such as complaints management, safeguarding and infection control.

Complaints systems encouraged candour, openness and honesty. Staff were aware of their responsibilities regarding Duty of candour.

We saw that practice meetings took place on a monthly basis. Staff told us that the minutes of the most recent staff meeting were always put on display on the noticeboard to enable those staff who were unable to attend the meeting to be updated about discussions held.

Staff told us that the principal dentist 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.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that infection control audits were completed on a six monthly basis. Other audits included radiography, record card, disability access audit, waiting time audit and a clinical waste audit. Action plans were recorded as required.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Staff told us that support was provided to enable them to complete any training required.

Annual appraisal meetings were held and personal development plans available for all staff. Foundation dentists received on-going appraisal during their 12 month period of working at the practice. We saw evidence that the principal dentist had a personal development plan (PDP) in place with their last appraisal meeting taking place on 7 September 2016.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to

No action

Are services well-led?

complain. For example there was a compliments book and the friends and family test (FFT) box in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided.

Annual patient satisfaction surveys are given to 50 patients each year by reception staff. The results were collated by the foundation dentist as part of their training. We looked at the results of the last satisfaction survey and saw that all of the surveys recorded extremely positive feedback about the practice with the majority of responses rating the practice as outstanding.

We saw that a poster regarding the April to September 2016 FFT results was on display in the waiting room. All responses were extremely positive.

The practice team indicated and were able to describe ways in which suggestions they had made had elicited change in the practice to the benefit of the staff and patients.

Staff said that they would speak with the principal dentist manager or senior nurse if they had any issues they wanted to discuss. We were told that the management team were open and approachable and always available to provide advice and guidance. Staff spoken with felt that Trinity Dental Practice was a very friendly place to work and everyone worked well together as a team.