Dr. Claire Rumley

Dr Claire Rumley - Stratford Road

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 May 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

Claire Rumley dental practice is a small NHS dental practice located in the Hall Green area of Birmingham. The provider, Claire Rumley is one of three dentists who work in the same building under a separate registration with the Care Quality Commission (CQC). Some of the facilities and staff are shared between each practice located in the building. For example the receptionist, reception area, toilets, staff room, waiting area and first floor X-ray facilities are used by all three dental practices under an expense sharing agreement. This report will make references to the practice but this inspection only related to the services provided by Dr Claire Rumley.

The practice is located on the ground floor, with one treatment room and provides regulated dental services to both adults and children. Three qualified dental nurses and a receptionist work alongside the dentist. The practice's opening hours are: Monday, Tuesday, Thursday and Friday: 8.30am to 5.30pm; and Wednesday: 8.30am to 1pm.

The dentist is registered with the CQC as an individual. Like registered providers, they are 'registered persons'.

Summary of findings

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 positive feedback from 52 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

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.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.
- Feedback from patients about their experiences at the practice was positive. Patients said they were treated with dignity and respect.
- The dentist identified the treatment options, and discussed these with patients.
- The practice was visibly clean and well maintained.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff. Staff were aware of procedures to follow if they had any concerns.
- The appointment system met the needs of patients and waiting times were kept to a minimum.

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

- Review the current legionella risk assessment and implement the required actions including the monitoring and recording of water temperatures, giving due regard to the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.
- Review its responsibilities as regards to the Control of Substance Hazardous to Health (COSHH) Regulations 2002, ensure all documentation is up to date and staff understand how to minimise risks associated with the use of and handling of these substances.
- Review procedures to ensure that the practice is in compliance with its legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review the storage of dental care records to ensure this is secure in accordance with the Data Protection Act 1998.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.

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).

Arrangements were in place to ensure that the practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts.

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

The practice had emergency medicines and oxygen available. Regular checks were being completed to ensure emergency equipment was in good working order.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance.

X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

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

The practice used oral screening tools to identify oral disease. All patients were clinically assessed by the dentist before any treatment began. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

Staff received professional training and development appropriate to their roles and learning needs. Qualified staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration.

Are services caring?

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

We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection. Patients said staff were welcoming, polite and professional. Feedback identified that the practice treated patients with dignity and respect. We observed staff treating patients with kindness and respect and were aware of the importance of confidentiality.

Patients said they received good dental treatment and they were involved in discussions about their dental care.

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. Patients said they were easily able to get an appointment. Patients confirmed that they urgent appointments available on the day that they phoned the practice.

The practice had access for patients with restricted mobility; the treatment room was on the ground floor, although X-ray facilities were located on the first floor. The practice did not have a hearing induction loop to help those patients with hearing difficulties.

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

Are services well-led?

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

Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them.

Staff said that they felt well supported and could raise any issues or concerns with the registered person. We were told that the practice was a friendly place to work and everyone worked well as a team. Regular formal and informal practice meetings were held and staff said that they were kept up to date with any relevant information relating to the practice.

Dr Claire Rumley - Stratford Road

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 carried out an announced, comprehensive inspection on 17 May 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with five members of staff, including the registered person who is the only dentist working at the practice. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments.

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 recorded and investigated accidents, significant events and complaints. We were told that there had been two staff accidents; an accident book was available which recorded details of these accidents. We were told that accidents would be analysed, learning points identified and discussed with staff at a staff meeting.

Discussions with the registered person demonstrated that they were aware of when to contact the Care Quality Commission regarding any incidents that occurred at the practice. All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) and information was available to enable staff to report incidents under RIDDOR regulations if necessary. We were told that there had been no events at the practice that required reporting under RIDDOR.

Two significant events had been recorded at the practice, one related to faulty electrical equipment and the other about a member of the public who was abusive to staff. There was a policy for reporting and managing untoward incidents or significant events. This policy recorded who held the lead role and reporting procedures including recording lessons learnt. All policies and procedures were accessible to staff and staff spoken with knew where they were located.

The practice had made arrangements to receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. The practice received these alerts via email and any that were relevant were forwarded to all staff at the practice; discussed at a staff meeting and a copy was printed off and kept in a medical alerts log.

We saw that the practice had recently developed a Duty of Candour policy. This policy states that patients 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. The policy identified how to respond to and escalate any safeguarding concerns. Contact details of the local organisations responsible for investigation were available on the policy and on a poster displayed in the reception area. The registered person had been identified as lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. We were told that safeguarding would be discussed at a practice meeting if an issue was identified; there had been no safeguarding issues to report. We saw evidence that all staff had completed the appropriate level of safeguarding training. On-line training was available to all staff.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. We were told that there had been no sharps injuries at the practice. The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. A special device was used during the recapping stage and the responsibility for this process rested with the dentist.

