H Yagnik and P Vishnupurikar

Village Dental Surgery

Inspection Report

28 Station Road
Acocks Green
Birmingham
West Midlands
B27 6DN
Tel: 01217060275
Website: www.villagedentalsurgery.co.uk

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Overall summary

We carried out an announced comprehensive inspection on 25 April 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

Village Dental Surgery has two dentists who own the practice, an associate dentist and a foundation dentist, three qualified dental nurses who are registered with the General Dental Council (GDC), two apprentice dental nurses, a hygienist, a compliance manager and a receptionist. The practice's opening hours are 9am to 5.30pm on Monday to Friday.

Village Dental Surgery provides NHS and private dental treatment for adults and children. The practice has three dental treatment rooms; one on the ground floor and two on the first floor. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception and two waiting areas.

The registered manager was present during this inspection. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We

Summary of findings

received feedback from 48 patients who provided an overwhelmingly positive view of the services the practice provides. All of the patients commented that the quality of care was very good.

Our key findings were

- Systems were in place for the recording and learning from significant events and accidents.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place. The practice were completing their own infection prevention and control audits, however Infection Prevention Society (IPS) infection prevention and control audits were not being undertaken on a six monthly basis. The Department of Health's guidance on decontamination (HTM 01-05) recommends the use of IPS self-assessment audits every six months. Following this inspection we received confirmation that these audits would be completed on a six monthly basis.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- 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 appointment system met the needs of patients and waiting times were kept to a minimum.
- The practice was well-led and staff felt involved and worked as a team.
- Patients received clear explanations about their proposed treatment, costs, benefits and risks and were involved in making decisions about it.
- We received positive feedback from patients. Patients felt they received a good service from dental staff that they trusted; they felt involved in their care and said that staff were attentive and friendly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Systems were in place for recording significant events and accidents. Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Medicines for use in an emergency were available on the premises as detailed in the Guidance on Emergency Medicines set out in the British National Formulary (BNF). Emergency medical equipment was also available and documentation was available to demonstrate that checks were being made to ensure equipment was in good working order and medicines were within their expiry date. Staff had received training in responding to a medical emergency.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

All staff had received up-to-date training in infection control, responding to a medical emergency and safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and advice.

The practice had infection control procedures to ensure that patients were protected from potential risks. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely. However, the practice completed Infection Prevention Society (IPS) infection prevention and control audits on an annual basis. The Department of Health's guidance on decontamination (HTM 01-05) recommends IPS self-assessment audits every six months.

X-rays were carried out safely in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

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

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Dental care provided was evidence based and focussed on the needs of the patients. Oral screening tools were used to identify oral disease. We were told that information about treatment options, risks, benefits and costs was clearly explained to patients in a way that they understood. Medical history questionnaires were completed and updated as required.

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

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Staff were able to demonstrate that referrals had been made in a timely way when necessary.

Are services caring?

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

Summary of findings

Staff understood the need for maintaining patient confidentiality and were able to demonstrate how they achieved this. We observed privacy and confidentiality were maintained for patients using the service on the day of the inspection.

Patients said staff were friendly, attentive and caring. The needs of patients were understood and catered for by staff.

Feedback from patients was positive. Patients praised the staff and the service and treatment received. Feedback was that patients were involved in discussions about their dental care and they were able to express their views and opinions.

Are services responsive to people's needs?

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

The service was aware of the needs of the local population and considered these in how the practice was run. Patients in dental pain or who were in need of urgent treatment were able to get an appointment within 24 hours of their phone call. Staff told us that routine appointments were available within a few days of the request. Patients we spoke with confirmed this.

The practice had completed a disability discrimination act audit which had identified the need for a hearing induction loop, to assist patients who used a hearing aid. The purchase of a hearing loop was included on the practice's action plan. A portable ramp was available for use by patients with restricted mobility to gain access to the practice; there was a ground floor treatment room.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

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

There were good governance arrangements and an effective management structure in place. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

Regular staff meetings were held and staff said that they felt well supported and could raise any issues or concerns with the registered manager.

