Mr. Stephen Hambleton

Mr Stephen Hambleton - Warley

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 11 January 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 not providing well-led care in accordance with the relevant regulations.

Background

Stephen Hambleton Dental Practice has two dentists, one of which works full time and one part time, five qualified dental nurses who are registered with the General Dental Council (GDC), a part time administration assistant and a dental therapist/hygienist. The practice's opening hours are 9am to 5.30pm Monday to Thursday and 9am to 1pm on Friday. The practice is closed between 1pm – 2pm on Monday to Thursday.

Stephen Hambleton Dental Practice provides NHS and private treatment for adults and children. The practice is located on the first floor of a converted property and has a reception, waiting area and two dental treatment rooms. Decontamination of dental instruments (cleaning, sterilising and packing dental instruments) takes place in each dental treatment room. There is also a reception and waiting area.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. Like registered

Summary of findings

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

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience of the practice. We collected 73 completed cards and spoke with three patients. These provided an overwhelmingly positive view of the services the practice provides. Patients commented that the quality of care was excellent.

Our key findings were:

- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The provider had emergency medicines in line with the British National Formulary (BNF) guidance for medical emergencies in dental practice.
- Staff had been trained to deal with medical emergencies.
- The practice kept up to date with current guidelines when considering the care and treatment needs of patients.
- Some infection prevention and control systems were in place, although audits were not completed on a six monthly basis.
- Options for treatment were identified and explored and patients said they were involved in making decisions about their treatment.
- Patients' confidentiality was maintained.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Health promotion advice was given to patients appropriate to their individual needs such as smoking cessation or dietary advice.
- Feedback from 73 patients gave us a positive picture of a friendly, caring and professional service.

We identified regulations that were not being met and the provider must:

- Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. This should include regular clinical audits to assess, monitor and improve the quality and safety of the service and six monthly infection prevention and control audits.

You can see full details of the regulations not being met at the end of this report.

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

- Implement systems for the reporting and recording of significant events and agree learning outcomes which should be discussed with staff.
- Register with the MHRA to receive medicine safety alerts and ensure that any alerts relevant to the practice are discussed with staff and actions taken as appropriate.
- Implement a system to ensure that the information located in the policies and procedures files is the most up to date information held at the practice.
- Develop a system to demonstrate cleaning undertaken at the practice with records available and ensure that cleaning equipment is stored correctly.
- Develop a robust policy regarding the safe use and disposal of sharps which includes contact details for the local occupational health department.
- Regular staff meetings should be held to discuss any issues within the practice and records should be available to demonstrate discussions held.
- Consider that an accurate, complete and contemporaneous record is kept in respect of each patient, including a record of the decisions taken in relation to the care and treatment provided and justification for taking X-rays.
- Review the way in which patient consent is recorded in dental care records.
- Review at appropriate intervals the training, learning and development needs of individual staff members, ensure that staff have completed relevant training/ updates and have an effective process established for staff appraisals.
- Implement systems to demonstrate that smoke detectors are checked to ensure they are in good working order and records kept to demonstrate this.
- Provide evidence that the actions identified in the 2007 fire risk assessment have been addressed.
- Implement clear procedures for managing comments, concerns or complaints. Review the complaints process and ensure that patients receive written confirmation of investigation and actions taken and that learning is identified to improve the service.

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 in place for recording significant events and accidents were not effective. Details of incidents were recorded on patient care records and learning outcomes were not recorded. Staff were aware who to report incidents and accidents to within the practice and we were told that new systems would be implemented which included completion of significant event forms.

Medicines and equipment available for use in a medical emergency were being checked for effectiveness. However, we found that the automated external defibrillator (AED) battery and pads had passed their expiry date. (An AED is 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). Following the inspection we received confirmation that a new AED battery and pads had been ordered and were due for delivery at the practice on 25 January 2016. Medicines for use in an emergency were all available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF).

Infection control audits were being undertaken, although not on a six monthly basis. Corrective action had been taken two days following our inspection and a further infection prevention and control audit had been completed. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

Are services effective?