The practice had an Employers' liability insurance certificate which was due for renewal in October 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

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

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received training in basic life support on 10 May 2016; this training had been completed on an annual basis. Emergency equipment including 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), and oxygen were located in a secure central location. Records were available to demonstrate that this equipment was checked regularly to ensure it was in good working order.

The dental practice had emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. All emergency medicines were appropriately stored and were regularly checked to ensure they were within date for safe use. 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).

There was a well-stocked first aid box in the practice. The registered person was the designated first aider and had completed an emergency first aid at work course. We saw that items in the first aid box were all in date; however there were no records to demonstrate that checks were being completed, apart from eyewash which was recorded as being checked on a weekly basis. Following our inspection we received email confirmation that checks of the first aid equipment would be completed at the same time as checks of emergency medicines. We were told that records would be kept to demonstrate this.

Staff recruitment

Practice staff included the dentist, three qualified dental nurses and a receptionist. We saw evidence to demonstrate that all staff were up to date with their professional registration with the General Dental Council (GDC).

We looked at the staff recruitment files for three members of staff. We were told that the newest member of staff was employed prior to regulation by the Care Quality Commission (CQC). (Dental practices were required to register with the CQC under the Health and Social Care Act in 2011). All staff had worked at the practice for over twenty years. There was a very low staff turnover and staff said that they enjoyed working at the practice.

We were told that dental nurses had not received a Disclosure and Barring Service (DBS) check. A DBS check identifies 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. However, we noted that the practice were not following their pre-employment check policy which recorded that DBS checks should be completed for all staff who had patient contact. Following this inspection we were told that a risk assessment would be completed for dental nurses to identify any risks involved in staff working without DBS checks. However we were not shown a copy of a completed risk assessment as evidence.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that there were enough dental nurses to provide cover during times of annual leave or unexpected sick leave. There are two other dentists who work at this practice and who are registered separately with the Care Quality Commission. We were told that at times of unexpected leave one of these dentists would be asked to provide cover at times of need. There were enough staff to support the dentist during patient treatment. We were told that the dentist always worked with a dental nurse.

Monitoring health & safety and responding to risks

Arrangements were in place to monitor health and safety and deal with foreseeable emergencies. The practice had both a health and safety policy and environmental risk assessments. The registered person was the named lead and all staff spoken with said that they could speak with the registered person for health and safety advice if required. Risks to staff and patients had been identified and assessed. For example, we saw risk assessments for fire, radiation, sharps injury and a general practice risk assessment.

A health and safety poster was on display. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

We looked at the practice's fire safety risk assessment and associated documentation. We saw that issues for action had been identified. The fire risk assessment was discussed at a staff meeting held in February 2016. Staff were informed of the action taken to address issues identified in the risk assessment. We saw evidence that action had been taken such as six monthly fire drills, regular checks of fire extinguishers and the addition of smoke alarms.

Records showed that fire detection and firefighting equipment such as fire alarms, emergency lighting and smoke alarms were regularly tested and were subject to routine maintenance by external professionals. The fire extinguishers had also been serviced in May 2016 and staff were completing weekly checks of fire alarms, fire doors,

Are services safe?

fire extinguishers and exit routes. Staff spoken with were aware of the muster point for staff and visitors. Fire drills took place on a six monthly basis and records were kept to demonstrate this.

We saw records to confirm that all staff had completed fire safety training and update training was required in February 2017. A fire training manual was available for staff to review if required. Staff had been identified as fire wardens and fire marshals and all staff were aware who held these roles.

Cleaning materials were securely stored at the practice. A well organised COSHH file was available which recorded details of all substances used at the practice which may pose a risk to health. We were told that this had been updated in May 2016; however there was no documentary evidence to demonstrate that the update had been completed. The responsible person told us that this would be updated as soon as possible.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment room, waiting area, reception and toilet were visibly clean, tidy and uncluttered. Patients we spoke with said that the dental practice was clean and comfortable.

Instruments were being cleaned and sterilised in the treatment room. We observed a decontamination process being undertaken. 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 (a device for sterilising dental and medical instruments). 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. Decontamination processes were as outlined in the published guidance (HTM 01-05). Clean instruments were packaged; date stamped and stored in accordance with the latest HTM 01-05 guidelines. All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

Systems were in place to reduce the risk and spread of infection within the practice. There was hand washing facilities in the treatment room. Signs were in place to identify that these sinks were only for hand wash use. The hand hygiene policy was on display above the sink. Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers.

