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# Brandhall Dental Care

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 7 June 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**

Brandhall Dental Care has one dentist who works full time, and two part time dentists, one of whom is the principal dentist and one undertaking dental foundation training. (Dental foundation training is a post qualification training period which graduates need to undertake to work in NHS practice). There are two qualified dental nurses who are registered with the General Dental Council (GDC) and a trainee dental nurse. One of the dental nurses is the practice manager. In addition to these staff there is also a part time hygienist and a receptionist. The practice's opening hours are 9am to 5pm on Monday to Friday with late night opening on some Wednesdays until 7pm.

Brandhall Dental Care provides NHS and private dental treatment for adults and children. The practice has three dental treatment rooms, two of which are on the ground floor. There is also a separate decontamination room for cleaning, sterilising and packing dental instruments. There was also a reception and waiting area.

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

# Summary of findings

during the inspection we spoke with patients. We received feedback from 48 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.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six 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.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions.
- Staff demonstrated knowledge of whistleblowing and were confident they would raise a concern about another staff member's performance if it was necessary.
- 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.

# 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 sufficient numbers of suitably qualified staff working at the practice. The practice followed procedures for the safe recruitment of staff, this included carrying out disclosure and barring service (DBS) checks, and obtaining references.

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.

Infection control audits were being undertaken on a six monthly basis in line with the recommendations of HTM 01-05. 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?**

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. Patients' dental care records provided comprehensive information about their current dental needs and past treatment.

The dentist was aware of 'The Delivering Better Oral Health Toolkit' (DBOH) with regards to prevention of oral disease and 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.

### **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.

### **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 developed a complaints procedure and information about how to make a complaint was available for patients to reference.

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

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

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.

There were good governance arrangements and an effective management structure in place. Regular staff meetings were held and staff said that they felt well supported and could raise any issues or concerns with the practice manager or principal dentist.

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills.

# Brandhall Dental Care

## 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 7 June 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 seven 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 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

Systems were in place to enable staff to report incidents and accidents. We saw that an accident reporting book and significant event reporting forms were available. We were shown three staff accidents that had occurred within the last 12 months. We saw that advice follow up action; such as staff training, had been recorded on the staff accident records seen. Accidents, as well as any learning points identified were discussed at staff meetings as and when they occurred. We were told that the records of any accidents involving patients were kept on their patient care records. Staff accident records prior to 2015 were kept on staff files. Without a search through patient care records or staff files it would be difficult to identify the date or details of accidents. The practice had not kept a log of accidents and there was no monitoring to identify any trends. Following this inspection we received a copy of a patient and staff accident log which had been implemented at the practice. This required information regarding the accident, further action and details of any risk assessment completed.

Significant events had been reported and were recorded on a log sheet. This sheet recorded the number of significant events that had occurred during the year and included a summary of each event. Details of actions taken and any changes implemented as a result of the significant event were also recorded. We saw that there had been six significant events during 2015/2016. Three administrative and three clinical significant events had been reported such as the X-ray machine having an electrical fault and being put out of action and an error regarding the collection of dentures. We saw the minutes of staff meetings which recorded discussions held regarding significant events. We were told that the principal dentist was the lead for significant events and staff spoken with were aware who held this role.

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. A health and safety booklet 'RIDDOR Explained' was available for staff to review. We were told that there had been no events at the practice that required reporting under RIDDOR.

Systems were in place to ensure that all staff members were kept up to date with any national patient safety and medicines alerts. The practice received these alerts via email. Relevant alerts were forwarded to all staff at the practice; a copy was printed off and kept in a medical alerts file and staff signed and dated documentation to confirm that they had read and understood these safety alerts. The practice kept a spread sheet on the computer which recorded information regarding the alert received and details of any action taken as a result of the information received.

We saw that information regarding Duty of Candour was available in the patient information folder in the waiting room. This informed patients that they would be informed when things went wrong, when there was an incident or accident and would be given an apology.

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

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. Details of how to report suspected abuse to the local organisations responsible for investigation were available. We were told that the practice manager and principal dentist were the safeguarding leads at the practice. There had been no safeguarding issues to report. We saw evidence that all staff had completed the appropriate level of safeguarding training. The principal dentist told us that staff were given copies of the practice's safeguarding policies and procedures on an annual basis and these were discussed during in-house refresher training during a practice meeting.