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

The practice demonstrated that they followed professional guidance, for example, issued by the National Institute for Health and Care Excellence (NICE). The practice monitored patients' oral health and gave appropriate health promotion advice. Staff were registered with the General Dental Council (GDC).

Patients told us that staff explained treatment options to ensure that they could make informed decisions about any treatment they received. However some dental care records seen recorded minimal evidence of discussions regarding detailing consent.

Staff we spoke with had a good understanding of the process of consent including the situations in which a child under the age of 16 could consent for themselves (Gillick competence).

Are services caring?

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

We received feedback from 73 patients which was overwhelmingly positive. Patients praised staff and gave a positive view of the service and treatment received. Patients commented that treatment was explained clearly and staff confirmed that dentists always took their time to explain treatment to patients. Patient records were stored securely and patient confidentiality was maintained

Staff knew patients well and were welcoming and friendly when patients attended the 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

Patients had good access to appointments, including emergency appointments, which were available on the same day. Patients were invited to provide feedback via the 'Friends and Family' Test and the test results had been reviewed by the practice. The NHS Choices website recorded that 100% of people who completed this survey would recommend this dental practice.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference. We saw that where complaints had been received at the practice they were responded to and patients were offered a meeting with the principal dentist to discuss their concerns.

Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

We found that staff had not had training in fire safety although this had been booked.

The practice held monthly team meetings with opportunities for staff to bring up concerns although these meetings were not minuted. Staff said that they also held other informal meetings as and when required to discuss any issues or concerns.

Limited amounts of clinical audit were available to highlight and improve areas of practice. However, following this inspection we were told about the clinical audits that were immediately implemented as a result of the inspection.

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Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection on 11 January 2016 as part of our planned inspection of all dental practices. The inspection took place over one day and was carried out by a lead inspector and a dental specialist adviser.

We informed NHS England area team that we were inspecting the practice, however there were no immediate concerns from them.

During our inspection visit, we reviewed policy documents and staff records. We spoke with six members of staff, including the management team. We conducted a tour of the practice and looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments. We reviewed comment cards completed by patients and spoke to three patients. Patients gave very positive feedback about their experience at the practice.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We were told that there had been one significant event at the practice recently, the details of which were recorded in the patient's dental care record. Staff spoken with were aware of the significant event and confirmed that a discussion had been held regarding this at an informal staff meeting. There were no minutes of this meeting to demonstrate discussions held or any learning outcomes.

There was no significant events policy. An incident reporting training hand-out was available on file. The practice were not following the guidance in the training hand-out which recorded that incident reporting forms should be completed, staff spoken with confirmed that they did not have access to any reporting forms. During the inspection we were told that a policy would be developed and significant event reporting forms would be implemented. We received confirmation following the inspection that this action had been addressed.

We discussed the reporting of injuries, diseases or dangerous occurrences (RIDDOR). We saw that guidance was available for staff about RIDDOR regulations. There had been no incidents reported under RIDDOR regulations.

Accident books demonstrated that any accidents at the practice were recorded and action taken, although information recorded was very brief.

Dental nurses told us that they did not receive national alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding patient safety.

Reliable safety systems and processes (including safeguarding)

Child protection and vulnerable adult safeguarding policies were not easily accessible to staff. Various copies of policies were kept on two separate files, some with out of date or conflicting information. Policies did not have a date of implementation or review recorded which made it difficult to identify which was the most up to date. The principal dentist confirmed that action would be taken to remove all out of date information from the policy file. Following this inspection we received confirmation to confirm that this action had been taken.

Staff had signed to confirm that they had read and would work to the safeguarding policies. Staff spoken with felt that the principal dentist was the safeguarding lead although one policy seen recorded conflicting information. Policies did not record the contact details for the local authority child protection or adult safeguarding authorities, although this information was recorded on a flow chart located on the wall in the reception area. We were told that there had been no safeguarding issues reported at the practice.

Copies of various documents such as multi-agency referral forms for reporting child protection issues, Department of Health information regarding child protection and the dental team and information regarding dental care and dementia produced by the Alzheimer's disease society were available for staff.

We saw copies of training certificates to demonstrate that staff had undertaken safeguarding training appropriate to their role and as part of their continuous professional development (CPD) they had undertaken refresher training on a regular basis.