The practice had developed an infection control policy; this had a date of implementation of 2012 and no date of review recorded. An infection control lead had been identified on the policy. This staff member was responsible for ensuring infection prevention and control measures were followed. Staff spoken with were aware who held this lead role. We were told that staff had undertaken on-line training regarding infection prevention and control in May 2016 and also completed other infection prevention and control training throughout the year.

Regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The latest audit was completed on 15 April 2016; only one minor issue was identified. Previous audits had been completed in July and October 2015.

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).

Staff described the methods they used for flushing the dental unit water lines. This was done according to the dental chair manufacturer's instructions; at the start of the day and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of bacteria developing. A risk assessment regarding Legionella had been carried out by an external agency in February 2016. There were two issues for action. The registered person confirmed that one of the issues had been addressed. We saw evidence that all water outlets were flushed for two minutes each week and we were told that routine temperature monitoring checks were completed. However we were not shown any documentary

evidence to demonstrate this. Following this inspection we received an email to confirm that the practice would commence taking and recording hot and cold water outlet temperatures.

We discussed clinical waste with the registered manager. The practice had a contract with a company to collect waste matter on a regular basis. Clinical waste was stored securely away from patient areas while awaiting collection. We looked at waste transfer notices. We were told that clinical waste was collected every few weeks. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Sharps bins were not fixed to walls but were in appropriate locations which were out of the reach of children. Needle stick policies were on display in each treatment room. These recorded the contact details for the local occupational health department.

A dental nurse who worked at the practice was responsible for undertaking all environmental cleaning of both clinical and non-clinical areas. The practice did not fully comply with the national colour coding scheme for cleaning materials and equipment in dental premises. We saw that one colour of mop and bucket was not available. We were told that this would be purchased and put into use as soon as possible. We also received email confirmation that this action would be completed.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. We saw that maintenance contracts were in place for essential equipment such as X-ray sets, dental chairs, fire safety equipment, and the autoclave. Records seen demonstrated the dates on which the equipment had most recently been serviced. The dental chair had been serviced in September 2015 and the autoclave in October 2015. All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in November 2015. We were shown a certificate to demonstrate that a landlord's gas safety check had been completed in April 2016.

We saw that the practice had two supplies of Glucagon; one was kept with the emergency medicines and the other was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine had a shortened expiry date when it was stored at room temperature. We saw that the expiry date for the Glucagon stored in the emergency medicines box had been appropriately amended. We saw records to demonstrate that the Glucagon and other medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. Staff completed and signed records every day.

Prescription pads were securely stored and a log of each prescription issued was kept. We were told that the practice did not dispense medicines.

Radiography (X-rays)

The Health and Safety Executive had been notified that the practice were planning to carry out work with ionising radiation. The practice had one intraoral X-ray machine located in a dedicated X-ray room (intraoral X-rays concentrate on one tooth or area of the mouth). This X-ray machine was shared amongst the three dentists who worked at the location. Copies of the critical examination pack for the X-ray set along with the maintenance logs were available for review. The maintenance logs were within the recommended interval of three years.

The practice had a well maintained Radiation Protection file. This identified the radiation protection supervisor (RPS) as a dentist who worked within the building. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only. Local rules were available in the room where the X-ray machine was located for all staff to reference if needed. We saw that the local rules had not been amended to make them relevant to the practice and specific equipment in use.

We saw evidence that the dentist was up to date with the required continuing professional development on radiation safety. One of the dental nurses had also undertaken training to enable them to take radiographs.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken and the clinical findings.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

When registering with the practice patients completed a medical history form. This was reviewed and updated at every appointment. The dentist then verbally checked the medical history with the patient. This helped to ensure that the dentist was kept informed of any changes to the patient's health and medication before treatment began. The patients' medical histories included health conditions, medicines being taken, smoking and alcohol history and whether the patient had any allergies.

The practice held paper 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. 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.

Our discussions with the dentist demonstrated that they were aware of and used the National Institute for Health and Care Excellence (NICE) guidelines. For example in deciding the length of time to recall patients for a check-up and prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal.

The dentist was aware of the Faculty of General Dental Practice guidelines regarding clinical examinations and record keeping.

Health promotion & prevention

We saw that information was available in the waiting room regarding 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).