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

Annual appraisal meetings took place and staff said that they were encouraged to undertake training to maintain their professional development skills. Staff told us the provider was very approachable and supportive and the culture within the practice was open and transparent. Staff told us they enjoyed working at the practice and felt part of a team.

Village Dental Surgery

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.

This inspection took place on 25 April 2016 and was led by a CQC inspector and supported by a specialist dental advisor. Prior to the inspection, we reviewed information we held about the provider. We informed NHS England area team that we were inspecting the practice and we did not receive any information of concern from them. We asked the practice to send us some information that we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, and the details of their staff members including proof of registration with their professional bodies.

During our inspection we toured the premises; we reviewed policy documents and staff records and spoke with six members of staff, including the registered manager. We looked at the storage arrangements for emergency medicines and equipment. We were shown the decontamination procedures for dental instruments and the computer system that supported the dental care records and patient dental health education programme.

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

Systems were in place to enable staff to report incidents and accidents. Records demonstrated that there had been three accidents within the last 12 months with the last accident being reported in 2015. Accident reports recorded identified learning points. Action taken to reduce the risk of the accident occurring again was recorded. We saw that there was an accident reporting policy which also covered the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR). Links to further guidance regarding RIDDOR were available. All staff we spoke with understood when and how to report under RIDDOR and forms were available to enable staff to report incidents if necessary. We were told that there had been no events at the practice that required reporting under RIDDOR. Policy documents were easily accessible to staff in the staff handbook which was kept in the staff room.

Significant events had been reported and staff spoken with were able to recall a recent significant event. We were told that significant events were discussed at practice meetings and learning points identified and discussed. Significant event reporting forms were available and staff were aware of the process to follow to report significant events and who within the practice held the lead role.

Systems were in place to ensure that all staff members were kept up to date with any national patient safety and medicines alerts. The practice received these alerts via email and any that were relevant were printed off and a copy was kept in a file. We saw that safety alerts that were relevant to the dental practice were discussed at practice meetings.

We saw that information regarding duty of candour was on display in the waiting room. Staff spoken with confirmed that they would always offer an apology when things went wrong. We saw documentary evidence to support this.

Reliable safety systems and processes (including safeguarding)

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. Details of how to report suspected abuse to the local authority responsible for investigation were available including their contact details. Staff were aware where these contact details and the intra agency safeguarding referral forms were kept. Contact details to report child protection and adult safeguarding issues were on display in the waiting room for patients to view. Staff had signed documentation to demonstrate that they had read the safeguarding information on file. Staff spoken with were aware that they should report safeguarding referrals to the Care Quality Commission. We were told that the staff handbook contained all of the information they needed to help them identify and report safeguarding issues. For example there was a flow chart for reporting safeguarding and a facial injury record. We were told that there had been no safeguarding issues to report.

We saw evidence that all staff had completed the appropriate level of safeguarding training. Staff said that safeguarding was discussed at two practice meetings each year but would also be discussed should any safeguarding issues arise at the practice. We saw that staff were given a copy of the safeguarding policy during the practice meeting of October 2015 and all staff signed documentation to confirm that they had read and would work to this policy.

Records demonstrated that there had been two sharps injuries at the practice during 2015. The practice used a system whereby needles were not re-sheathed using the hands following administration of a local anaesthetic to a patient. The disposal of sharps was the responsibility of each dentist. We saw that there was a safe sharps risk assessment and inoculation injury information on display in appropriate areas of the practice. Sharps boxes were wall mounted and out of reach of children.

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

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received annual training in basic life support and emergency equipment

was available and checked regularly to ensure it was in good working order. Emergency equipment including oxygen and an automated external defibrillator (AED) (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm), was available. Records confirmed that emergency medical equipment was checked regularly by staff. Expiry dates of equipment such as defibrillator pads and adult and paediatric oxygen masks were recorded.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. All emergency medicines were appropriately stored and were regularly checked to ensure they were within date for safe use. A member of staff was responsible for ensuring that regular daily or weekly checks of equipment and medicines were undertaken and recorded. We saw that the arrangements for dealing with medical emergencies were in line with the Resuscitation Council UK guidelines and the British National Formulary (BNF).