We asked about the instruments and equipment which were used during root canal treatment. We were told that root canal treatment was carried 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). The practice was following the guidance from the British Endodontic Society in relation to the use of the rubber dam.

We spoke to the principal dentist about the prevention of needle stick injuries. Sharps boxes were located in treatment rooms. We saw that information posters to guide staff regarding the safe use and disposal of sharps were on display in these rooms. These posters recorded the contact details of the local occupational health department. We saw a document in the policy file regarding the safe use and disposal of contaminated sharps. This document did not record how to deal with a sharps injury and did not record details of the closest occupational health department.

The practice used a system whereby needles were re-sheathed by the dentist following administration of a

local anaesthetic to a patient. Dental nurses spoken with confirmed that the responsibility for disposal of sharps instruments rested with the dentist. We were told that there had been no sharps injuries.

Medical emergencies

The practice had some arrangements in place to deal with medical emergencies. Oxygen and other emergency equipment was available and these were checked on a regular basis to ensure they were in good working order and were within their expiry dates. The practice did not have an

automated external defibrillator (AED) that was in good working order as we were told that the battery and pads had expired. (AED is 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). The principal dentist confirmed to us that the battery and pads were being replaced on 25 January 2016 and staff had been booked on a further life support training course for 4 February 2016.

The practice had in place the emergency medicines as set out in the British National Formulary guidance for dealing with medical emergencies in a dental practice. These were checked and all were within their expiry dates. The expiry dates of medicines were monitored using a check sheet which enabled the staff to replace out of date medicines promptly. Staff spoken with were aware of the location of the emergency equipment and medication. Staff had attended training to maintain their competence in dealing with medical emergencies. A poster regarding medical emergencies was on display to guide staff as well as a resuscitation poster and emergency medicines list.

The practice had first aid kits available for use which were checked on a monthly basis and records were kept to demonstrate this. One member of staff had been trained in first aid at work, although update training was required (expired 29 Jan 2015).

Staff recruitment

There was a recruitment policy in place and although this did not record that disclosure and barring service (DBS) checks should be undertaken for some roles prior to employment, we saw evidence that these had been completed. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We discussed staff recruitment and looked at staff files which contained details of the immunisation status for each member of staff. Information was available regarding the staff member's professional registration and also copies of training certificates. 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 other staff had worked at the practice for over eight years. There was a very low staff turnover and staff said that they enjoyed working at the practice.

There were enough staff to support the dentists and therapist/hygienist during patient treatment. Staff said that they had to book annual leave in advance and this and any unplanned absences were covered by part time staff working additional hours. Sufficient numbers of staff were on duty to ensure that the reception area was not left unmanned at any time.

Monitoring health & safety and responding to risks

The practice had some arrangements in place to monitor health and safety and deal with foreseeable emergencies. We discussed fire safety with dental nurses. Staff spoken with were aware of the 'muster' points where they should meet in the event of a fire. There were two smoke detectors located in the waiting room and corridor to the treatment rooms. There was no documentary evidence to demonstrate any checks undertaken on smoke detectors to ensure they were in good working order. An external agency provided fire extinguisher servicing and these were all up to date with the next service booked for 15 January 2016.

Staff had not received fire training but we were told that this would be booked as soon as possible. We saw documentary evidence to demonstrate that fire drills took place twice per year. Following this inspection we received confirmation that fire training had been booked for 18 January 2016.

Information was available on file for staff detailing how to complete a fire risk assessment. A separate document produced by the Health and safety executive regarding fire

Are services safe?

risk assessments was also available. The practice had completed a risk assessment which identified some issues that required action such as drawing up an emergency plan in case of major fire. This risk assessment was implemented in 2007 and had been reviewed annually. However there was no evidence that the actions identified in the risk assessment had been addressed.

A standardised model risk log was available on file and the practice had developed a risk log. A Control of Substances Hazardous to Health (COSHH) information file was available which contained data sheets regarding products used at the practice.

We saw that a health and safety legislation poster was on display in the reception area. A copy of the health and safety at work statement of intent produced by Sandwell Primary Care Trust (now the Clinical Commissioning Group (CCG)) and the practice's health and safety policy statement were available on file. These policy documents required updating as they contained out of date of information.