The dentist told us that patients were motivated and required minimal advice regarding oral hygiene. However, where relevant, preventative dental information was given in order to improve the outcome for the patient. Patients would be referred to the hygienist located at the practice. Fluoride varnish was applied to the teeth of children aged three to 18 and high concentration fluoride toothpaste was prescribed for adults as required. We were told that the hygienist would give oral health advice and would explain tooth brushing and interdental cleaning techniques to patients in a way they understood.

We saw that free samples of toothpaste were available to patients in the treatment room. Staff spoken with told us that patients were given advice appropriate to their individual needs such as dietary, smoking cessation and alcohol consumption advice was given when needed. Leaflets were available regarding smoking cessation.

Staffing

We discussed staff training and looked at staff training records. 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.

We were told that every year core continuing professional development training (CPD) was completed by all staff at the practice. This included training regarding safeguarding, disinfection and decontamination, medical emergencies, radiography and legal and ethical issues. CPD is a compulsory requirement of registration as a general dental professional. The dental nurses we spoke with said that completing the core CPD training as a dental team was enjoyable. In addition to this other training and development needs were identified during the appraisal process. Staff said that lunch and learn training sessions and dental nursing magazines were provided by the practice. The dentist told us that all staff were registered and completed on-line training on a regular basis. Systems were in place to monitor on-line training to ensure staff completed the required amount to meet CPD requirements. We were told that staff kept their own CPD logs and that CPD was discussed during appraisal and the practice provided sufficient amounts of training to ensure all staff met CPD requirements. We were told that staff CPD hours claimed were recorded annually by the GDC but that the practice would implement their own monitoring system.

Are services effective?

(for example, treatment is effective)

Records were available to demonstrate that annual appraisal meetings were held. Staff said that they could speak out at these meetings and request training. We saw that staff completed a questionnaire as part of the appraisal process which enabled them to formally record any needs, issues or concerns.

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. The practice had templates for making referrals to the Birmingham dental hospital. Patients were offered a copy of any referral letters. A referral log was set up for each patient. The practice made contact with each patient to ask if they had received their referral appointment and whether they had any issues or concerns.

Consent to care and treatment

The practice had a consent policy which had been reviewed in February 2014. However, the policy did not clearly identify all of the issues involved in the consent process. There was no information regarding the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves; and Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. There were no recent examples of patients where a mental capacity assessment or where a 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. Consent was recorded in the patients' dental care records.

Staff confirmed individual treatment options were discussed with each patient. We were told that patients were given verbal and written information to support them to make decisions about treatment, which allowed the patient to give their informed consent.

We were shown entries in dental care records where treatment options were discussed with patients. We were told that any risks involved in treatment were also discussed, although dental care records did not demonstrate this.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. Music was played in the treatment room and in the reception, 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.

The practice did not have computerised patient's dental care records and all patients' information including clinical records were stored in storage cabinets. Current patient dental care records were stored in the treatment room in a lockable filing cabinet. Other records were stored in open cabinets behind the reception area. These were not securely stored to maintain confidentiality of information.

Throughout the inspection we observed staff speaking with patients. We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. Patients told us that staff were extremely friendly and helpful. We received feedback from 52 patients which was overwhelmingly positive.

The reception desk was located in the waiting room. We asked how patient confidentiality was maintained within reception. Staff said that they tried to be discreet, if it were necessary to discuss a confidential matter; there were areas of the practice where this could happen, such as an unused treatment room, or the office behind the reception.

Involvement in decisions about care and treatment

We received feedback from 52 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback was positive with patients saying the staff were friendly, caring and respectful. We were also told that staff provided information and advice to enable patients to maintain their dental care routines.

Clear treatment plans were given to patients which detailed possible treatment and costs. Some patients said in the CQC comment cards that options were always discussed and the reasons for any treatment were always explained. 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. Patients confirmed that they were involved in discussions and decisions about their dental care and treatment.

Posters detailing both NHS and private costs were on display in the treatment room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

As part of our inspection we conducted a tour of the practice and we found the premises and facilities were appropriate for the services that were planned and delivered. The practice provided NHS and private treatment and treatment costs were clearly displayed in the treatment room and at reception. We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

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. Staff told us that patients were usually able to get an appointment within a few days of their request and were always able to get a same day appointment if they were in dental pain. Staff said that patients were generally seen on time. We observed that appointments ran smoothly on the day of the inspection and patients were not kept waiting. Feedback from patients confirmed that they were rarely kept waiting beyond their appointment time and were able to get an appointment at a time that suited them.

Tackling inequity and promoting equality

The reception, waiting area and treatment room was situated on the ground floor. A portable ramp provided access to the front of the building. Once inside the practice there was an internal step before the reception desk. We were told that the receptionist would leave the reception desk to speak with patients in a wheelchair or those with restricted mobility so that they could access treatment at the practice.

The practice did not have a hearing induction loop for use by people who were hard of hearing. We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language. Staff said that they knew their patients well and had systems in place to communicate with patients who were hard of hearing.

The practice had access to a recognised company to provide interpreters. Staff said that there were very few patients who could not speak English and therefore interpreting was not an issue.

Access to the service

Patients were able to make appointments over the telephone or in person. Staff we spoke with told us that patients could access appointments when they wanted them. Patients in dental pain were given any vacant appointment slots or were asked to call in to the practice to sit and wait to see the dentist. We were told that these patients would always be seen within 24 hours of calling the practice.

The practice's opening hours were: Monday, Tuesday, Thursday and Friday 8.30am to 5.30pm; and Wednesday: 8.30am to 1pm. The practice was closed for lunch between 1pm to 2pm each day. The telephone answering machine informed patients when the practice was closed for lunch and also gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays. Patients had direct access to Dr Rumley via her mobile telephone as necessary. Patients commented that they were able to see a dentist easily in an emergency. Patients could access care and treatment in a timely way and the appointment system met their needs.

One day before their appointment patients were received a telephone call to remind them of their appointment. We were told that a few patients had requested a text message reminder and this was now happening for these patients.

Concerns & complaints

The practice had a complaints procedure. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patient's satisfaction. Staff were aware of the procedure to follow if any complaints were received at the practice. A copy of the complaint policy was on display in the waiting room.

Staff told us that there had been no complaints made about the practice. Staff felt this was because they were all approachable and the majority of patients had been visiting the practice for many years.

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Our findings

Governance arrangements

There was an effective management structure in place to ensure that responsibilities of staff were clear. The provider was in charge of the day to day running of the practice. Staff said they understood their role and could speak with the dentist if they had any concerns. Staff told us that they enjoyed working at the practice and commented that there were good lines of communication within the staff team.

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. Discussions with staff showed they had a good understanding and knowledge of policies and procedures. Staff had signed documentation to confirm that they had read the policies in the policy folder. We saw that some of these policies did not record a date of review or implementation and some had not been reviewed for a few years. We were told that updated policies were available on the practice's computer. We saw evidence that these policies had recently been adapted to meet the needs of the practice. However, they had not been printed off and staff were working to old policies in the folder. Following our inspection we were told that staff had been made aware of the location of all updated policies.

As well as regular scheduled risk assessments, the practice undertook both clinical and non-clinical audits. These included six monthly infection prevention and control audits, audits regarding clinical record keeping, oral cancer risk factors and radiography. We saw evidence to demonstrate that all audits and risk assessments were reported on and action plans completed.

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

We spoke with three of the staff at the practice who all told us that the dentist was helpful, supportive and approachable. We were told that everyone got on well, and worked well as a team. Staff had worked at the practice for many years and said that they enjoyed their job.

Observations showed there was a friendly and welcoming attitude towards patients from staff throughout the practice. Patients we spoke with confirmed that staff were friendly and helpful. One patient had moved house but wished to remain at this practice and so travelled a great distance for appointments.

We saw that formal staff meetings took place every few months. We looked at the minutes of the meetings held in January, February and May 2016. We saw that practice issues were discussed such as the fire risk assessment and actions taken to address issues identified, the laptop and lighting at the practice. We were told that accidents, incidents and complaints would be discussed as they occurred. Staff said they could voice their views, and raise concerns during staff meetings. Staff confirmed that informal meetings were held on a daily basis at the start of the day or during lunch. This enabled staff to discuss issues or ask for support and advice. Staff also said that they were kept up to date with any changes at the practice or changes in working practices during their daily meetings. Staff told us that lines of communication were good and they could speak with the dentist at any time.

The practice had a whistleblowing policy. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. Staff spoken with said that they would have no hesitation in 'blowing the whistle' on poor practice.

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 and record card. The audits identified both areas for improvement, and where quality had been achieved, particularly in respect of the clinical areas.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. All staff at the practice completed core CPD training together as a team. Staff confirmed that they were encouraged and supported to undertake training. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period. Annual appraisal meetings were held but we were told that personal development plans (PDP) were not available for all staff as they had worked at the practice for

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many years. We were told that informal systems were in place for identification of training needs. However, following this inspection we received email confirmation that PDPs had been developed for all staff.

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. The practice also conducts a satisfaction survey on an annual basis. We were told that the response rate for the annual survey was low since the introduction of the FFT.

Staff completed an annual survey as part of the appraisal process. Staff spoken with said that they felt involved at the practice and were able to raise issues or concerns at any time.