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Roe Street Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 25 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

Roe Street Dental Practice is located in the centre of Macclesfield and comprises a reception and waiting room

on the ground floor, and three treatment rooms on the first floor. Parking is available in nearby car parks. The practice is accessible to patients with disabilities and impaired mobility, but not to wheelchair users.

The practice provides general dental treatment to patients on an NHS or privately funded basis. The opening times are Monday to Thursday 9.00am to 5.00pm and Friday 9.00am to 4.45pm. The practice is staffed by a principal dentist, three associate dentists, a dental therapist/hygienist, six dental nurses, and one receptionist.

The principal dentist is registered with the Care Quality Commission 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.

We received feedback from ten people during the inspection about the services provided. Patients commented that they found the staff friendly, and caring, and that all the staff listened to them and took appropriate action. They commented that the dentists were knowledgeable and that they were always given good and helpful explanations about dental treatment. Patients commented that the practice was clean and comfortable.

Our key findings were:

Summary of findings

- The practice had procedures in place to record and analyse significant events and incidents.
- Staff had received safeguarding training, and knew the process to follow to raise concerns.
- There were sufficient numbers of suitably qualified, skilled staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies, and emergency medicines and equipment were available.
- The premises and equipment were clean, secure and well maintained.
- Staff followed current infection control guidelines for decontaminating and sterilising equipment.
- Patients' needs were assessed, and care and treatment were delivered, in accordance with current legislation, standards, and guidance.
- Patients received information about their care, proposed treatment, costs, benefits, and risks and were involved in making decisions about it.
- Staff were supported to deliver effective care, and opportunities for training and learning were available.
- Patients were treated with kindness, dignity, and respect, and their confidentiality was maintained.
- The appointment system met the needs of patients, and emergency appointments were available.
- Services were planned and delivered to meet the needs of patients, and reasonable adjustments were made to enable patients to receive their care and treatment.
- The practice gathered the views of patients and took their views into account.

- Staff were supervised, felt involved, and worked as a team.
- Governance arrangements were in place for the smooth running of the practice, and for the delivery of high quality person centred care.

We identified the practice did the following which had a positive impact on patient experience and health outcomes.

The provider demonstrated a commitment to promoting a good quality of life to patients and supporting patients to achieve positive outcomes, in respect of their general health and well-being, in addition to their oral health.

- The provider was aware that people often experienced a range of issues in their lives in relation to, for example, health or social problems, and did not always feel comfortable in addressing those directly with a health care professional. We observed that the provider had produced a range of information cards for patients to take away providing brief information on sources of specialised help and advice, for example, Childline, NSPCC, Mind and other organisations providing help with health issues, abuse or domestic violence. The cards were made available to patients in a discreet location in the patient toilet facilities.

We believe this to be notable practice worth sharing as it demonstrates involvement with the local community and other organisations to make sure people's needs are met.

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.

The provider had systems and processes in place to ensure care and treatment were carried out safely, for example, there were systems in place for infection prevention and control, dental radiography, and for investigating and learning from incidents and complaints.

Staff were appropriately recruited, suitably trained and skilled.

The practice had emergency medicines and equipment available, including an automated external defibrillator. Staff were trained in responding to medical emergencies and practiced regularly as a team.

We found the equipment used in the practice, including medical emergency and radiography equipment, was well maintained and tested at regular intervals.

The premises was secure and properly maintained. The practice was cleaned regularly and there was a cleaning schedule in place identifying tasks to be completed.

There was guidance for staff on the decontamination of dental instruments which they were following.

The practice was following current legislation and guidance in relation to X-rays, to protect patients and staff from unnecessary exposure to radiation.

No action



Are services effective?

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

The practice followed current guidelines when delivering dental care and treatment to patients. Patients' medical history was recorded at their initial visit and updated at subsequent visits. Clinicians obtained consent from patients before treatment was provided; and treatment focused on the patients' individual needs. Patients were given a written treatment plan which detailed the treatments considered and agreed, together with the fees involved.

Patients received an assessment of their dental health. Staff provided oral health advice to patients and monitored changes in their oral health. Patients were referred to other services, where necessary, in a timely manner.