Infection control

The practice had an infection control policy that outlined the procedure for all issues relating to minimising the risk and spread of infections. This policy was implemented in 2010 and did not have a date of review to demonstrate that it had been reviewed and updated if required. Information recorded on this policy was out of date as recommended practice had changed regarding bagging instruments following decontamination but the policy had not been amended. The policy was not on display in the area that decontamination of used dental equipment took place. A dental nurse was identified as the infection control lead. We saw that dental nurses had undertaken in-house training regarding infection prevention and control and completed annual updates.

An infection control audit was completed on an annual basis at the practice; the last audit was completed in March 2015. The Department of Health's guidance on decontamination (HTM 01-05) recommends self-assessment audits every six months. It is designed to assist all registered primary dental care services to meet satisfactory levels of decontamination of equipment. There was no evidence that infection prevention and control audits were undertaken on a six monthly basis. Following this inspection we received email confirmation that a further infection prevention audit was completed on 13 January 2016 and six monthly audits were scheduled for the future.

It was noted that the two dental treatment rooms, waiting area, reception and toilets were visibly clean, tidy and clutter free. Patients spoken with and comment cards received confirmed that the practice was always generally clean. Hand washing facilities were available including wall mounted liquid soap and gels and paper towels in each of the treatment rooms and toilets. Signs reminding staff of appropriate hand washing techniques were available by each sink.

Decontamination of dental equipment took place in treatment rooms. There was one hand washing sink in each room. Bowls were used in these sinks when they were used for washing and rinsing dental instruments. One of the dental nurses gave a demonstration of the decontamination process. This included manually cleaning; inspecting under an illuminated magnifying glass to visually check for any remaining contamination (and re-washing if required); placing in the autoclave (a machine used to sterilise instruments); instruments were pouched and date stamped at the end of each session. Designated clean and dirty areas were identified in the decontamination area. We saw that test strips were used to demonstrate that the autoclave was working effectively for every cycle. These strips were dated and stored for future reference.

Each treatment room had the appropriate routine personal protective equipment (PPE) available for staff and patient use. Patients we spoke with confirmed that dental staff wore PPE during any checks or treatment they carried out.

Staff spoken with were able to describe the end to end process of infection control procedures at the practice. They explained the decontamination of the general treatment room environment following the treatment of a patient and demonstrated how the working surfaces, dental unit and dental chair were decontaminated. This included the treatment of the dental water lines. Discussions with staff demonstrated that the management of dental water lines was appropriate and included disinfection and regular testing to prevent the growth and spread of legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings).

Are services safe?

A legionella risk assessment was completed in July 2011; the risk assessment stated that it should have been reviewed every three years. We saw that hot and cold water temperatures were being monitored and recorded on a monthly basis. This was being undertaken in accordance with the action plan from the 2011 risk assessment. The principal dentist confirmed that they would have another legionella risk assessment completed and this was booked for 14 January 2016. Following the inspection we received email confirmation that the legionella risk assessment had been completed and that the procedures for monitoring water temperatures had been assessed as robust.

Environmental cleaning was carried out by a cleaning company employed by the practice. There were no records to demonstrate the cleaning that was completed. We saw that cleaning equipment available was in accordance with the national colour coding scheme, however mops were not stored correctly to allow them to air dry correctly. We discussed this with the principal dentist who confirmed that action would be taken to address this.

We observed that clinical waste bags were securely stored away from patient areas. Consignment notices demonstrated that clinical waste was removed from the premises on a regular basis by an appropriate contractor. Patients could be assured that they were protected from the risk of infection from contaminated dental waste.

Spill kits were available; these are used to treat any spillage of mercury, blood or bodily fluid to reduce the potential for spread of infection. These were checked and were within their expiry date.

Equipment and medicines

We saw that one emergency medicine was being stored in the fridge and staff were carrying out fridge temperature checks to ensure that this medication was stored at the appropriate temperature. The practice did not dispense medicine. The practice stored prescription pads securely to prevent loss due to theft and all prescriptions were noted and details recorded.

