

Drs S & N Waddell

# No.1 Nursery Road Dental Practice

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 30 March 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**

No.1 Nursery Road Dental Practice is a dental practice providing general dental services on a private basis. The service is provided by two dentists. They are supported by two dental nurses (one of whom was on maternity leave at the time of our inspection). Both of the dentists worked part-time at the practice and one was available to assist with dental nursing duties in the absence of the staff member on maternity leave.

The practice is located near a busy High Street in a commercial area. There is wheelchair access to the practice and a car parking bay for patients with disabilities. The premises consist of a waiting room, two treatment rooms and toilet facilities on the ground floor. The first floor comprises two decontamination rooms used for the cleaning and sterilisation of used dental instruments, an X-ray room, a staff room, an office and toilet facilities. Opening hours are from 9am to 5:30pm on Monday to Friday.

The two practice owners are registered with the Care Quality Commission (CQC) as a partnership. Like individual registered providers, they are 'registered

# Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Twenty-nine 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 helpful, friendly and professional.

## **Our key findings were:**

- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- The practice had systems to assess and manage risks to patients, including infection prevention and control, health and safety, safeguarding and the management of medical emergencies. We identified some areas for improvement and we were told these would be actioned promptly.
- Patients' care and treatment was planned and delivered in line with evidence based guidelines, best practice and current legislation; however, the dental care records were not sufficiently detailed to record this.
- Staff received training appropriate to their roles.
- Patients told us they found the staff helpful and friendly. Patients commented they felt involved in their treatment and that it was fully explained to them.
- Patients were able to make routine and emergency appointments when needed.
- The practice had an effective complaints process in place and the practice was able to demonstrate they made improvements as a direct result of patient feedback.
- 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. However, learning points and action plans were not always documented.

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

- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review the protocol for completing accurate, complete and detailed records relating to employment of staff. This includes making appropriate notes of verbal references taken and ensuring recruitment checks, including references, are suitably obtained and recorded. All staff appraisals should be documented.
- Review the practice's audit protocols for various aspects of the service, such as dental care records, at regular intervals to help improve the quality of service. The practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

# 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.

Staff told us they felt confident about reporting accidents and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Accidents in the previous 12 months to our inspection had been documented.

The practice had systems to assess and manage risks to patients. These included whistleblowing, complaints, safeguarding and the management of medical emergencies. It had a recruitment process to help ensure the safe recruitment of staff; however, not all of the staff files contained references.

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.

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 and we were assured these would be actioned promptly.

### **Are services effective?**

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

The dentists followed national guidelines when delivering dental care. These included the Faculty of General Dental Practice (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.

The practice monitored any changes to the patients' oral health. Explanations were given to patients in a way they understood and risks, benefits and options were explained. Record keeping required improvement in order to be in line with guidance issued by the FGDP.

### **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 commented they were treated with kindness and respect while they received treatment. Patients described staff as caring and professional. 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. Feedback from patients stated that some travelled long distances to see the dentists here. The provider told us that some patients lived abroad and they would only visit this practice.

### **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 informal methods to successfully gain feedback from patients and they were able to demonstrate improvements that had been made as a result. Staff meetings took place on a regular basis.

The practice carried out audits such as radiography and infection control at regular intervals to help improve the quality of service. However, not all audits had documented learning points with action plans. No audits had been completed in dental care record keeping.

# No.1 Nursery Road Dental Practice

## Detailed findings

### Background to this inspection

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

We inspected No.1 Nursery Road Dental Practice on 30 March 2016. The inspection was carried out by one Care Quality Commission (CQC) inspector who was dentally trained.

Prior to the inspection we reviewed information we held about the provider from various sources. We informed Healthwatch 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 two providers (both of whom are dentists) and one dental nurse. We also reviewed CQC comment cards which patients had completed. 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. The last entry in the accident book was recorded in August 2015. We were told accidents were discussed with staff members at the earliest opportunity. There was an accident book present but no separate records for reporting incidents. The provider told us this would be implemented although we were told they had previously reported incidents elsewhere. They contacted us in June 2016 and told us that they had introduced a written protocol for reporting incidents.