The provider had produced a range of information cards for patients to take away with details of sources of advice and help on a range of health and social issues.

Qualified staff were registered with their professional body, the General Dental Council, and were supported in meeting the requirements of their professional regulator. Staff received on-going training in a variety of subjects to assist them in carrying out their roles.

No action



Are services caring?

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

No action



Summary of findings

Patients commented that staff were caring and friendly. They told us they were treated with respect, and that they were happy with the care and treatment given.

Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Patient feedback on CQC comment cards confirmed that staff were understanding and made them feel at ease.

The practice had separate rooms available if patients wished to speak in private.

We found that treatment was clearly explained, and patients were given time to decide before treatment was commenced. Patients commented that information given to them about options for treatment was helpful.

Are services responsive to people's needs?

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

Patients had access to appointments to suit their preferences, and emergency appointments were available on the same day. Patients could request appointments by telephone or in person. The practice opening hours and the 'out of hours' appointment information was provided at the entrance to the practice, in the practice leaflet, and on the practice website.

The practice captured social and lifestyle information on the medical history forms completed by patients which helped the dentists to identify patients' specific needs and direct treatment to ensure the best outcome was achieved for the patient. Dentists were familiar with the specific issues of their patient population and regularly updated their knowledge of these issues.

The provider had taken into account the needs of different groups of people and put adjustments in place, for example, for people with disabilities and patients whose first language was not English. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records.

The practice had a complaints policy in place which was displayed in the waiting room and outlined in the practice leaflet, and on the practice website. Complaints were thoroughly investigated and responded to appropriately.

No action



Are services well-led?

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

The provider had effective systems and processes in place for monitoring and improving services.

The practice had a management structure in place, and some of the staff had lead roles. Staff reported that the provider was approachable and helpful, and took account of their views.

The provider had put in place a range of policies, procedures and protocols to guide staff in undertaking tasks and to ensure that the service was delivered safely. We saw that these were regularly reviewed.

No action



Summary of findings

The provider used a variety of means to monitor quality and safety at the practice and to ensure continuous improvement in the practice, for example, learning from complaints and patient feedback.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete, accurate, and securely stored. Patient information was handled confidentially.

The culture of the practice encouraged openness and honesty. Staff told us they were encouraged to raise any issues or concerns.

The practice held regular staff meetings, and these gave everybody an opportunity to openly share information and discuss any concerns or issues.

Roe Street Dental Practice

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 25 October 2016 and was led by a CQC Inspector assisted by a dental specialist adviser.

Prior to the inspection we asked the practice to send us some information which we reviewed. This included details of complaints they had received in the last 12 months, their latest statement of purpose, and staff details, including their qualifications and professional body registration number where appropriate. We also reviewed information we held about the practice.

During the inspection we spoke to dentists, dental nurses and the receptionist. We reviewed policies, protocols and other documents and observed procedures. We also reviewed CQC comment cards which we had sent prior to the inspection for patients to complete about the services provided at the practice.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The provider had procedures in place to report, record, analyse, and learn from significant events and incidents. We discussed examples of significant events which could occur in dental practices and we were assured that should one occur it would be reported and analysed in order to learn from it, and improvements would be put in place to prevent re-occurrence.

Staff had a good understanding of the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 and were aware of how and what to report. The provider had procedures in place to record and investigate accidents, and we saw examples of these in the accident book.

Staff understood their responsibilities under the Duty of Candour. Duty of Candour means relevant people are told when a notifiable safety incident occurs, and in accordance with the statutory duty, are given an apology and informed of any actions taken as a result. The provider knew when and how to notify CQC of incidents which could cause harm.

The provider received safety alerts from the Medicines and Healthcare products Regulatory Agency and Department of Health. These alerts identify problems or concerns relating to a medicine, or medical and dental equipment, or detail protocols to follow, for example, in the event of an outbreak of pandemic influenza. The provider brought relevant alerts to the attention of the staff. The dentists were able to discuss examples of recent alerts with us. We saw that copies of alerts were retained and actions taken in response to them were recorded.

Reliable safety systems and processes (including safeguarding)

We saw that the practice had systems, processes and practices in place to keep people safe from abuse.