Systems were in place to ensure that maintenance checks were undertaken on equipment used at the practice.

Electrical appliances had received a portable appliance test (PAT) in January 2016. Stickers were in place on portable electrical equipment to demonstrate the testing undertaken. Equipment checks were regularly carried out in line with the manufacturer's recommendations. For example we saw a pressure vessel inspection certificates dated October 2015 and an oxygen cylinder checklist which demonstrated that the oxygen cylinder is in date.

Radiography (X-rays)

We checked the radiation protection records and looked at the X-ray machines at the practice. We saw two intra-oral X-ray machines. The practice kept a radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). We saw the critical examination packs of all X-rays sets used in the practice. These demonstrated that the X-ray machines were working within normal parameters.

We saw documentation to demonstrate that a routine survey of the X-ray equipment had been completed in April 2015, recommendations for action detailed in the report had not been acted upon. The principal dentist confirmed that this would be completed immediately. Following this inspection we received confirmation that the risk assessment and all recommendations had been completed with information relating to action taken being sent to the appropriate monitoring body.

All treatment rooms displayed the 'local rules' of the X-ray machine on the wall. These detailed the specifics of each machine as well as the responsible persons to contact. We also saw a copy of the most recent radiological audit which was dated 2013; the principal dentist confirmed that no audits had been completed since that date but stated that another dentist within the practice would begin an audit immediately. We saw that all X-rays were graded on quality but the results recorded were not audited or acted upon to ensure continuous improvement of standards.

Evidence was seen that staff were up to date with required training in radiography as detailed by IR(ME)R.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We saw that a medical history form was filled in by patients, and checked verbally at every appointment. Patients were asked to disclose any health conditions, medicines being taken and any allergies suffered. This ensured that the dentist was kept informed of any changes to the patient's general health which may have impacted on treatment. Patients that we spoke with confirmed that they were asked about their medical history at every visit to the dentist.

Dental care records showed that details of the condition of the gums (using the basic periodontal examination (BPE)) and soft tissues lining the mouth were recorded. (The BPE is a simple and rapid screening tool that is used to indicate the level of examination needed and to provide basic guidance on treatment need). The dentist would refer to the dental hygienist/therapist for more complex periodontal treatment.

The dentists working in the practice carried out consultations, assessments and treatment in line with recognised general professional guidelines. For example, the practice referred to National Institute for Health and Care Excellence (NICE) guidelines to determine how frequently to recall patients and regarding removal of lower wisdom teeth.

Patient care recorded did not record the justification for taking X-rays in line with the Faculty of General Dental Practitioners directive. The principal dentist confirmed that this would be acted upon immediately.

A treatment plan was then given to each patient and this included the cost involved.

Health promotion & prevention

The waiting room at the practice contained leaflets and posters regarding how to reduce the risk of poor dental health, oral cancer, smoking cessation, periodontal disease, acid foods and plaque. Free samples of toothpaste were also available.

Staff told us, and patients that we spoke with confirmed that they were given advice appropriate to their individual needs regarding oral hygiene, smoking cessation or dietary advice. Adults and children attending the practice were advised during their consultation of steps to take to maintain healthy teeth. Fluoride varnish was applied to childrens' teeth; high concentration fluoride toothpastes were prescribed for adult patients at high risk from dental decay and disclosing tablets were used to explain to patients where improvements were required with their tooth brushing technique. This was in line with the Department of Health guidelines on prevention known as 'Delivering Better Oral Health'. However, the dental care records we observed did not demonstrate that dentists had given oral health advice to patients.

One dental nurse was trained as dental health educator and leaflets were provided for patients regarding oral health and hygiene.

Staffing

The practice did not have a method of quickly identifying training undertaken by staff. Staff files contained training certificates and continuing professional development logs (CPD), some of which required updating. Staff told us that they were responsible for ensuring their CPD was up to date. The principal dentist provided journals as a source of learning for staff. CPD is a compulsory requirement of registration as a general dental professional. Training certificates demonstrated that staff had undertaken basic life support training within the last 12 months. However, staff confirmed that they had not undertaken specific fire safety training. This training had been booked for 18 January 2016.