We saw that emergency equipment and medicines were stored centrally and were well maintained and easy to access. A first aid kit was also available which contained equipment for use in treating minor injuries. Records were available to demonstrate that equipment in the first aid box was checked on a weekly basis to ensure it was available and within its expiry date.

Staff recruitment

We discussed the recruitment of staff and looked at six recruitment files in order to check that recruitment procedures had been followed. We saw that files contained pre-employment information such as proof of identity, written references details of qualifications and registration with professional bodies. Recruitment files also contained other information such as contracts of employment, job descriptions and copies of policies and procedures such as disciplinary and grievance. We saw that the practice had requested disclosure and barring service checks (DBS) for all staff prior to this inspection. The practice also had evidence of DBS checks from previous places of employment. 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.

Staff absences were planned for as far as possible to ensure the service was uninterrupted. A dental nurse told us that they had to book annual leave in advance wherever possible. We were told that there were usually enough dental nurses to provide cover during times of annual leave or unexpected sick leave and agency dental nurses would be used if necessary.

There were enough staff to support dentists during patient treatment. We were told that the hygienist who worked one and a half days per week worked alone. The hygienist worked under prescription from the dentist and also completed some private work. A dental nurse completed any decontamination of used dental instruments for the hygienist and dental nurses worked with the hygienist if they needed to complete six point charting. We were told that there was always a dental nurse available to provide assistance if required on the day that the dental hygienist worked at the practice.

Sufficient numbers of staff were on duty to ensure that the reception area was not left unmanned at any time. All dental nurses were expected to work on the reception and with dentists on a rotational basis. A weekly duty rota detailed where dental nursing staff would be working. For example on reception or it recorded the name of the dentist they would be working with. This was available in the staff room.

Monitoring health & safety and responding to risks

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. Numerous risk assessments had been completed and risk management policies were in place. For example, we saw risk assessments for fire, radiation, sharps injury, general health and safety and a general practice risk assessment. We saw that the practice had developed a health and safety policy and a health and safety poster was on display in the staff room. Other health and safety related policies were available. For example regarding display screen equipment and the practice's smoking policy. These policies were reviewed on an annual basis.

We discussed fire safety with staff and looked at the practice's fire safety risk assessment and associated documentation. The fire risk assessment was completed in 2015 and had a date of review of December 2016. We saw that appropriate fire signage was on display around the practice. Fire safety equipment such as fire extinguishers,

smoke alarms, emergency lighting and a fire alarm were available. Records were available to demonstrate that this equipment was subject to routine maintenance and checks by external professionals. Staff at the practice also completed a daily, weekly and monthly fire precautions test form. For example, staff checked that escape routes were clear, waste paper bins emptied and smoke alarms were working. Fire drills took place on a six monthly basis with the last fire drill recorded as taking place in January 2016.

Details of all substances used at the practice which may pose a risk to health were recorded and Control of Substances Hazardous to Health (COSHH) risk assessments were in place. This information was available to staff in the staff handbook.

Infection control

As part of our inspection we conducted a tour of the practice we saw that the dental treatment rooms, waiting areas, reception and toilet were visibly clean, tidy and uncluttered. Patient feedback also reported that the practice was always clean and tidy. A cleaning company were responsible for undertaking all environmental cleaning of the practice. Records were kept to demonstrate cleaning undertaken, although from a sample of records reviewed we noted that not all had been fully completed. We noted that some steps had been taken to follow the national colour coding scheme for cleaning materials and equipment in dental premises. We saw that two colour coded mops were available but these were stored incorrectly. We were told that the cleaning company provided all equipment and the lack of appropriate equipment and storage would be addressed with the cleaning company immediately. Following this inspection we received email evidence that the appropriate colour coded mops and buckets had been purchased by the cleaning company.

Systems were in place to reduce the risk and spread of infection within the practice. There were hand washing facilities in each treatment room and in the decontamination room. Signs were in place to identify that these sinks were only for hand wash use. Adequate supplies of liquid soaps and paper hand towels were available throughout the premises. Staff had completed training in hand hygiene and an annual hand hygiene audit was conducted. This helped to ensure that staff were following appropriate hand hygiene procedures. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene performed by health care workers. Sufficient supplies of personal protective equipment (PPE) were available for staff and for patients use.