Staff members we spoke with all understood the Reporting of Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR). There had not been any RIDDOR reportable incidents in the last 12 months.

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 also had arrangements in place for staff to report any adverse drug reactions via the Yellow Card Scheme.

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

The practice had child protection and vulnerable adult policies and procedures in place. These provided 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 dentists were due to have training in safeguarding in July 2016 as they had not completed any in the past few years due to course cancellations.

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 at the practice and that both dentists used them when carrying out root canal treatment whenever practically possible. If they were unable to place the rubber dam in certain situations, the dentist risk assessed and used alternative measures to protect the airway.

The practice had a system for raising concerns. 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.

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

### Medical emergencies

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. The AED did not contain any pads for children. The provider told us they stored these on site but they appeared to have been misplaced, possibly by the instructor during recent training. The provider contacted us in June 2016 and informed us these had been ordered and were now stored with the AED.

Staff received annual training in the management of medical emergencies and this last took place in December 2015. 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.

The practice undertook regular checks of the equipment and emergency medicines to ensure they were safe to use. We looked at records dating back to January 2016 to confirm this. 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 daily. However, staff were not documenting the daily fridge temperature. We were assured this would be documented with immediate effect. The provider contacted us in June 2016 and informed us that the temperatures were now included in an audit and they remained well within the recommended parameters.

# Are services safe?

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 process for the safe recruitment of staff. We looked at the recruitment records for two members of the practice team. The records we saw contained evidence of staff identity verification, curriculum vitae, immunisation status, employment contracts, induction plans and copies of their General Dental Council (GDC) registration certificates. There were also Disclosure and Barring Service (DBS) checks present for both 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 GDC requires all of its registrants to have appropriate indemnity arrangements in place so that patients can claim any compensation to which they may be entitled. We reviewed a selection of staff files and saw evidence that one of the dental nurses had their own dental indemnity cover but the other did not. This was discussed with the provider and they contacted their indemnity organisation who stated that it was not mandatory for the dental nurses to have their own cover but that they 'strongly advise that the dental nurses have their own indemnity'. The provider contacted us in June 2016 and stated that both of the dental nurses now had their own indemnity cover.

Not all staff members had references in place. We were told that the provider sought verbal and written references but not all references were documented.

The practice had a system in place to monitor the professional registration of its clinical staff members. We reviewed a selection of staff files and found that certificates were present and had been updated to reflect the current year's membership.

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

The practice had arrangements in place to monitor health and safety. We reviewed several risk management policies. We saw evidence that the fire extinguishers and fire alarms had been serviced in June 2015. We were told that the fire

alarms were checked monthly but not documented. Fire drills took place on a monthly basis and there was a fire exit to the rear of the practice. A fire risk assessment had taken place internally.

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 (to patients, staff and visitors) 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 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)'. 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 all clinical staff were immunised against Hepatitis B to ensure the safety of patients and staff.

We observed the treatment rooms and the decontaminations 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 two dedicated decontamination rooms. HTM 01-05 recommends the provision of two separate rooms as this provides for a higher degree of separation between dirty instruments awaiting decontamination and cleaned/sterilized instruments that are to be placed in trays, packs or containers for use. 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 rooms.



# Are services safe?

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 a locked container but this was not enclosed or secured to a wall. We discussed this with the provider and they contacted us in June 2016 to inform that the container was now secured to a wall. 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.

The practice had invested in a worktop washer-disinfector to clean the used instruments. This device was introduced in 2015 and combines thermal disinfection with an ultrasonic cycle. The ultrasonic process uses high frequency sound waves to clean instruments. The instruments were subsequently examined visually with an illuminated magnifying glass and then sterilised in an autoclave. Staff wore appropriate personal protective equipment during the process and these included disposable gloves, aprons and protective eye wear.

The practice had systems in place for quality testing the decontamination equipment daily and weekly. We saw records which confirmed these had taken place.

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.

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

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 six months in line with current guidance.

Action plans were not 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 the practice recorded water temperature on a monthly basis to check that the temperature remained within the recommended range. We looked at records dating back to October 2015. They also tested the water quality every six months and the last two tests showed zero cultures of Legionella bacteria. Risk assessment processes for Legionella were carried out internally by the provider – one was carried out in July 2014 and the other in 2015 (but it did not have a date on it). The HSE (Health and Safety Executive) states that a risk assessment must be carried out by a competent person. The HSE defines a competent person as someone with the necessary skills, knowledge and experience to manage health and safety, including the control measures. The provider informed us that they had excellent knowledge of the water system at the practice as they were heavily involved during the installation.

## 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. Internal visual tests were carried out a fortnight before our visit. An electric installation test took place in May 2014. Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. The provider told us they carried out PAT using a PAT kit. The provider told us they tested the appliances and logged the results in March 2016.

The practice kept a log of medicines that were dispensed to patients so they could ensure that all medicines were tracked and safely given.

There was a separate fridge for the storage of medicines and dental materials. We saw a thermometer in the fridge and were told that the temperature was checked daily; however, it was not documented. The provider assured us they would begin logging this with immediate effect.



# Are services safe?

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 weekly 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. Equipment was present to enable the taking of orthopantomograms (OPG). An OPG is a rotational panoramic dental radiograph that allows the clinician to view the upper and lower jaws and teeth. It is normally a 2-dimensional representation of these.

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.

On the day of our visit, we did not see any evidence of notification to the Health and Safety Executive (HSE) but the provider told us that they had been informed. Employers planning to carry out work with ionising radiation are required to notify HSE and retain documentation of this. The provider contacted us in June 2016 and sent us a notification ID number.

On the day of our visit, the X-ray equipment in one treatment room was fitted with a part called a collimator which is good practice as it reduces the radiation dose to the patient. The provider contacted us in June 2016 to state that the X-ray equipment in the second treatment room had been upgraded and also had a collimator.

We saw evidence that the practice carried out an X-ray audit in December 2015. 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 did not see any evidence that the results were analysed and reported on with subsequent action plans.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The practice kept up to date dental care records but not all were comprehensive and in line with guidance from the Faculty of General Dental Practice (FGDP). The dental care records contained information about the patient's current dental needs and past treatment. The dentists carried out assessments in line with recognised guidance from the FGDP but the details were not always recorded. The provider contacted us in June 2016 and told us that they had upgraded their record keeping processes and they would review this in six months.

We spoke with both 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. Medical history checks were updated by each patient at each visit. This included an update on their health conditions, current medicines being taken and whether they had any allergies.

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 but not for children. The guidelines recommend that all children above 7 years old have their BPE checked and documented. However, the provider told us that all children in this age range were taken into immediate intervention if any gum problems arose. The provider contacted us in June 2016 with a description of appropriate treatment pathways that they undertook in these situations. They agreed that they would record the BPE for children too.

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 dentist 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 were discussed with the patient and a written treatment plan was given upon request.

### 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 gum disease and oral hygiene.

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.

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.

The dentists monitored staffing levels and planned for staff absences to ensure the service was uninterrupted. We were told that staff were flexible and were willing to carry out additional hours at the practice. The dentists would also carry out dental nursing duties if they were short-staffed as it was rare that both dentists treated patients on the same day.

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

# Are services effective?

(for example, treatment is effective)

We were told that the dental nurses were encouraged to carry out further training. One of the dental nurses had undertaken additional training which enabled them to take X-rays. One of the dental nurses was due to start further training on oral health education.

## **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.

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.

Staff members confirmed individual treatment options, risks, benefits and costs were discussed with each patient. Written treatment plans were available for patients upon request. Patients were given time to consider and make informed decisions about which option they preferred.

# Are services caring?

## Our findings

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

Twenty-nine patients provided feedback about the practice. We looked at CQC comment cards patients had completed prior to the inspection. Patient feedback was overwhelmingly positive about the care they received from the practice. Patients commented they were treated with kindness and respect while they received treatment. They described staff as friendly, experienced and professional. 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. Some patients commented that they lived far from the practice but they were willing to travel (some over 80 miles) to this practice. Other patients had been patients of the practice for forty years.

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. We were told that some patients preferred to have the doors open during their treatment. Staff were keen to provide a friendly atmosphere and accommodated patients' requests wherever possible.

We observed that staff members were helpful, discreet and respectful to patients.

We were told that the practice appropriately supported anxious patients using various methods. The practice booked longer appointments so that patients had ample time to discuss their concerns with the dentist. For children (especially anxious patients), the dentists used child appropriate language and the tell-show-do technique. The tell-show-do technique is an effective way of establishing rapport as it is very much an interactive and communicative approach. They also had the choice of seeing different dentists.

We were told that the two dentists treated up to four generations of the same families. Many patients had been visiting the same practice for several decades and comments made by patients corroborated this.

### **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 appointments were long enough for them to discuss their dental treatment.

Examination and treatment fees were displayed in the waiting room and on the practice's website.

# 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. A portable ramp was available for patients using wheelchairs or patients with pushchairs. There was a car parking bay immediately adjacent to the practice and this was reserved for patients with disabilities. There were toilet facilities available on the ground floor but they were not wheelchair-accessible.

The practice had an appointment system in place to respond to patients' needs. We saw evidence that the dentists booked ample time for each appointment – this allowed the dentists to spend sufficient time with the patients to discuss their dental care. This also meant that patients were usually seen on time as the appointments were unlikely to fall behind schedule.

Staff told us the majority of patients who requested an urgent appointment would be seen within 24 hours. We were told 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 by text message to all patients that had consented. In addition to this, written reminders were sent to patients due for dental recalls.

### Tackling inequity and promoting equality

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.

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. All patients had access to the provider's mobile telephone number and the dentists aimed to always provide a personalised and friendly service to their patients. The dentists had also re-opened the practice when their patients required urgent dental care that could not be postponed until the next working day. Patients were able to contact the providers whenever possible. However, if the dentists were abroad, they had arrangements with a local dental practice so that patients could be temporarily treated there in their absence.

Opening hours were from 9am to 5:30pm on Monday to Friday.

### 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 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. 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. 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 provider was in charge of the day to day running of the service. 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.

### **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 and infection control lead.

### **Learning and improvement**

The provider 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. We saw evidence that both dentists had completed CPD in 2015 in topics such as infection control, radiography and oral cancer.

Staff audited areas of their practice regularly as part of a system of continuous improvement and learning. These included audits of radiography (X-rays) and infection control. However, not all of these audits had action plans.

All audits should have documented learning points so that the resulting improvements can be demonstrated. The practice had not carried out any recent audits in dental care record keeping.

Staff meetings took place regularly. We noted that topics such as infection control and record keeping had been discussed and documented. Not all of the staff meetings had associated minutes. It is important to document minutes so that staff members who were not present also had the information. Also, staff could update themselves at a later date.

We were told that the dental nurses had regular appraisals where learning needs, concerns and aspirations could be discussed. However, these were not always documented and we did not see any evidence on the day of our visit. The provider told us they did not record fixed points on a training timeline because it was a continuous process.

### **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 an informal approach to involve, seek and act upon feedback from people using the service. Patient satisfaction surveys were carried out a few years ago but the dentists told us that they have an open and friendly approach with the patients. Due to this, many of the patients will discuss matters directly with the dentists during their visits. The dentists told us this works for them although they did not have any formal methods for patients to leave feedback anonymously.

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