There was no system in place for supervision and appraisal of staff. We were told that all dental nurses had received an appraisal in 2011 but none had been undertaken since. We were told that appraisals had been booked for week commencing 18 January 2016. Staff spoken with said that they could discuss working practices, concerns or training needs with the principal dentist at any time. Records showed professional registration with the GDC was up to date for all staff.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment. For example patients requiring oral surgery and orthodontic treatment were referred to a local hospital. A referral letter

Are services effective?

(for example, treatment is effective)

was prepared and sent to the treatment provider; patients were not given a copy of their referral letter. Referrals were also made to the therapist/hygienist who worked at the practice for complex periodontal treatment.

Where oral cancer was suspected, referrals were made by telephone and followed up with a letter. We were told that the individual dentist would chase these referrals to ensure that an appointment had been received by the patient.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Most staff had undertaken specific training in this area. Staff we spoke with understood the concept of the MCA and how to obtain consent, considering a patient's capacity to consent and making decisions in the patient's best interests.

The dentist showed us a selection of dental care records to demonstrate the recording of patient consent. We saw these records contained minimal evidence. We were told that the dentist had conversations with patients and explained options but was not recording this in sufficient detail. We were told that written treatment plans were provided for all patients which detailed costs as well as options for treatment. The practice did not review or audit consent procedures. Patients we spoke with commented that they always felt involved in their treatment and were given ample opportunities to ask questions.

A copy of the NHS Choices consent policy was available at the practice. This was implemented in May 2010 but had no date of review recorded.

The principal dentist was able to detail the circumstances in which a child under the age of 16 may be able to give consent to treatment without involvement of a parent or legal guardian. This forms the basis of the legal precedent of Gillick competence, and relies on the child having a clear understanding of the benefits and possible consequences of choosing a course of action.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We reviewed the 73 CQC comment cards patients had completed prior to the inspection and we spoke with three patients during the inspection. Patients told us that dental staff were professional, friendly and helpful. Patients commented that privacy and dignity was always maintained. We were told that the dentist put them at ease, had a good sense of humour and always made them laugh. We observed how staff interacted with patients and noted that patients were treated with dignity and respect. Staff appeared to know the patients well and had a good relationship with them. We were told that the majority of patients had been visiting the dental practice for many years. Staff entered the reception area to book people in for their appointment where they did not approach the reception desk. Staff appeared to be friendly, helpful and caring.

Staff were aware of the actions to take to ensure confidentiality was maintained. The waiting area was situated near to the reception desk. Staff said that they were aware that conversations held at the reception desk could possibly be overheard by patients waiting to be seen. We saw that staff were careful to try and ensure that conversations held at the reception desk could not be overheard. Staff told us that there was a room available to have confidential discussions with patients if required.

Treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the rooms which protected patient's privacy. We saw that the practice had developed a confidentiality policy and staff had signed to confirm that they had read and would work in accordance with this policy. The practice did not operate a computerised appointment or dental care record system. Paper dental care records were kept behind the reception area which was constantly manned whilst the dental practice was open. The reception was secured when the dental practice was closed.

Involvement in decisions about care and treatment

Posters on display in the waiting room detailed NHS fees. Treatment plans were provided to patients receiving NHS treatment which detailed the treatment and costs of treatment.

Staff told us that children were always involved in their treatment decisions and consent to treatment. We were told that dentists took their time to explain treatment to patients. We saw some evidence of discussions held with patients in the dental care records we looked at but these were not detailed. However, patients that we spoke with said that they always felt involved in the decisions made about their treatment, and dentists took the time to explain all the options available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

We discussed appointment times and scheduling of appointments. We looked at the appointment schedules for patients and found that patients were given adequate time slots for appointments of varying complexity of treatment.

Appointments were booked by telephoning the practice or in person by attending the practice. Staff told us that routine appointments could be booked up to 12 months in advance and a reminder by post or text message would be sent a few weeks before the due date. This helped to reduce the amount of patients who did not attend their appointment. Staff told us that patients were usually able to get an appointment within a day or two of their phone request. However emergency appointments were available on the same day that patients telephoned the practice. Patients we spoke with confirmed this and one patient said that they had telephoned the practice and was given an appointment within an hour. During the inspection we saw a patient who was not registered at this practice obtain an emergency appointment as they were suffering with tooth ache.

Patients we spoke with told us that they were generally seen within a few minutes of their appointment time and confirmed that they found it easy to get an appointment at the practice. Staff told us that the dental practice closed early on a Friday but the dentist always worked later than the allocated closing time seeing emergency patients.

Tackling inequity and promoting equality

The practice was located on the first floor of a converted building on a busy high street, there was no car park and patients would use the nearby pay and display car park if required. There were two treatment rooms and a toilet for patients use; this had not been adapted to meet the needs of disabled patients.

We were told that the majority of patients registered at the practice could speak English and the practice had access to interpreting services if they needed one. There was no hearing loop; however staff confirmed that there were a few patients who were hard of hearing but who could lip read. Staff described the actions they took to assist these patients during their visit to the practice. Staff said that they helped patients with mobility difficulties up and down the stairs if required. Staff spoken with were aware of the individual needs of patients registered at the practice and were able to explain these in detail.

Staff had signed to confirm that they had read the practice's equality and diversity policy and this was available to staff in the policy file.

The feedback we received from patient comment cards was positive. Patients described staff as professional, friendly and helpful and said that they received excellent, professional care.

Access to the service

The practice was open from 9am to 5.30pm on Monday to Thursday (closed between 1pm to 2pm) and 9am to 1pm on Friday. When the practice was closed patients were directed to call NHS 111.

Patients we spoke with were aware of how to access appointments both during opening hours and

outside of opening hours. Patients told us that they could get an appointment at a time to suit them and said that they did not have difficulty getting through to the practice on the telephone.

Patients told us that appointments generally ran on time and confirmed that they rarely waited past their appointment time. Staff said that if they were aware that the dentist was running late they would inform patients in the waiting room.

Concerns & complaints

Information for patients about how to complain was on display in the waiting area. This gave the contact details of other organisations patients could contact if they were unhappy with the practice's response to a complaint. For example the Dental complaints service for complaints about private treatment. This document required updating as it referred to Sandwell Primary Care Trust (PCT) and gave these contact details. The PCT was abolished in 2013 and changed to the clinical commissioning group (CCG).

There was no complaint leaflet to guide patients on how to make a complaint. However, none of the patient feedback we received raised any issues or concerns about this dental practice. Patients we spoke with confirmed that they had no concerns or complaints about the practice and had never felt the need to complain.

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that any comments or complaints received were forwarded to the principal dentist for action and to ensure that these were responded to. Details of complaints were recorded on patient care records and in a complaint log. We looked at the complaint log and saw details of the complaints received at the practice within the last 12 months. We saw that staff had recorded details of the complaint received and action taken. This included offering a meeting with the dentist if necessary. We saw that the practice did not always send a letter confirming receipt or closing the complaint. We were told that where a complainant was offered a meeting with the dentist but declined the complaint was closed. It was therefore difficult to identify if patients had been updated with the outcome of any complaint or any actions taken.

The practice had received four complaints within the last 12 months. Staff spoken with were aware of these complaints. We were told that complaints were discussed at informal meetings as and when they were received at the practice. There were no minutes of these meetings and no systems in place to monitor complaints to identify trends and learn from issues identified.

Are services well-led?

Our findings

Governance arrangements

The principal dentist was in charge of the day to day running of this practice, there was no practice manager in post. Dental nurses took responsibility for nursing, reception and administrative tasks; management tasks were undertaken by the dentists and delegated to other staff at the practice. Staff told us that they would speak with the principal dentist about any issues or concerns within the practice.

The practice had policies and procedures in place to support the management of the service, and these were available in a policy folder. Policies were noted in infection control, health and safety, complaints handling, safeguarding children and vulnerable adults and whistleblowing. Some of the policies seen contained out of date information and required updating. Staff had signed a document in March 2015 to confirm that they had read and would adhere to all policies.

In addition risk assessments were in place to minimise risks to staff, patients and visitors to the practice for example, fire safety. However, there was no documentary evidence available to demonstrate the actions taken as a result of the fire risk assessment. Infection prevention and control audits were not completed on a six monthly basis and the practice had completed a low number of clinical audits. A control of substances hazardous to health (COSHH) file was available which contained data sheets for all chemical products used at the practice.

Patient care records that we looked at did not always record details of discussions held with patients regarding treatment options and consent. We were told that dentists took their time to explain treatment to patients but did not always record this. Patients spoken with said that they were given sufficient information to enable them to make an informed choice.

Leadership, openness and transparency

We found staff to be caring towards the patients and committed to the work they did. Staff reported a culture of honesty and transparency throughout the practice and felt confident to raise issues or concerns with the principal dentist.

The practice had in place a whistleblowing policy that directed staff on how to take action against a co-worker whose actions or behaviours were of concern. This directed staff to speak with the principal dentist or the public concern at work authority. A separate document was available for reporting whistleblowing information to the Care Quality Commission (CQC).

Learning and improvement

Very few clinical audits had been completed to identify areas of practice which could be improved. We saw a clinical waste audit completed in August 2015, record keeping audits completed in August 2012, May and August 2014 and an X-ray audit completed in October 2013. The practice were not following the Department of Health's guidance on decontamination (HTM 01-05) which recommends self-assessment infection control audits are completed on a six monthly basis. Annual audits had been completed at the practice. We were told that there was no lead for clinical audits at the practice. Following this inspection we were told that a radiography audit had commenced and record keeping and clinical waste disposal was being re-audited.

Dentists and dental nurses completed training to support their continuous professional development (CPD). We saw that CPD logs were available which recorded the number of hours of training staff had completed. Staff told us that they were responsible for ensuring that their CPD was up to date. Some of the CPD logs seen required updating. CPD must be completed for continued registration with the General Dental Council (GDC). Staff had not received annual appraisals (these were booked for week commencing 18 January 2016) and did not have personal development plans. Staff said that they talked regularly with the principal dentist and could meet with him at any time to discuss work issues or training needs. We were told that dentists were approachable and helpful.

The practice did not hold formal staff meetings but held informal meetings to discuss complaints, events or any changes at the practice. There were no minutes of these meetings and no evidence of lessons learnt. There were no systems in place to monitor complaints to identify trends and learn from issues identified. Staff said that they would raise issues at these meetings or would speak with the

Are services well-led?

principal dentist personally. Staff said that they worked well as a team, supported each other and had a good relationship with the principal dentist who was approachable and supportive.

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

We spoke with staff about the methods used to obtain feedback from patients and from staff who worked at the practice. We were told that there was no suggestions or comments box in the waiting room. Since the implementation of the Friends and Family Test (FFT) the practice had not conducted their own satisfaction survey. The friends and family test is a national programme to allow patients to provide feedback on the services provided. The results of a recent FFT were available on the NHS Choices website; we saw that 100% of people who completed this survey would recommend this dental practice (five patients). We looked at the results of the FFT for April to July 2015, we saw that patients had recorded positive comments and all were extremely likely to recommend the dental practice.

We saw that information on display in the waiting room recorded feedback from a patient survey undertaken at the practice previously. Patients had asked for more up to date reading material and a stair lift to gain access to the dental practice. Action taken or the reason the action could not be taken had been recorded.

We discussed the systems in place to feedback or receive feedback from staff. We were told that there were no formally documented practice meetings. Informal meetings were held as and when required but there were no minutes of these meetings. The dental nurse we spoke with said that in future they would record details of practice meetings in a meeting book. Following the inspection we were told that the book had been started with details of a staff meeting held on 12 January 2016 recorded within it.

Staff said that they were able to speak with the principal dentist at any time if they had any concerns. Patients spoken with said that staff were friendly and approachable; none of the patients spoken with could remember being asked to complete a survey about the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The practice did not have effective systems in place to mitigate risks associated with patient health, safety and welfare. ; • Ensure an effective system is established to assess, monitor and mitigate the various risks arising from undertaking of the regulated activities. This should include regular clinical audits to assess, monitor and improve the quality and safety of the service and six monthly infection prevention and control audits. Regulation 17 (1)(2)(a)(b)(c)(f)