Accident records demonstrated that there had been two sharps injuries within the last 12 months. The practice were using a system whereby needle guards and single hand re-sheathing was used for needles following administration of a local anaesthetic to a patient. The responsibility for disposal of sharps sometimes rested with the dental nurse. Sharps information was on display in treatment rooms and other locations where sharps bins were located. We were told that the practice would amend their policy and practice to ensure that only dentists re-sheath and dispose of sharps. Following this inspection we received a copy of the amended policy which recorded that the responsibility for disposal of sharps rested with dentists.

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

## Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support and emergency equipment was available and checked regularly to ensure it was in good working order. 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. Records confirmed that emergency medical equipment was checked regularly by staff. We saw that the oxygen cylinder was half full. We also noted that the practice had previously reported an issue with an oxygen cylinder valve not working properly and the oxygen cylinder being empty upon checking. The principal dentist told us that they were considering purchasing a second oxygen cylinder for the practice in case of emergency.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. Emergency medicines were stored in a dedicated medical emergency box. This contained laminated sheets with information on for staff regarding each medicine in the box. All emergency medicines were appropriately stored and there was a log sheet which recorded the expiry dates of emergency medicines. There was no documentation to demonstrate that regular checks were made to ensure that all emergency medicines were available for use. The principal dentist confirmed that these details would be added to the expiry date log sheet. We were sent a copy of this document following this inspection. 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).

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. The practice manager and principal dentist were the designated first aiders. Update training regarding first aid was due for both of these staff in June 2016; we were told that the practice manager was in the process of booking this training.

## Staff recruitment

We discussed the recruitment of staff and looked at two recruitment files in order to check that recruitment procedures had been followed. We saw that both files contained a front sheet which recorded information such as hepatitis B status, core CPD training dates, appraisal date, holiday and sick leave information. Risk assessments were on file for staff working at the practice prior to receipt of their Disclosure and Barring Service check (DBS) and where these had been received the application number and the date on which this was due for renewal was recorded. We were told that DBS checks 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. We also saw that staff had signed an annual declaration to confirm that there had been no change to their DBS status.

Recruitment files contained pre-employment information such as proof of identity, written references details of qualifications and registration with professional bodies, signed confidentiality agreements, contracts of employment, job descriptions and copies of policies and procedures such as disciplinary, grievance, equal opportunities and sickness.

The practice planned for staff absences to ensure the service was uninterrupted. We saw evidence to demonstrate that staff booked annual leave in advance and an annual leave planner was on display in the practice manager's office so that cover could be arranged. The practice had recruited a dental nurse who was due to start their employment on 13 June 2016. The practice manager was also a qualified dental nurse who would be able to undertake dental nursing duties in times of need. We were told that agency dental nurses had been used in the past and would always be used if necessary to provide cover. However, we were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave. All nursing staff had been trained to work on reception and would be able to provide cover for



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the receptionist whilst this member of staff was on leave. A weekly duty rota detailed where dental nursing staff would be working. For example on reception or it recorded the name of the dentist they would be working with. There were enough staff to support dentists during patient treatment. We were told that all dentists worked with a dental nurse.

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

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that a practice safety folder had been developed which contained for example, information regarding first aid, health and safety, lone working, manual handling, risk assessments and control of substances hazardous to health (COSHH) information. COSHH information booklets produced by the health and safety executive were available for staff. Staff had signed a document to confirm that they had read the COSHH assessment procedure. Material safety data sheets were available for clinical chemical substances used. Details of all cleaning substances used were available in the cleaners file.

Numerous risk assessments had been completed. For example, we saw risk assessments for fire, sharps injury, display screen equipment, hepatitis B non-responder, working without a DBS check and a general practice risk assessment. Risk assessments were reviewed on an annual basis. We saw that the practice had developed a health and safety policy which had been reviewed on an annual basis and updated as required. A health and safety poster was on display in the staff room. Staff had signed a document to confirm that they had read the practice's health and safety policy.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire risk assessment was completed in 2010 and had been reviewed on an annual basis thereafter. Issues for action had been identified and we saw evidence of actions taken such as introduction of a no smoking policy. Staff had signed to confirm that they had read the fire risk assessment.

The principal dentist was identified as the fire marshal and they had undertaken training regarding this in July 2014. Records seen confirmed that fire safety equipment such as fire extinguishers; fire alarms and emergency lighting was subject to routine maintenance by external professionals.

We saw documentary evidence to confirm that a fire drill had been completed in January and May 2016. The principal dentist told us that staff regularly checked emergency lighting to ensure it was in good working order. However, there was no documentary evidence to confirm this. Following this inspection we received email confirmation that an external company were visiting the practice on 13 June 2016 to provide a log book, test key and training for staff regarding tests for emergency lighting.

## **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. An external cleaning company attended the practice each morning and 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.

Systems were in place to reduce the risk and spread of infection within the practice. Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

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. Posters describing hand washing techniques were on display above these sinks. 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. We were told that a hand hygiene assessment was undertaken on a regular basis. We saw a report to demonstrate this dated April 2016. When issues were identified with staff hand hygiene techniques we were told that staff were re-trained and then re-assessed within two weeks.

The practice had an infection control policy which had been reviewed on an annual basis. The names of the staff



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with the lead role regarding infection prevention and control were recorded. The policy was available in the office and we were told that this was to be laminated and put on display in the decontamination room.

Infection prevention and control audits were completed on a six monthly basis. The last audit was undertaken in January 2016 and the practice achieved an assessment score of 98%. The practice were meeting the requirements of the Department of Health's guidance on decontamination (HTM 01-05). Infection prevention and control including the findings of audits was discussed at staff meetings. We looked at some of the recent audits and saw that outcomes, improvements and action plans were recorded. For example we saw an action plan dated June 2014. We saw that the practice completed an annual cross infection statement.

We looked at the procedures in place for the decontamination of used dental instruments. A separate decontamination room was available for instrument processing. The decontamination room had dirty and clean zones in operation to reduce the risk of cross contamination and staff were aware of this. However there was no signage to demonstrate the work flow. 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. 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 an external agency and a certificate recorded that the next assessment was due in August 2016.

We discussed clinical waste and looked at waste transfer notices and the storage area for clinical and municipal waste. Clinical waste storage was in an area where members of the public could not access it. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Sharps bins were situated in appropriate locations which were out of the reach of children. Needle stick policies were on display in each treatment room.

## Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, fire safety equipment, and the autoclave. Records seen demonstrated the dates on which the equipment had recently been serviced. The practice had a contract for servicing of autoclaves and records were available to demonstrate that these machines were serviced on a quarterly basis. Compressors did not require servicing again until January 2017. All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in May 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test. We saw the Gas safety certificate which was due for renewal in May 2017.

We saw that the temperature of the room in which the emergency medicines were being stored was being monitored by the practice. This was to ensure that medicines were stored at the required temperature below 25 degrees Celsius.

The practice manager kept a log of expiry dates for all medicines to be used in an emergency. This was checked on a regular basis to ensure that those medicines available could be replaced as required.

Prescription pads were securely stored and a log of each prescription issued was kept. We were told that the practice intended to include an audit of prescription pads as part of their record keeping audit. Following this inspection we were sent a copy of the newly implemented documentation to be used to audit prescriptions.

# Are services safe?

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.

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

The practice had well documented and organised radiation protection information. We saw that processing and chemical logs were present and tests and checks easily accessible and well organised. 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. We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety. The practice manager and one of the dental nurses had also undertaken training to enable them to take radiographs. Local rules were available in each of the treatment rooms where X-ray machines were located for all staff to reference if needed. Emergency cut-off switches were also located outside of the treatment room.

We saw that the practice had notified the Health and Safety Executive that they were planning to carry out work with ionising radiation. This notification was displayed in the staff room. 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. We saw that only one of the three pieces of X-ray equipment was fitted with collimators, (collimators reduce the radiation dose to the patient). Following the inspection we were sent evidence to demonstrate that two further collimators had been ordered.

Copies of X-ray audits completed from 2011 to October 2015. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw that improvements required and improvements made were documented.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The practice held computerised dental care records for each patient. They contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by the dentist. Patients at the practice completed a medical history form, or updated their details at every visit to the practice. The dentist then checked the medical history with the patient before any examination or treatment began.

The dentist told us and we saw records to confirm that an assessment of the patients' soft tissues of the mouth and periodontal tissues (the gum and underlying bone) was undertaken using the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums. During the assessment the dentist looked for any signs of mouth cancer. Patients were then made aware of the condition of their oral health and following the clinical assessment the diagnosis was discussed with the patient and treatment options explained in detail.

Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE), particularly in respect of lower wisdom teeth removal and antibiotic prescribing. 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 and gum disease into consideration to determine the likelihood of patients experiencing dental disease. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Patient dental care records that we saw demonstrated that all of the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

### Health promotion & prevention

We discussed 'The Delivering Better Oral Health Toolkit' with the principal dentist. (This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting). Patient care records we saw demonstrated that high concentration

fluoride toothpastes were prescribed when required and advice given to patients regarding diet and smoking cessation. Two dental nurses had been trained in the application of fluoride varnish to children.

A stop smoking information booklet was available for patients and oral health posters were on display in the waiting room. A television in the waiting room showed oral health messages. Free samples of toothpaste were available and patients could purchase products to assist with oral hygiene.

Two dental nurses had received training to become oral health educators. The practice had recently introduced drop in oral health clinics on a Thursday afternoon. The number of patients who had attended these clinics was low and these were being promoted. We were also told about an oral cancer drop in session which had taken place. This was to make patients aware of oral cancer risks and to have an oral cancer assessment.

The practice had taken part in national smile month and promotional boards were seen as evidence of this. The foundation dentist had visited a local school and playgroup to provide education to children. We were told that the practice was considering providing educational visits to mother and toddler groups and local care homes.

### Staffing

Practice staff included a principal dentist (responsible person), practice manager, one full time associate dentist and the foundation dentist, two dental nurses, (one qualified and one trainee) and a part time receptionist.

We discussed staff training with the principal dentist and with staff. We saw that a training log was on display in the practice manager's office. This listed the staff member with details of training to be completed during the year. For example, mental capacity act, equality and diversity and decontamination. The training log recorded the policies and procedures to be discussed with staff and the in-house training provided. This was in addition to the core continuous professional development (CPD) to be completed by staff. Staff told us that they were encouraged to attend training courses and supported to develop their skills. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Records showed professional registration with the GDC was up to date for all relevant staff. The practice manager had a system in place to ensure that all GDC

# Are services effective?

## (for example, treatment is effective)

registrations were up to date. A GDC check and reminder log was in place which detailed, for example the name of staff, their GDC renewal date, details of indemnity insurance, DBS check, hepatitis B status and appraisal information.

The principal dentist confirmed that they monitored staff continuing professional development (CPD) to ensure staff 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 and personal development meetings. Training was provided to staff via attendance at courses, in-house and on-line training. Core CPD was monitored to ensure staff undertook training regarding safeguarding, mental capacity, complaints, radiation protection, decontamination and disinfection, medical emergencies, legal and ethical issues and oral cancer.

Appraisal systems were in place. We saw that staff had received an annual appraisal and a six monthly review. Personal development plans were available for staff.

### **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, oral surgery or community services. A referral log was set up and maintained by reception. We were told that when information was returned to the practice it was scanned and put on patient notes. However, there was no system in place to check whether referrals had been received and acted upon. The principal dentist said that a system would be implemented immediately. We

were sent a copy of a new referral log sheet which also requested staff to report to dentists on a monthly basis the details of any referrals that hadn't been received or acknowledged.

We saw a template that was used in the treatment room to refer patients to hospital if they had a suspected oral cancer. These were comprehensive, and dentists followed Federation of General Dental Practice (FGDP) guidelines when making notes for these referrals.

### **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. The practice displayed guidance on the principles of the MCA and staff spoken with were aware of the MCA and best interest decisions. We saw evidence that staff had completed training regarding the mental capacity act. 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. The practice had developed a consent policy which had been reviewed on a regular basis. We were told that a written consent form was used when complex procedures were completed. The form recorded details of options, risks and complications as well as a breakdown of costs of treatment. Patient records we saw demonstrated that consent had been obtained for both adults and children having treatment. We saw evidence to demonstrate that consent was reviewed as part of a recent record card audit.

# Are services caring?

## Our findings

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

We discussed privacy and confidentiality with staff. We were told that all staff received a copy of the confidentiality policy upon employment at the practice and this was regularly discussed during staff meetings. We saw documentation which staff had signed to confirm that they had read and would work in accordance with the confidentiality policy. Staff we spoke with discussed the ways in which privacy and confidentiality were maintained for patients who used the service. Private discussions could be held with patients in treatment rooms away from the reception area if required. 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. A television in the waiting area also played dental information which may also distract anxious patients and also provided useful dental information to all.

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. All dental nurses had received training to enable them to work on the reception; this helped to ensure that the reception desk was staffed at all times.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. Staff told us that they made general conversation and took their time with anxious patients to try and make them feel relaxed. We received feedback from 48 patients which was overwhelmingly positive. Patients commented that staff were caring, helpful and professional. Patients also said that they were treated with respect and dignity.

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

The practice provided patients with information to enable them to make informed choices. Clear treatment plans were given to patients which detailed possible treatment and costs. Consent forms also gave patient information regarding treatments, risks and benefits. 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. NHS and private costs were on display in the reception area. Patients commented they felt involved in their treatment and it was fully explained to them. Patients were also informed of the range of treatments available.

The principal dentist demonstrated a good understanding of Gillick principles. The test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions about their care and treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice provided NHS and private treatment and treatment costs were clearly displayed in the waiting area, in the patient information folder in the waiting area and on the practice website. Information was available about appointments on the practice's website. Patients were able to book an appointment and give feedback about the service received via the website. Details of the staff team, opening times, treatments available and some patient feedback was provided on the practice's website. The practice was open until 5pm each night Monday to Friday and was open until 7pm most Wednesday evenings. The late evening opening was implemented at the request of patients. This helped to ensure that those patients with work commitments were still able to receive an appointment with a dentist.

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.

### Tackling inequity and promoting equality

The practice appeared to recognise the needs of different groups in the planning of its services. The practice had policies on disability and equal opportunities to support staff in understanding and meeting the needs of patients. Staff were given copies of these policies upon employment at the practice and these were reviewed and discussed with staff on a regular basis. Staff had signed a document to confirm that they had read these policies. Equality and diversity training had also been provided for staff.

We asked about communication with patients for whom English was not a first language. We were told that the majority of patients were able to communicate with staff in English; some staff were able to speak Punjabi and staff had contact details for a translation service if required. Patient's computer records alerted staff to those patients whose first language was not English and those who may require a translation service.

This practice was suitable for wheelchair users, having ramped access to the front of the building and two ground floor treatment rooms. There was also one toilet for patient use on the ground floor and this had an emergency pull cord and grab rails to assist those with restricted mobility. The practice had a hearing induction loop at the reception, to assist patients who used a hearing aid. We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language. There was also a large portable magnifying viewer for use by patients with sight difficulties.

### Access to the service

The practice was open from 9am to 5pm Monday to Friday (closed between 1pm to 2pm) and there was some late night opening on a Wednesday until 7pm. The opening hours were displayed in the practice, on the practice's website. A telephone answering machine informed patients that the practice was closed between 1pm to 2pm each day and appropriate signage was placed on the entrance door to the practice during this time. Patients were able to leave a message during this time and staff told us that their first job after lunch was to call patients who had left answer phone messages. The telephone answering machine also gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays.

Patients were able to make appointments over the telephone, via the practice website or in person. Staff we spoke with told us that patients could access appointments when they wanted them. Emergency appointments were set aside for each dentist every day; this ensured that patients in pain could be seen in a timely manner. Patients requiring emergency appointments were told to telephone the practice before 11am to receive an appointment on the same day. We were told that when all of the vacant emergency slots were filled patients would be asked to visit the practice to sit and wait to see the dentist. Staff told us that patients in dental pain were always seen within 24 hours of their initial contact with the practice. We were told that patients were usually able to get an appointment on the day that they telephoned and were rarely kept waiting beyond their appointment time. Patients we spoke with and information on comment cards confirmed this.

### Concerns & complaints



# Are services responsive to people's needs?

(for example, to feedback?)

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 General Dental Council. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice. Staff spoken with were knowledgeable about how to handle a complaint. We were told that complainants would always be offered a meeting with the practice manager or the principal dentist. Details of all complaints would be sent to the practice manager. We saw that a complaint log was on display in the practice manager's office. This recorded the details of complaints received during the year. This enabled the practice manager to monitor complaints to ensure appropriate action had been taken within the required timescales as detailed in the practice's complaint procedure. The complaint log recorded details of the complaint, action taken, follow up and outcome. We were told that complaints were discussed at practice meetings and any learning points identified and shared with staff.

We saw that information regarding 'Duty of Candour' was available in the patient information folder in the waiting

area. This recorded that the practice would admit any error and patients would be informed of any incident that affected them; they would be given feedback and an apology. Staff were aware of Duty of Candour and said that they always offered an apology. We saw correspondence between the practice and complainants which demonstrated this.

Patients were given information on how to make a complaint. The practice leaflet gave patients information on how to make a complaint and patients were able to leave feedback via the practice website if they preferred. We saw that the practice had developed a code of conduct for patient complaints. Information regarding how to complain was on display in the waiting area and in the practice folder.

Staff spoken with were aware of the practice's policies and procedures regarding complaints and all had signed documentation to confirm that they had read these documents. Staff confirmed that complaints were discussed at practice meetings as and when they arose.



# 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 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. Staff had been given a number of policies during their induction to the practice. For example staff had copies of the information governance, confidentiality, equality and diversity, grievance and disciplinary policies.

The practice had clear lines of responsibility and accountability. Staff were aware of their roles and responsibilities and were also aware who held lead roles within the practice.

We saw a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment.

### Leadership, openness and transparency

The culture of the practice was open and supportive. Staff told us that they worked well as a team, and enjoyed working at the practice. There was an effective management structure in place to ensure that responsibilities of staff were clear. The principal dentist and practice manager held all lead roles. Staff were aware of this and said that the management team were approachable, always available to provide advice and guidance and were helpful. Practice meetings were held on a regular basis and staff said that they were encouraged to contribute ideas to the running of the practice. Staff told us that they felt involved, valued and supported.

Complaints systems encouraged candour, openness and honesty. Duty of candour information was available for patients to see in the patient information folder.

### 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, hand hygiene and numerous other audits were completed. Action plans were recorded as required and we saw evidence to demonstrate that the findings of audits were discussed with staff. There was a designated lead for clinical audit at the practice and clinical staff spoken with were aware who held this lead role.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). The practice manager monitored to ensure staff were up to date with their CPD requirements and staff said that support was provided to enable them to complete training required. Annual appraisal and six monthly review meetings were held and personal development plans available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

Practice meetings were held where learning was disseminated and these were minuted. Staff said that they found these meetings useful.

### 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 complain. Patients had various avenues available to them to provide feedback, for example; a suggestions box and the friends and family test (FFT) box in the waiting room. The friends and family test is a national programme to allow patients to provide feedback on the services provided. Patients were able to contact the practice via their website to leave comments or ask questions. The practice also conducted patient satisfaction surveys on a six monthly basis. We were told that the current survey related to treatment received.

We looked at the FFT results for June 2015. All responses were positive, with the large majority of patients recording that they were very satisfied to questions asked such as confidentiality of information and the manner in which they were welcomed. Patients commented they were welcomed by the dentist in a friendly manner, staff were caring and courteous. We saw that the results of FFT were on display on the patient noticeboard in the waiting room. There was a 'you said we did' poster on display which

## Are services well-led?

recorded comments made by patients and the action taken by the practice to address issues. For example patients had requested late night opening on one night per week and toys to keep children occupied. We saw that toys had been provided and the practice was opening most Wednesday

evenings until 7pm. The results of the 2015 patient satisfaction survey were available in the patient information folder in the waiting room. The principal dentist told us that the results from satisfaction surveys, FFT and suggestions were discussed at staff meetings.