The practice had an infection prevention and control policy which had been reviewed on an annual basis. The infection prevention and control lead was named on this policy. Staff spoken with were aware who held the lead role and confirmed that they could speak with this person to obtain any advice or guidance. We saw that relevant infection prevention and control protocols were on display in the decontamination room.

The Department of Health's guidance on decontamination (HTM 01-05) recommends that practices should audit their decontamination processes every six months using an audit tool (the use of the Infection Prevention Society (IPS)/DH audit tool is strongly recommended).We saw that IPS Infection prevention and control audits were completed on an annual basis but the practice were completing their own infection control audits as well as this. Following this inspection we received email confirmation that IPS audits would be completed on a six monthly basis in future.

Records demonstrated that all staff had undertaken training in July 2015 regarding the principles of infection control. In addition to this in-house training had been provided by the compliance manager at the practice.

We looked at the procedures in place for the decontamination of used dental instruments. A separate decontamination room was available for instrument processing. The decontamination room had dirty and clean zones in operation to reduce the risk of cross contamination and these were clearly identified. A dental nurse demonstrated the decontamination process and we found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). Systems were in place to ensure that instruments were safely transported between treatment rooms and the decontamination room. The dental nurse showed us the procedures involved in cleaning, rinsing, inspecting and decontaminating dirty instruments. Instruments were manually scrubbed before being placed into an ultra-sonic cleaner. A visual inspection was then undertaken using an illuminated magnifying glass before instruments were

sterilised in an autoclave. We saw one piece of equipment which had gone through the cleaning and inspection process which contained a small amount of cotton wool. We examined a sample of dental instruments that had been cleaned and sterilised, using the illuminated magnifying glass. We found these instruments to be clean and undamaged.

There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury which included gloves, aprons and protective eye wear. Clean instruments were packaged; date stamped and stored in accordance with the latest HTM 01-05 guidelines. All the equipment used in the decontamination process had been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.
Service

The dental water lines were maintained to prevent the growth and spread of Legionella bacteria (Legionella is a term for particular bacteria which can contaminate water systems in buildings). Staff described the method they used which was in line with current HTM 01 05 guidelines. Dip slide tests were also used to confirm the efficacy of prevention methods used regarding legionella. A risk assessment regarding Legionella had been carried out by an external agency in February 2015 and again in February 2016. We saw evidence that routine temperature monitoring checks were being completed as identified in the risk assessment.

We discussed the disposal of sharps, clinical waste and looked at waste transfer notices and the storage area for clinical and municipal waste. Sharps bins were fixed to walls in appropriate locations which were out of the reach of children. Needle stick policies were on display in each treatment room and in the decontamination room. We saw that clinical waste was appropriately stored in an area that was not accessible to members of the public. Waste contracts were in place and copies of consignment notices were available. (When clinical waste is moved it must be accompanied by correctly completed paperwork called a consignment note). The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health.

Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, dental chairs, fire safety equipment, the ultra-sonic cleaner and the autoclave. Records seen demonstrated the dates on which the equipment had most recently been serviced. For example the dental chair and X-ray machines were serviced in October 2015 and the compressor was serviced in November 2015. All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in January 2016. All electrical equipment tested was listed with details of whether the equipment had passed or failed the test.

We saw that one of the emergency medicines (Glucagon) was being stored in the fridge. Glucagon is used to treat diabetics with low blood sugar. Staff spoken with were aware that this medicine could be stored at room temperature with a shortened expiry date. However, the practice's preference was to store this medicine in the fridge. We saw that records were kept to demonstrate that medicines were stored in the fridge at the required temperature of between two and eight degrees Celsius. Staff completed and signed records every day and these were available for review.

Dental treatment records showed that the batch numbers and expiry dates for local anaesthetics were recorded when these medicines were administered. These medicines were stored safely for the protection of patients. We were told that this practice did not dispense medicine.

Radiography (X-rays)

A radiation protection advisor and a radiation protection supervisor had been appointed to ensure that the equipment was operated safely and by qualified staff only. We saw evidence to demonstrate that dentists were up to date with the required continuing professional development on radiation safety.

The practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. Local rules were available in all treatment rooms where X-ray sets were located for all staff to reference if needed.

We saw copies of the critical examination packs for each of the X-ray sets along with the maintenance logs. The critical examinations had been conducted within the current recommended interval of three years. We saw that signs

Are services safe?

were in place on doors conforming to legal requirements to inform patients that X-ray machines were located in the room. We saw certificates that showed maintenance for this equipment was completed at the recommended intervals.

The practice used digital X-ray images; these rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional X-rays. This makes them safer for both patients and staff.

Dental care records where X-rays had been taken showed that dental X-rays were justified, and reported on every time. We saw X-ray audits were carried out on a six monthly basis. This included an individual analysis of the quality of the X-rays which had been taken and action plans developed if necessary. Audits help to ensure that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with dentists about oral health assessments and dental care records which were available for each patient. We were told that medical history records contained information regarding the patient's smoking status, alcohol use and details of any health conditions, allergies and medicines taken. These were reviewed and updated with the dentist before any treatment began. Following this an examination of the patient's teeth, gums and soft tissues was completed.

During this assessment dentists looked for any signs of mouth cancer. The dental care records confirmed that dentists used the basic periodontal examination (BPE) screening tool to assess the patients' periodontal tissues (the gums). (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). Patients were then made aware of the condition of their oral health and whether it had changed since the last appointment. Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail. Dental care records recorded discussions held and advice given to patients.

Discussions with the dentists showed they were aware of and referred to National Institute for Health and Care Excellence guidelines (NICE), particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients. Patient care records demonstrated that risk factors had been documented and discussed with patients. The decision to take an X-ray was made in line with recognised general professional guidelines. Patient dental care records that we saw demonstrated that all of the dentists were following the guidance from the Faculty of General Dental Practice (FGDP) regarding record keeping.

Health promotion & prevention

We discussed 'The Delivering Better Oral Health Toolkit' with one of the dental partners. (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 placed a high emphasis on preventative care. High concentration fluoride toothpastes were prescribed when required. Fluoride varnish was also applied to children's teeth if required. We saw entries in dental care records that detailed patients' oral health and details of discussions that had taken place regarding improving oral health.

During appointments the dentist and dental nurse explained tooth brushing and interdental cleaning techniques to patients using models of the mouth if required. This helped patients understand the techniques required to maintain oral hygiene. Patients were given advice appropriate to their individual needs such as the harmful effects of poor diet (acidic and sugary foods), smoking and alcohol consumption. Where gum problems were identified patients were referred to the dental hygienist who worked at the practice for one and half days per week.

An information folder was available in both waiting rooms. This folder contained useful information for patients regarding local health services and dental information and advice. Information regarding diet, alcohol and smoking cessation was also available in these folders.

Free samples of toothpaste were available on reception. We saw one patient taking samples of toothpaste and asking staff questions about the differences in the toothpastes. We were told that denture adhesives and mouth wash was also often available as free samples. The practice sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

A dental nurse told us about some recent health promotion initiatives that had taken place. This included children from a local nursery visiting the practice and having a look around. The dental nurse had also suggested that the practice undertook children's walk in clinics. These clinics took place during the February half term. Balloons and signs on local streets were in place to advertise the walk in clinics. We were told that children were given 'goody bags' as encouragement to maintain good oral hygiene.

Staffing

Practice staff included two dentists who owned the practice, an associate dentist and a foundation dentist,

Are services effective?

(for example, treatment is effective)

three qualified dental nurses who were registered with the General Dental Council (GDC), two apprentice dental nurses, a hygienist, a compliance manager and a receptionist.

Staff spoken with said that they enjoyed their work, were well supported and all said that staff worked together well as a team.

We saw records to demonstrate that newly employed staff received an induction and regular probationary reviews. Staff spoken with confirmed that the induction process gave them the information needed to perform their job role at the practice. We were told that staff were supported during their probationary period and were always praised for a job well done.

The practice had purchased a system which helped with setting up and monitoring systems to aid compliance. This included appraisal and training systems. Appraisal meetings were held on an annual basis. We saw appraisal records for 2015. The dentist told us that appraisal meetings were used to determine training and development needs. Staff told us that they were able to discuss issues or concerns, working practices or training requirements. Personal development plans (PDP) had been developed as part of the appraisal process. We saw that staff had requested training during their 2015 PDP discussions. We were told that training was being arranged as requested wherever possible.

Information regarding core continuous professional development (CPD) and any other training updates were sent to the practice as part of the compliance package. Staff said that they were provided with on-line training, in-house training and email reminders were sent to them when update training was required. Staff confirmed that they received regular training including infection prevention and control, safeguarding and basic life support.

We were told that dental nursing staff were responsible for ensuring that they met their continuing professional development (CPD) requirements. CPD is a compulsory requirement of registration as a general dental professional. Not all of the CPD logs seen for dental nurses had been completed. Support would be given to staff who were falling behind their CPD requirements. Following this inspection we were forwarded a copy of a new CPD log which recorded details of core and other CPD undertaken by staff and the hours completed. Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Records showed professional registration with the GDC was up to date for all relevant staff.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for anxious patients who required sedation, oral surgery or community services. A dentist told us that when referrals were made, they received copies of information from the external provider. This helped to keep records up to date regarding treatment received. However the practice had not developed a system to check whether the patient had received their referral appointment. We were told that there had been occasional complaints relating to referrals. Following this inspection we received email confirmation that the practice had developed a referral log which would be used to monitor referrals to other dental services.

We discussed the fast track referral of patients to hospital if they had a suspected oral cancer. The dentists followed Faculty of General Dental Practice (FGDP) guidelines when making notes for these referrals.

Consent to care and treatment

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent. A consent policy was in place and staff said that a copy of this policy was available in the staff handbook.

Patient care records contained detailed accounts of discussions held regarding treatments. This included the options available and the risks and benefits associated with each treatment option. We were told that patients were shown models, and given verbal and written information such as information leaflets. We saw that where verbal consent had been obtained this was recorded in patient notes. Treatment plans had been signed by patients therefore giving their written consent. Patient care records seen evidenced that the practice had a robust consent process in place.

Patients were given time to consider treatment options and support to help them make decisions about treatment. A

Are services effective?

(for example, treatment is effective)

'cooling off period' was given to patients before any complex treatment took place. This gave the patient time to consider their options and gather further information if required.

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. Staff spoken with confirmed that they had completed on-line training regarding the Mental Capacity Act. Both clinical and non-clinical staff had a clear understanding of the MCA and its relevance to their role.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Staff told us that they had received training regarding confidentiality. Reception staff were aware of actions to take to main confidentiality. For example we were told that patient specific information and medical history forms were not discussed at the reception desk. Staff were not able to leave messages on patient's telephone answer machines or give information to relatives of patients. Music was played in the waiting area, this helped to distract anxious patients and also aided confidentiality as people in the waiting room would be less likely to be able to hear conversations held at the reception desk.

Patients' clinical records were stored electronically. Computers were password protected and regularly backed up to secure storage. The computer screens at the reception desks were not overlooked which helped to maintain confidential information at reception. If computers were ever left unattended then they would be locked to ensure confidential details remained secure. There was a sufficient amount of staff to ensure that the reception desk was staffed at all times. If patients wished to have a private conversation they would be asked to speak in one of the treatment rooms and not at the reception desk.

Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy.

We were told that systems were in place to ensure that the needs of anxious patients were met. This included discussion only appointments; longer appointment times to allow staff time to provide reassurance to the patient during treatment or referral for sedation. Staff said that they took their time to chat to patients and tried to make them feel at ease. We saw a thank you card on display from an anxious patient thanking staff for the treatment received.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. We saw reception staff helping patients with prams and pushchairs in and out of the practice. 48 patients provided overwhelmingly positive feedback about the practice on comment cards which were completed prior to our inspection. Patients commented that staff were professional, friendly, helpful and caring.

Involvement in decisions about care and treatment

The practice provided patients with information to enable them to make informed choices. Staff said that explanations were given to patients using clear simple language, information leaflets, models and pictures were used to ensure patients understood the information given. A folder in each waiting area give detailed information to patients about dental treatments and oral health and hygiene. This helped patients understand their treatment choices and make informed decisions. Clear treatment plans were given to patients which detailed possible treatment and costs. Patient care records demonstrated that the dentists recorded the information they had provided to patients about their treatment and the options open to them. Posters detailing both NHS and private costs were on display in the reception area. 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. The practice website provided some information about treatments available at the practice.

The dentist we spoke with demonstrated a good understanding of Gillick competency. Gillick competency is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions about their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice provided NHS and private treatment. Treatment costs were clearly displayed in the waiting area and on the practice's website which also recorded details of any special offers for private treatment. The practice's website provided a wealth of information for patients such as details of the staff team, the services provided, opening times and how to book an appointment. Patients were able to request appointments via the website.

The practice was open until 5.30pm each night Monday to Friday and emergency appointments were available each day. We were told that the practice aimed to see patients within 24 hours of contact in any cases of a dental emergency. Staff told us that patients were usually able to get an appointment on the day that they telephoned and were always able to get an appointment if they were in dental pain. Feedback confirmed that patients were rarely kept waiting beyond their appointment time. The practice had undertaken a waiting time audit and no issues for action were identified. We were told that the reception always had two staff and the telephone system enabled patient's to leave a message if both phone lines were busy. Reception staff said that the phone system recorded calls and they always returned patient's calls.

We discussed appointment times and scheduling of appointments. We found the practice had an efficient appointment system in place to respond to patients' needs. Patients were given adequate time slots for appointments of varying complexity of treatment.

Tackling inequity and promoting equality

The practice had completed a disability discrimination act 2010 access audit in September 2015. An action plan had been developed which included the purchase of a hearing loop. We were told that staff were currently sourcing the appropriate equipment and this would be fitted in the near future.

A disabled car parking space was available at the rear of the practice and a portable ramp was available to gain access to the practice. Patient care records noted whether the patient required the use of the portable ramp. Staff could therefore ensure that the ramp was in place when required. There was one ground floor treatment room which was suitable for use by patients who required the use of a wheelchair. Patients were able to receive dental treatment whilst seated in their wheelchair. There was also a toilet which had been adapted to meet the needs of patients with restricted mobility.

The practice had policies on equal opportunities and staff had undertaken training to support them in understanding and meeting the needs of patients.

We asked about communication with patients for whom English was not a first language. We were told that staff could speak languages other than English and a translation service was available for use if required. A range of information such as clinical and practice information could be made available in other languages. There was a sign in the waiting area which gave practice information in a number of languages. We were told that arrangements could be made with an external company to provide assistance with communication via the use of British sign language.

Access to the service

The practice was open from 9am to 5.30pm Monday to Friday (closed between 1pm to 2pm). The opening hours were displayed in the practice, on the practice's website and in the practice leaflet. A telephone answering machine informed patients that the practice was closed between 1pm to 2pm each day and appropriate signage was placed on the entrance door to the practice during this time. The telephone answering machine also gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays. A buddy arrangement was in place when the practice was closed so patients in dental pain could be seen by a dentist from a local practice.

Patients were able to make appointments over the telephone or in person. Staff we spoke with told us that patients could access appointments when they wanted them. Emergency appointments were set aside for each dentist every day; this ensured that patients in pain could be seen in a timely manner. We were told that these patients would always be seen within 24 hours of calling the practice. Patients commented that they were able to see a dentist easily in an emergency. Patients could access care and treatment in a timely way and the appointment system met their needs.

Are services responsive to people's needs?

(for example, to feedback?)

Patients were sent letters and received a telephone call to remind them of booked appointments. We were told that a text messages reminder service was also starting in the near future.

Concerns & complaints

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. A copy of the complaint policy was on display in the reception for patients and in the staff handbook for staff to review. