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Blue Cross Dental Care (Bilston)

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

Blue Cross Dental Care (Bilston) is a dental practice providing general dental services on a NHS (predominantly) basis. Some private treatment is also offered. The service is provided by four dentists. They are supported by five dental nurses (two of whom are trainees), a practice manager and a receptionist. All of the dental nurses also carry out reception duties.

The practice is located in a busy shopping area in the town centre. There is wheelchair access to the practice and nearby car parking facilities. The premises consist of a waiting room, three treatment rooms and accessible toilet facilities on the ground floor. The first floor comprises of a decontamination room, a staff room/ kitchen, an office, a stock room, a storage room and toilet facilities. One of the treatment rooms was not used. Opening hours are from 7:30am to 5:30pm on Mondays, 8am to 5pm on Tuesdays and Wednesdays, 8am to 8pm on Thursdays and 8am to 6:30pm on Fridays. The practice is also open on Saturdays between 9am and 3pm.

The provider is registered with the Care Quality Commission (CQC) as an individual. Registered persons

Summary of findings

have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. The provider does not carry out dental treatment at this practice.

Eleven patients provided feedback about the practice. We looked at comment cards patients had completed prior to the inspection and we also spoke with three patients. Overall the information from patients was complimentary. Patients were positive about their experience and they commented that staff were friendly and polite.

Our key findings were:

- The practice appeared clean and tidy on the day of our visit. Many patients also commented that this was their experience.
- Patients told us they found the staff polite and friendly. Patients were able to make routine and emergency appointments when needed.
- The practice had systems to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding, safe staff recruitment and the management of medical emergencies. However, some improvements were required.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation.
- Staff received training appropriate to their roles.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had an effective complaints system in place and there was an openness and transparency in how these were dealt with.
- Staff told us they felt well supported and comfortable to raise concerns or make suggestions.
- The practice demonstrated that they regularly undertook audits in infection control, radiography and dental care record keeping.

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

- Review the practice's arrangements for dealing with medical emergencies during domiciliary visits.
- Review the practice's recruitment procedures to ensure they are in line with Schedule 3 of the Health and Social Care Act 2008 Regulations 2014.
- Review the practice's infection control procedures regarding the testing of autoclaves giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.
- Review staff awareness of the duty of candour and RIDDOR regulations.
- Complete all recommendations provided on the practice's fire risk assessment.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It also had a recruitment process to help ensure the safe recruitment of staff. Some of these systems required improvements.

Patients' medical histories were obtained before any treatment took place. The dentist was aware of any health or medicines issues which could affect the planning of treatment. Staff were trained to deal with medical emergencies. Emergency equipment and medicines were in date and in accordance with the British National Formulary (BNF) and Resuscitation Council UK guidelines. Staff did not take any emergency medicines or equipment with them when carrying out domiciliary visits.

The practice was carrying out infection control procedures as described in the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary dental practices'. We identified some necessary improvements on the day of our visit.

Staff told us they felt confident about reporting accidents and incidents. Not all staff were aware of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Are services effective?

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

The practice monitored any changes to the patients' oral health and made referrals for specialist treatment or investigations where indicated. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping was in line with guidance issued by the Faculty of General Dental Practice (FGDP).

The dentists followed national guidelines when delivering dental care. These included FGDP and National Institute for Health and Care Excellence (NICE). We found that preventative advice was given to patients in line with the 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. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting.

Are services caring?

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

On the day of the inspection we observed privacy and confidentiality were maintained for patients using the service. Patient feedback was positive about the care they received from the practice. Patients described staff as friendly and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding.

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

The practice had an efficient appointment system in place to respond to patients' needs. They were usually able to see patients requiring urgent treatment within 24 hours. Patients were able to contact staff when the practice was closed and arrangements were subsequently made for these patients requiring emergency dental care.

The practice had an effective complaints process.

The practice offered access for patients with limited mobility.

Are services well-led?

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

There was a clearly defined management structure in place and staff we spoke with felt supported in their own particular roles.

There were systems in place to monitor the quality of the service including various audits. The practice used several methods to successfully gain feedback from patients. Staff meetings took place on a regular basis.

The practice carried out audits such as radiography, dental care record keeping and infection control at regular intervals to help improve the quality of service. All audits had documented learning points with action plans.

Blue Cross Dental Care (Bilston)

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.

We inspected Blue Cross Dental Care (Bilston) on 7 June 2016. The inspection was carried out by a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed NHS England that we were inspecting the practice. We also requested details from the provider in advance of the inspection. This included their latest statement of purpose describing their values and objectives and a record of patient complaints received in the last 12 months.

During the inspection we toured the premises, spoke with the provider, the practice manager, two other dentists and three dental nurses. We also reviewed CQC comment cards which patients had completed and spoke with patients. We reviewed a range of practice policies and practice protocols and other records relating to the management of the service.

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 practice had arrangements for staff to report accidents and incidents. The last accident was recorded in March 2015. The last incident was also recorded in the same month. We discussed events with the practice manager and found that at least one incident had occurred since March 2015 but had not been recorded. Discussing and sharing incidents is an excellent opportunity for staff to learn from the strengths and weakness in the services they offer.

Not all of the staff we spoke with understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). This was discussed with the practice manager and they told us that this would be discussed at a staff meeting.

The practice responded to national patient safety and medicines alerts that affected the dental profession. We were told that the practice had registered with the Medicines and Healthcare products Regulatory Agency (MHRA). The provider was responsible for obtaining information from relevant emails and forwarding this information to the rest of the team. The practice manager was not aware of the practice's arrangements for staff to report any adverse drug reactions.

Reliable safety systems and processes (including safeguarding)

The practice had child protection and vulnerable adult procedures in place. There was a specific policy for vulnerable adults but not for children. These policies provide staff with information about identifying, reporting and dealing with suspected abuse. The policies were readily available to staff. Staff had access to contact details for local safeguarding teams. The provider was the safeguarding lead in the practice. Staff members we spoke with were all knowledgeable about safeguarding. There had not been any safeguarding referrals to the local safeguarding team; however staff members were confident about when to refer concerns. The practice also had a record of child protection significant events – these were documented for staff to analyse the information and then make an informed decision about whether a referral was required. We were told that all staff received safeguarding training every two years. We saw evidence that appropriate safeguarding training was held at the practice in October 2014.

The British Endodontic Society recommends the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a rectangular sheet of latex used by dentists for effective isolation of the root canal, operating field and airway. We were told that rubber dam kits were available in both treatment rooms and that all dentists used them when carrying out root canal treatment whenever practically possible. The dentists we spoke with did not always record this in the patients' dental care records. They assured us they would document this with immediate effect.

The practice had a system for raising concerns – there was a policy present and this was reviewed annually. All staff members we spoke with were aware of the whistleblowing process within the practice. All dental professionals have a professional responsibility to speak up if they witness treatment or behaviour which poses a risk to patients or colleagues.

Staff we spoke with were not aware of the duty of candour regulation. The intention of this regulation is to ensure that staff members are open and transparent with patients in relation to care and treatment. The practice manager told us they would discuss this with staff at the next practice meeting.

Never events are serious incidents that are wholly preventable. Staff members we spoke with were not aware of 'never events' and the practice did not have written processes to follow to prevent these happening. For example, there was no written process to make sure they did not extract the wrong tooth. However, staff told us they worked in accordance with these protocols.

The practice had processes in place for the safe use of needles and other sharp instruments.

Medical emergencies

The practice had arrangements in place to deal with medical emergencies. However, these did not extend to domiciliary dental visits (visits made by the dentist to the patient's home). The dentist undertaking the domiciliary

Are services safe?

visits did not take emergency equipment or medicines with them. We discussed this with the dentist and they told us they would review these arrangements with the provider at the earliest opportunity.

Within the practice, the arrangements for dealing with medical emergencies in the practice were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF). The practice had access to emergency resuscitation kits, oxygen and emergency medicines. There was an automated external defibrillator (AED) present. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.

Staff received annual training in the management of medical emergencies and this last took place in February 2016. The practice took responsibility for ensuring that all of their staff received annual training in this area. All equipment and medicines were stored in a secure area.

Staff undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. They documented daily checks of the emergency oxygen and monthly checks of the emergency medicines and the AED. Staff told us they checked the AED daily but only documented this monthly. The practice manager instructed staff to begin documenting daily checks and we were told this would be carried out with immediate effect. The emergency medicines were all in date and stored securely. Glucagon (one type of emergency medicine) was stored in the fridge and the temperature was monitored and documented on a daily basis.

All staff we spoke with were aware of the location of this equipment and equipment and medicines were stored in purposely designed storage containers.

Staff recruitment

The practice had a recruitment policy for the safe recruitment of staff. We looked at the recruitment records for three members of the practice team. The records we saw contained evidence of employment contracts and induction plans. Where relevant, the files contained copies of staff's dental indemnity and General dental Council (GDC) registration certificates. Some of the files contained curricula vitae and only one contained the person's identity verification. Two of the three files contained evidence that staff were appropriately immunised. We were told that the third staff member's immunisation programme was in progress but we did not see any evidence of this.

There were also Disclosure and Barring Service (DBS) checks present for two staff members. The DBS carries out checks to 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 vulnerable adults. The practice manager told us that the DBS checks were renewed every five years for dentists and every three years for all remaining staff. We saw that two of the staff's DBS checks were within the practice's renewal protocols. However, the third member had not undergone a DBS check since they commenced employment (ten months ago). We were told that the DBS check was in progress but the practice did not follow their own recruitment policy which stated that a DBS check should be carried out before an individual was recruited at the practice.

The practice had a system in place to monitor the professional registration of its clinical staff members. GDC certificates were displayed in the reception area for all GDC registered staff. The practice manager also held copies of all staff's current certificates.

Monitoring health & safety and responding to risks

We saw evidence of a comprehensive business continuity plan which described situations which might interfere with the day to day running of the practice. This included extreme situations such as loss of the premises due to fire. We reviewed the plan and found that it had all relevant contact details in the event of an emergency.

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. Fire safety training was carried in-house every 12 months and was next due in July 2016. We saw evidence that the fire extinguishers had been serviced in November 2015. We were told that new fire alarms were installed in May 2016. We saw evidence that the fire alarms were checked weekly. Fire drills took place every six months and there were fire exits on both floors. Fire safety signs were clearly displayed. We saw evidence that a fire risk assessment had taken place in February 2013 by an external contractor. Several

recommendations were made but not all had been actioned. This was discussed with the practice manager and they assured us they would follow these through as soon as possible.

Information on COSHH (Control of Substances Hazardous to Health 2002) was available for all staff to access. We looked at the COSHH file and found this to be comprehensive where risks associated with substances hazardous to health had been identified and actions taken to minimise them.

Infection control

There was an infection control policy and procedures to keep patients and staff safe. The practice mostly followed the guidance about decontamination and infection control issued by the Department of Health, namely 'Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05)'. However, some improvements were required. The practice had a nominated infection control lead that was responsible for ensuring infection prevention and control measures were followed.

We reviewed a selection of staff files and saw evidence that clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff. One staff member was undergoing training at the practice and we were told that their immunisation programme was in progress (but we did not see any documentation of this).

We observed the treatment rooms and the decontamination room to be visually clean and hygienic. Several patients commented that the practice was clean and tidy. Work surfaces and drawers were clean and free from clutter. The clinical areas had sealed flooring which was in good condition.

There were handwashing facilities in the treatment rooms and staff had access to supplies of personal protective equipment (PPE) for themselves and for patients.

Decontamination procedures were carried out in a dedicated decontamination room. In accordance with HTM 01-05 guidance, an instrument transportation system was in place to ensure the safe movement of instruments between the treatment rooms and the decontamination room.

Sharps bins were appropriately located and out of the reach of children. We observed waste was separated into safe and lockable containers for monthly disposal by a registered waste carrier and appropriate documentation retained. Clinical waste storage was in an area where members of the public could not access it. The correct containers and bags were used for specific types of waste as recommended in HTM 01-05.

We spoke with clinical staff about the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Clean instruments were packaged, date stamped and stored in accordance with current HTM 01-05 guidelines. There appeared to be sufficient instruments available and staff confirmed this with us. Staff we spoke with were aware of disposable items that were intended for single use only.

Staff used manual scrubbing techniques to clean the used instruments; they were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. The decontamination room had clearly defined clean and dirty zones to reduce the risk of cross contamination. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear. Heavy duty gloves are recommended during the manual cleaning process and they were replaced on a weekly basis in line with HTM 01-05 guidance.

The practice had some systems in place for quality testing the decontamination equipment daily and weekly. The practice did not undertake one type of daily test on the autoclaves as recommended by HTM 01-05. Staff logged time and pressure parameters but were not completing the automatic control test.

The practice had a protocol which provided assistance for staff in the event they injured themselves with a contaminated sharp instrument – this included all the necessary information and was easily accessible. Staff we spoke with were familiar with the Sharps Regulations 2013 and were following guidance. These set out recommendations to reduce the risk of injuries to staff from contaminated sharp instruments.

The practice manager informed us that checks of all clinical areas such as the decontamination room and treatment rooms were carried out daily by the dental nurses. All

Are services safe?

clinical and non-clinical areas were cleaned daily by staff at the practice. The practice had a dedicated area for the storage of their cleaning equipment. Cleaning logs were seen for all areas.

The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits of infection control procedures every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. We saw evidence that the practice carried these out every three months in line with current guidance. Action plans were documented subsequent to the analysis of the results. By following action plans, the practice would be able to assure themselves that they had made improvements as a direct result of the audit findings.

Staff members were following the guidelines on managing the water lines in the treatment rooms to prevent Legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw evidence that a Legionella risk assessment was carried out by an external contractor in May 2016. We saw evidence that the practice recorded water temperature on a regular basis to check that the temperature remained within the recommended range.

Equipment and medicines

The practice had maintenance contracts for essential equipment such as pressure vessels and autoclaves.

Employers must ensure that their electrical equipment is maintained in order to prevent danger. Regular portable appliance tests (PAT) confirms that portable electric items used at the practice are safe to use. The practice previously had PAT carried out in April 2016.

The prescription pads were kept securely so that prescriptions were safely given by authorised persons only. The prescription number was recorded in the patients' dental care records. The practice did not keep a log of prescriptions given so they could not ensure that all prescriptions were tracked.

There was a fridge for the storage of medicines and dental materials. The temperature was monitored and recorded daily.

We were told that the batch numbers and expiry dates for local anaesthetics were always recorded in patients' dental care records and corroborated what they told us by viewing a sample of records.

Stock rotation of all dental materials was carried out on a regular basis by the dental nurse and all materials we viewed were within their expiry date. A system was also in place for ensuring that all processed packaged instruments were within their expiry date.

Radiography (X-rays)

The practice had a radiation protection file and a record of all X-ray equipment including service and maintenance history. The practice used digital X-rays.

A Radiation Protection Advisor (RPA) and a Radiation Protection Supervisor (RPS) had been appointed to ensure that the equipment was operated safely and by qualified staff only. Local rules were available in the practice for all staff to reference if needed.

We saw evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this.

The X-ray equipment in the treatment rooms was fitted with a part called a collimator which is good practice as it reduces the radiation dose to the patient.

We saw evidence that the dentists were up to date with required training in radiography as detailed by the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

We saw evidence that the practice carried out an X-ray audit in December 2015. We were told these usually took place every six months. Audits are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care. We saw evidence that the results were analysed and reported on.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept up to date, detailed electronic dental care records. They contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the Faculty of General Dental Practice (FGDP).

We spoke with two dentists about the oral health assessments, treatment and advice given to patients and corroborated what they told us by looking at patient dental care records. Dental care records included details of the condition of the teeth, soft tissues lining the mouth, gums and any signs of mouth cancer. Medical history checks were documented in most of the records we viewed. This should be updated and recorded for each patient every time they attend.

The Basic Periodontal Examination (BPE) is a screening tool which is used to quickly obtain an overall picture of the gum condition and treatment needs of an individual. We saw that the practice was recording the BPE for all adults and children aged 7 and above (as per guidelines). We saw evidence that patients diagnosed with gum disease were appropriately treated.

The practice kept up to date with other current guidelines and research in order to develop and improve their system of clinical risk management. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines in relation to lower wisdom teeth removal and in deciding when to recall patients for examination and review. Following clinical assessment, the dentists told us they followed the guidance from the FGDP before taking X-rays to ensure they were required and necessary. Justification for the taking of an X-ray was recorded and reports on the X-ray findings were available in the dental care records.

Staff told us that treatment options and costs (where applicable) were discussed with the patient and this was corroborated when we spoke with patients.

Health promotion & prevention

The dentists we spoke with told us that patients were given advice appropriate to their individual needs such as smoking cessation, alcohol consumption or dietary advice.

There were oral health promotion leaflets available in the practice to support patients in looking after their health. Examples included information on smoking, dentures and children's teeth. There was also a poster with information about mouth cancer.

The practice was aware of the provision of preventative care and supporting patients to ensure better oral health in line with 'The Delivering Better Oral Health Toolkit'. This is an evidence based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. For example, the practice recalled patients, as appropriate, to receive oral hygiene advice. Where required, toothpastes containing high fluoride were prescribed.

Staffing

New staff to the practice had a period of induction to familiarise themselves with the way the practice ran. This included areas such as child protection, fire safety and infection control.

Staff told us they were encouraged to maintain the continuous professional development required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, orthodontic therapists, dental hygienists, dental nurses, clinical dental technicians and dental technicians. All clinical staff members were registered with the GDC (apart from the trainee dental nurses as only qualified staff can register).

The practice manager monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that dental nurses were often transferred from the provider's other local practice and staff were happy to travel between the two locations if required. We were told that the dentist would always carry out domiciliary visits with a dental nurse present.

Dental nurses were supervised by the dentists and supported on a day to day basis by the practice manager. Staff told us that senior staff were readily available to speak with at all times for support and advice.

We were told that the dental nurses were encouraged to carry out further training. We were told that the provider had previously paid for dental nurses to carry out

Are services effective?

(for example, treatment is effective)

additional training. Some of the dental nurses were currently considering whether to enrol on additional training which would enable them to take dental X-rays or dental impressions.

Working with other services

The practice worked with other professionals in the care of their patients where this was in the best interest of the patient. For example, referrals were made to specialist dental services for complex oral surgery. We viewed one referral letter and noted that it was comprehensive to ensure the specialist services had all the relevant information required.

Staff understood the procedure for urgent referrals, for example, patients with suspected oral cancer.

Consent to care and treatment

Patients were given appropriate information to support them to make decisions about the treatment they received. Staff ensured patients gave their consent before treatment began and this was recorded in the dental care records.

Staff members we spoke with were knowledgeable about how to ensure patients had sufficient information and the mental capacity to give informed consent (in accordance with the Mental Capacity Act 2005). The MCA provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Staff members we spoke with were clear about involving children in decision making and ensuring their wishes were respected regarding treatment. They were familiar with the concept of Gillick competence regarding the care and treatment of children under 16. Gillick competence principles help clinicians to identify children aged under 16 who have the legal capacity to consent to examination and treatment.

There was no evidence of recording capacity assessments for patients who lacked the capacity to consent. One of the dentists regularly undertook domiciliary visits and we were told that several of these patients lacked mental capacity. However, they told us that the dental care records did not contain any clear capacity assessments. The dentist told us they were assessing patients and their capacity and acting in accordance with the MCA whenever patients were unable to consent, although they were not documenting this. The dentist informed us they would discuss this with the provider so that assessments were always formally carried out and documented in the dental care records.

Staff members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Written treatment plans were available for all patients but some of these lacked details about the proposed treatment. Patients were given time to consider and make informed decisions about which option they preferred.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Eleven patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection and spoke with three patients during our visit. Patient feedback was positive about the care they received from the practice. They described staff as friendly and polite. Patients commented they felt involved in their treatment and it was fully explained to them. Nervous patients said they felt at ease here and the staff were supportive and understanding. Several patients commented that they would recommend this practice to their friends and family.

We observed privacy and confidentiality were maintained for patients who used the service on the day of the inspection. For example, the doors to the treatment rooms were closed during appointments and confidential patient details were not visible to other patients. Staff members we spoke with were aware of the importance of providing patients with privacy. The reception area was not left unattended and confidential patient information was stored in a secure area. We were told that all staff had individual passwords for the computers where confidential patient information was stored. There was a room available for patients to have private discussions with staff. We observed that staff members were helpful, discreet and respectful to patients on the day of our visit.

We were told that the practice appropriately supported children and anxious patients using various methods. For children (especially anxious patients), the dentists used child appropriate language and diagrams.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. 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. Patients commented that the cost of treatment (where applicable) was discussed with them and this information was also provided to them in the form of a customised written treatment plan. We were told that all patients received written treatment plans. We reviewed a range of records and found that many plans lacked sufficient details regarding the proposed treatment. Charges were clearly indicated on the plans but not details of the clinical treatment. We discussed this with the practice manager and they told us they would speak to staff about this.

Examination and treatment fees were displayed in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. Patients with mobility difficulties were able to access the practice as the treatment rooms were on the ground floor. There were toilet facilities available on the ground floor and these were wheelchair-accessible.

The practice had an appointment system in place to respond to patients' needs. Patients we spoke with told us that they were not always seen on time but they felt the wait was not too long. We were told it was easy to make an appointment.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We reviewed the appointment system and saw that dedicated emergency slots were available on a daily basis to accommodate patients requiring urgent treatment.

Patient feedback confirmed that the practice was providing a good service that met their needs. The practice sent appointment reminders to all patients that had consented. The method used depended on the patient's preference, for example, via text message or telephone reminders. The patient's preference was recorded on their file.

Tackling inequity and promoting equality

The practice had an equality and diversity policy to support staff in understanding and meeting the needs of patients. This was signed and reviewed by all staff annually. The practice recognised the needs of different groups in the planning of its services. The practice did not have an audio loop system for patients who might have hearing impairments. However, the practice used various methods so that patients with hearing impairments could still access the services such as providing written information to them.

The practice had access to an interpreting service for patients that were unable to speak fluent English but this was rarely used. Several staff members (including the dentists) spoke different languages relevant to patients.

Patients told us that they received information on treatment options to help them understand and make an informed decision of their preference of treatment.

Access to the service

Feedback from patients confirmed they could access care and treatment in a timely way and the appointment system met their needs.

The practice had a system in place for patients requiring urgent dental care when the practice was closed. Patients were signposted to the NHS 111 service for advice on obtaining emergency dental treatment. There was information in the waiting room and the practice leaflet for patients about this service.

Opening hours were from 7:30am to 5:30pm on Mondays, 8am to 5pm on Tuesdays and Wednesdays, 8am to 8pm on Thursdays and 8am to 6:30pm on Fridays. The practice also opened on Saturdays between 9am and 3pm.

Concerns & complaints

The practice had a complaints process which provided staff with clear guidance about how to handle a complaint. Staff members we spoke with were fully aware of this process. Information for patients about how to make a complaint was available at the practice and clearly displayed. This included details of external organisations in the event that patients were dissatisfied with the practice's response.

We saw evidence that complaints received by the practice had been recorded, analysed and investigated. There was a designated complaints lead and all verbal complaints were documented too. We found that complainants had been responded to in a professional manner. We were told that any learning identified was cascaded personally to team members and also discussed in staff meetings. We saw examples of changes and improvements that were made as a result of concerns raised by patients.

Are services well-led?

Our findings

Governance arrangements

The practice manager was in charge of the day to day running of the service. They worked at this practice on a part-time basis but had telephone availability on all other days. We saw they had systems in place to monitor the quality of the service. These were used to make improvements to the service. The practice had governance arrangements in place to ensure risks were identified, understood and managed appropriately. One example was their risk assessment of injuries from sharp instruments. This was reviewed every three months at the practice. We were told that the dentists always re-sheathed and dismantled needles so that fewer members of the dental team were handling used sharp instruments. This reduced the risk of injury to other staff members posed by used sharp instruments. The practice also had risk assessements for areas such as the autoclaves, manual handling and display screen equipment.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. All staff we spoke with were aware of whom to raise any issue with and told us the senior staff were approachable, would listen to their concerns and act appropriately. There were designated staff members who acted as dedicated leads for different areas, such as a safeguarding lead, complaints lead and infection control lead.

Learning and improvement

The practice manager monitored staff training to ensure essential staff training was completed each year. This was free for all staff members and included emergency resuscitation and basic life support. The GDC requires all registrants to undertake CPD to maintain their professional registration.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays), dental care record keeping and infection control. All of the audits we reviewed had been reported on and action plans devised. The results were discussed with staff and training was provided (if necessary). All audits should have documented learning points so that the resulting improvements can be demonstrated. The practice had a staff member who took the lead in clinical audits. Audits were also completed in areas such as oral cancer, hand hygiene and medical history recording.

Staff meetings took place on a monthly basis. The minutes of the meetings were available for all staff. This meant that any staff members who were not present also had the information and all staff could update themselves at a later date. Topics such as confidentiality, complaints and emergency medicines had been discussed in the last six months.

The practice manager told us that all staff received appraisals every November. We reviewed a selection of staff files and saw that some staff had received appraisals. Regular appraisals provide an opportunity where learning needs, concerns and aspirations can be discussed.

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

Patients and staff we spoke with told us that they felt engaged and involved at the practice.

The practice had systems in place to involve, seek and act upon feedback from people using the service. We were told that views and suggestions were cascaded to all members of the practice team in staff meetings. There was a suggestions box in the waiting room for patients but we were told that no comments had ever been made via this method. The practice undertook the NHS Family and Friends Test (FFT). The FFT captures feedback from patients undergoing NHS dental care. The results were collated monthly and displayed in the reception area so that patients were kept informed. We also saw blank patient satisfaction surveys – patients were invited to complete these.

Staff we spoke with told us their views were sought and listened to but there were no dedicated staff satisfaction questionnaires.