The provider had a whistleblowing policy in place with an associated procedure to enable staff to raise issues and concerns.

The provider had a policy for safeguarding children and vulnerable adults. The principal dentist had a lead role for safeguarding and provided advice and support to staff

where required. Local safeguarding authority's contact details for reporting concerns and suspected abuse to were displayed in the treatment rooms. Staff were trained to the appropriate level in safeguarding, and were aware of how to identify abuse and follow up on concerns.

The clinicians were assisted at all times by a dental nurse.

We observed that the dental care and treatment of patients was planned and delivered in a way that ensured patients' safety and welfare. Patients completed a medical history form at their first visit and this was reviewed by the clinician prior to the commencement of dental treatment, and at subsequent visits. The dental care records we looked at were well structured and contained sufficient detail to demonstrate what treatment had been prescribed and completed, and what was due to be carried out. The records were stored securely.

We saw that staff followed recognised guidance and current practice to keep patients safe, for example, we checked the dentists procedures for the provision of root canal treatments and dental implants and found these were in accordance with current guidelines.

Medical emergencies

The provider had procedures in place for staff to follow in the event of a medical emergency. Staff had received training in medical emergencies and resuscitation as a team and this was updated annually. Staff also participated in simulated medical emergencies every three months. Staff described to us how they would respond to a variety of medical emergencies. One of the staff was also trained in the provision of first aid.

The practice had emergency medicines and equipment available in accordance with the Resuscitation Council UK and British National Formulary guidelines. Staff had access to an automated external defibrillator (AED) on the premises, in accordance with Resuscitation Council UK guidance and the General Dental Council standards for the dental team. [An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm]. We saw records to show that the medicines and equipment were checked regularly.

The practice stored emergency medicines and equipment centrally and staff were able to tell us where they were located.

Are services safe?

Staff recruitment

The provider used the skill mix of staff in a variety of clinical roles, for example, dentists, a dental therapist and dental nurses, to deliver care in the best possible way for patients.

The practice had a recruitment policy and associated procedures in place which reflected the requirements of current legislation. The provider maintained recruitment records for each member of staff. We reviewed a number of the records and saw all the required information was present. The recruitment and employment records were stored securely to prevent unauthorised access.

The practice had a comprehensive induction programme in place for new staff. Several staff confirmed they had received an induction and described what was included in it.

Responsibilities were shared between staff, for example, there were lead roles for infection prevention and control, and safeguarding. Staff were aware of their own competencies, skills, and abilities.

Monitoring health and safety and responding to risks

The provider had systems in place to assess, monitor, and mitigate risks, with a view to keeping patients and staff safe.

The practice had an overarching health and safety policy in place, underpinned by several specific policies and risk assessments. A range of other policies, procedures, protocols and risk assessments were in place to inform and guide staff in the performance of their duties, and to manage risks at the practice. Policies, procedures and risk assessments were regularly reviewed.

The provider had a control of substances hazardous to health risk assessment and associated procedures in place. Staff maintained records of products used at the practice and retained manufacturer's product safety details to inform staff what action to take in the event of, for example, spillage, accidental swallowing, or contact with the skin. Measures were identified to reduce risks associated with these products, for example, the use of personal protective equipment for staff and patients, the secure storage of chemicals, and the display of safety signs.

We saw that the provider had carried out a sharps risk assessment and implemented measures to mitigate the risks associated with the use of sharps, for example, a

sharps policy was in place. The policy identified responsibility for the dismantling and disposal of sharps. The clinicians used a safer sharps system for the control of used needles. Sharps bins were suitably located in the clinical areas to allow appropriate disposal.

The sharps policy also detailed procedures to follow in the event of an injury from a sharp instrument. These procedures were displayed in the treatment rooms for quick reference. Staff were familiar with the procedures and able to describe the action they would take should they sustain an injury.

The provider also ensured that clinical staff had received appropriate vaccinations, including the vaccination to protect them against the Hepatitis B virus, and that the effectiveness of the vaccination was identified. People who are likely to come into contact with blood products, and are at increased risk of injuries from sharp instruments, should receive the Hepatitis B vaccination to minimise the risks of acquiring blood borne infections.

We saw that a fire risk assessment had been carried out. The provider had arrangements in place to mitigate the risks associated with fire, for example, one of the staff undertook a lead role for fire safety, safety signage was displayed, fire-fighting equipment was available, and fire drills were carried out regularly. Staff were familiar with the evacuation procedures in the event of a fire.

Infection control

The practice had an overarching infection prevention and control policy in place, underpinned by policies and procedures which detailed decontamination and cleaning tasks. Procedures were displayed in appropriate areas such as the decontamination room and treatment rooms for staff to refer to. One of the dental nurses had a lead role for infection prevention and control.

Staff undertook infection prevention and control audits six monthly. Actions were identified in the audits where appropriate, and we saw that these had been carried out.

We observed that there were adequate hand washing facilities available in the treatment rooms, the decontamination room, and in the toilet facilities. Hand washing protocols were displayed appropriately near hand washing sinks.

We observed the decontamination process and found it to be in accordance with the Department of Health's

Are services safe?

guidance, Health Technical Memorandum 01-05 Decontamination in primary care dental practices, (HTM 01-05). The practice had a dedicated decontamination room which was accessible to staff only. The decontamination room and treatment rooms had clearly defined dirty and clean zones to reduce the risk of cross contamination. Staff used sealed boxes to transfer used instruments from the treatment rooms to the decontamination room. Staff followed a process of cleaning, inspecting, sterilising, packaging, and storing of instruments to minimise the risk of infection. Staff wore appropriate personal protective equipment during the decontamination process.

We observed that instruments were stored in drawers in the treatment rooms. We looked at the packaged instruments in these drawers and found that the packages were sealed and marked with an expiry date which was within the recommendations of the Department of Health. Staff carried out random checks on the cleanliness of the sterilised, packaged instruments.

Staff showed us the systems in place to ensure the decontamination process was tested, and decontamination equipment was checked, tested, and maintained in accordance with the manufacturer's instructions and HTM 01-05. We saw records of these checks and tests.

The provider had had a recent Legionella risk assessment carried out to determine if there were any risks associated with the premises. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The provider reviewed the assessment regularly. Actions were identified in the assessment and these had been carried out, for example, we saw records of checks on water temperatures which assisted in monitoring the risk from Legionella. Staff described to us the procedures for the cleaning and disinfecting of the dental water lines and suction equipment. This was in accordance with guidance to prevent the growth and spread of Legionella bacteria.

The treatment rooms had sufficient supplies of personal protective equipment for staff and patient use.

The provider had a cleaning policy in place, with an associated cleaning schedule identifying tasks to be completed on a daily, weekly, and monthly basis. The practice had adopted the colour coding system to assist with cleaning risk identification in accordance with

National specifications for cleanliness : primary medical and dental practices, issued by the National Patient Safety Agency. We observed that the practice was clean, and treatment rooms and the decontamination room were clean and uncluttered. Cleaning equipment was not stored appropriately in accordance with current guidance. The provider informed us this would be addressed.

The segregation and disposal of dental waste was in accordance with current guidelines laid down by the Department of Health in the Health Technical Memorandum 07-01 Safe management of healthcare waste. The practice had arrangements for all types of dental waste to be removed from the premises by a contractor. Spillage kits were available for contaminated spillages. We observed that clinical waste awaiting collection was stored securely.

Equipment and medicines

We saw that the provider had systems, processes and practices in place to protect people from the unsafe use of materials, medicines and equipment used in the practice.

Staff showed us the recording system for the prescribing, storage, and stock control of medicines.

We saw contracts for the maintenance of equipment, and recent test certificates for the decontamination equipment, the air compressor and the X-ray machines. The practice carried out regular current portable appliance testing, (PAT). PAT is the name of a process under which electrical appliances are routinely checked for safety.

We saw records to demonstrate that fire detection and fire-fighting equipment, for example, the fire alarm and extinguishers were regularly tested.

We saw that the practice was storing NHS prescription pads securely in accordance with current guidance, and operated a system for checking deliveries of blank NHS prescription pads. The dentists maintained records of the serial numbers for prescriptions issued and void. Private prescriptions were printed out when required following assessment of the patient.

Radiography (X-rays)

Are services safe?

We saw that the provider was acting in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000, (IRMER), current guidelines from the Faculty of General Dental Practice of the Royal College of Surgeons of England and national radiological guidelines.

The practice maintained a radiation protection file which contained the required information.

The provider had appointed a Radiation Protection Advisor and a Radiation Protection Supervisor. We saw that the Health and Safety Executive had been notified of the use of X-ray equipment on the premises.

We saw a critical examination pack for the X-ray machines. Routine testing and servicing of the X-ray machines had been carried out in accordance with the current recommended maximum interval of three years.

We observed that local rules were displayed in areas where X-rays were carried out. These included working instructions for staff using the X-ray equipment. Details of the staff authorised to use the equipment were not included on the local rules but the provider addressed this immediately.

Dental care records confirmed that X-rays were justified, reported on, and quality assured. We saw evidence of regular auditing of the quality of the X-ray images.

We saw evidence of recent radiology training for relevant staff in accordance with IR(ME)R requirements.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The dentists carried out consultations, assessments, and treatment in line with current National Institute for Health and Care Excellence guidelines, Faculty of General Dental Practice, (FGDP), guidelines, the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention', and General Dental Council guidelines. The dentists described to us how examinations and assessments were carried out. Patients completed a medical history form with details of their health conditions, medicines being taken, and allergies, as well as details of their dental and social history. The dentists then carried out an examination. Patients were made aware of the condition of their oral health and whether it had changed since the last appointment. Following the examination the diagnosis was discussed with the patient and treatment options and costs explained. Follow-up appointments were scheduled to individual requirements.

We checked dental care records to confirm what was described to us and found that the records were complete, clear, and contained sufficient detail about each patient's dental treatment. We noted that details of medicines used in the dental treatments were recorded which would enable a specific batch of a medicine to be traced to the patient in the event of a safety recall or alert in relation to a medicine.

We saw patients' signed treatment plans containing details of treatment and associated costs. Patients confirmed in CQC comment cards that dentists were clear about treatment needs and options, and treatment plans were informative.

We saw evidence that the dentists used current guidelines issued by the National Institute for Health and Care Excellence Dental checks: intervals between oral health reviews to assess each patient's risks and needs, and to determine how frequently to recall them.

We observed that the provider had produced a range of information cards for patients to take away providing brief information on sources of specialised help and advice, for example, organisations providing help with mental health issues, abuse or domestic violence. The provider explained they were aware that people often experienced a range of

issues in their lives in relation to, for example, health or social problems, and did not always feel comfortable in addressing those directly with a health care professional. The cards were made available to patients in a discreet location in the patient toilet facilities.

Health promotion and prevention

We saw that staff adhered closely to guidance issued in the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention' when providing preventive oral health care and advice to patients. Tailored preventive dental advice, and information on diet, and lifestyle was given to patients, in a way they understood, in order to improve their health outcomes. Where appropriate, fluoride treatments were prescribed. Information in leaflet form was available in the waiting room in relation to improving oral health and lifestyles, for example, smoking cessation.

Staffing

We observed that staff had the skills, knowledge, and experience to deliver effective care and treatment.

New staff and trainees undertook a programme of training and supervision before being allowed to carry out any duties at the practice unsupervised.

The provider carried out staff appraisals regularly for all staff. We noted the appraisals were a two way process and included a competency and performance assessment. Staff confirmed appraisals were used to identify training needs.

All qualified dental professionals are required to be registered with the General Dental Council, (GDC), in order to practice dentistry. To be included on the register, dental professionals must be appropriately qualified and meet the GDC requirements relating to continuing professional development, (CPD). We saw that the qualified dental professionals were registered with the GDC.

We saw staff were supported to meet the requirements of their professional registration. The GDC highly recommends certain core subjects for CPD, such as medical emergencies and life support, safeguarding, infection prevention and control, and radiology. The provider had a training plan in place which outlined details of training for staff. The provider used a variety of training methods to deliver training to staff, for example, lunch and learn sessions, external courses, and online learning. Training included the mandatory General Dental Council

Are services effective?

(for example, treatment is effective)

core topics, health and safety, and a variety of generic and role specific topics. Checks to ensure dental professionals were up to date with their CPD were carried out by the provider. We reviewed a number of staff records and found these contained clear personal development plans and a variety of CPD, including the core GDC subjects. Dentists were aware of the needs of the practice's patient population and we saw their CPD reflected this.

Working with other services

We reviewed the practice's arrangements for referrals. Dentists were aware of their own competencies and knew when to refer patients requiring treatment outwith their competencies. Dentists referred patients to a variety of secondary care and specialist options as appropriate. Information was shared appropriately when patients were referred to other health care providers. Urgent referrals were made in line with current guidelines.

We saw examples of internal referrals, for example, to the dental therapist, and these followed recognised guidelines.

Consent to care and treatment

The dentists described how they obtained valid, informed, consent from patients by explaining their findings to them and keeping records of the discussions. Patients were given a treatment plan after consultations and assessments, and prior to commencing dental treatment. The patient's dental care records were updated with the proposed treatment once this was finalised and agreed with the patient. The signed treatment plan and consent form were retained in the patients' dental care records. The plan and discussions

with the clinicians made it clear that a patient could withdraw consent at any time, and that they had received an explanation of the type of treatment, including the alternative options, risks, benefits, and costs.

The dentists described to us how they obtained verbal consent at each subsequent treatment appointment. We saw this confirmed this in the dental care records we looked at.

NHS and private treatment costs were displayed in the waiting room along with information in a variety of formats on dental treatments to assist patients with treatment choices.

The dentists explained that they would not normally provide treatment to patients on their examination appointment unless they were in pain, or their presenting condition dictated otherwise. We saw the dentists allowed patients time to think about the treatment options presented to them.

The dentists told us they would generally only see children under 16 who were accompanied by a parent or guardian to ensure consent was obtained before treatment was undertaken. Dentists demonstrated an understanding of Gillick competency. (Gillick competency is a term used in medical law to decide whether a child of 16 years or under is able to consent to their own treatment).

The Mental Capacity Act 2005, (MCA), provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Staff had a good understanding of the principles and application of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback given by patients on CQC comment cards demonstrated that patients felt they were always treated with kindness and respect, and staff were friendly, caring, and helpful. The practice had a separate room available should patients wish to speak in private. Treatment rooms were situated away from the main waiting area, and we saw that the doors were closed at all times when patients were with the clinicians. Staff understood the importance of emotional support when delivering care to patients who were nervous of dental treatment. Several patients confirmed in CQC comment cards that staff put them at ease and that the dentists were encouraging.

Involvement in decisions about care and treatment

The dentists discussed treatment options with patients and allowed time for patients to decide before treatment was commenced. We saw this documented in the dental care records. CQC comment cards we reviewed told us treatments were always explained in a language patients could understand. Patients commented that they were listened to. Patients confirmed that treatment options, risks, and benefits were discussed with them and that they were provided with helpful information to assist them in making an informed choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We saw evidence that services were planned and delivered to meet the needs of people.

The practice was well maintained and provided a comfortable environment. The provider had a maintenance programme in place to ensure the premises was maintained to a high standard.

We saw that the clinicians tailored appointment lengths to patients' individual needs and patients could choose from morning or afternoon appointments.

The practice captured social and lifestyle information on the medical history forms completed by patients. This enabled clinicians to identify any specific needs and direct treatment to ensure the best outcome was achieved for the patient. Staff were prompted to be aware of patients' specific needs or medical conditions via the use of a flagging system on the dental care records which helped them treat patients individually.

We saw that the provider gathered the views of patients when planning and delivering the service via regular patient surveys. Staff told us that patients were always able to provide verbal feedback, and this was captured and analysed by the practice. We saw that patients' views were taken into account, for example, the provider had consulted patients in relation to the practice opening times.

Tackling inequity and promoting equality

The provider had carried out a Disability Discrimination Act audit, and had taken into account the needs of different groups of people, for example, people with disabilities and people whose first language was not English.

The practice was accessible to people with disabilities and impaired mobility, but not to wheelchair users. Staff

provided information on nearby practices which were accessible to wheelchair users. Parking was available near the premises. The waiting room and reception were on the ground floor, and the treatment rooms and toilet facilities were on the first floor accessed via a flight of stairs.

The practice offered interpretation services to patients whose first language was not English and to patients with impaired hearing. The practice also had an induction loop available.

The practice made provision for patients to arrange appointments by telephone or in person, and patients could choose to receive appointment reminders by a variety of methods. Where patients failed to attend their dental appointments, staff contacted them to re-arrange the appointment and to establish if the practice could assist by providing adjustments to enable patients to receive their treatment.

Access to the service

We saw that patients could access treatment and care in a timely way. The practice opening hours, and the 'out of hours' appointment information, were displayed at the entrance to the practice, provided in the practice leaflet, and on the practice website. Emergency appointments were available daily for patients registered with the practice and for non-registered patients through the NHS dental access scheme.

Concerns and complaints

The practice had a complaints policy and procedure which was available in the waiting room and outlined in the practice leaflet but not on the website. Details as to further steps people could take should they be dis-satisfied with the practice's response to their complaint were included. We saw that complaints were promptly and thoroughly investigated and responded to.

Are services well-led?

Our findings

Governance arrangements

We reviewed the provider's systems and processes for monitoring and improving the services provided for patients and found these were operating effectively.

The provider had arrangements in place to ensure risks were identified and managed and had carried out risk assessments and put measures in place to mitigate risks. We saw that risk assessments and policies were regularly reviewed to ensure they were up to date with regulations and guidance.

The provider used a variety of means to monitor quality and performance and improve the service, for example, via the analysis of patient feedback, carrying out a wide range of audits, beyond the mandatory audits for infection control and X-rays, and the analysis of complaints. We saw that these arrangements were working well.

Dental professionals' continuing professional development was monitored by the provider to ensure they were meeting the requirements of their professional registration. Staff were supported to meet these requirements by the provision of training.

Staff were aware of the importance of confidentiality and understood their roles in this. Dental care records were complete and accurate. They were maintained on paper and electronically. Paper records were stored securely in locked filing cabinets. Electronic records were password protected and data was backed up daily.

Leadership, openness and transparency

We saw systems in place to support communication about the quality and safety of the service, for example, the display of information for patients in the waiting area, and regular meetings for staff.

We saw that the provider displayed the results from the NHS Friends and Family Test, (FFT), and from the practice's patient survey in the waiting area to inform patients.

The practice held staff meetings every month. The meetings were scheduled in advance to maximise staff attendance. We saw recorded minutes of the meetings, and

noted that items discussed included clinical and non-clinical issues. Regular meetings were also held between the clinicians and the principal dentist to discuss issues as they arose.

The practice was managed by the provider, but some staff had lead roles. We saw that staff had access to suitable supervision and support in order to undertake their roles, and there was clarity in relation to roles and responsibilities.

The provider operated an open door policy. Staff said they could speak to the provider if they had any concerns, and that the provider and all their colleagues were approachable and supportive.

Learning and improvement

The provider used quality assurance measures, for example, auditing, to encourage continuous improvement in all aspects of service delivery. Audits we reviewed included treatment plans, record keeping, X-rays, referrals, handwashing, infection prevention and control, and cleaning. Where appropriate, audits had clearly identified actions, and we saw that these had been carried out and re-auditing used to measure improvement.

The provider gathered information on the quality of care from a range of sources, including patient feedback, patient surveys and the NHS FFT and used this to evaluate and improve the service.

Staff confirmed that learning from complaints, incidents, audits, and feedback was discussed at staff meetings to share learning to inform and improve future practice.

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

We saw that people who used the service and staff were engaged and involved. The provider carried out regular patient surveys to seek the views of patients about all areas of service delivery, and looked at the results to identify areas for improvement. A suggestion box for patient comments was also available in the waiting room.

We saw that patient feedback was acted on, for example, patients had requested a selection of magazines and these had been provided. The provider made NHS Friends and Family Test forms and the practice's own survey forms available in the waiting room for patients to indicate how likely they were to recommend the practice.

Are services well-led?

Staff told us they felt valued and involved. They were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. Staff said they were encouraged to challenge any aspect of practice which caused concern.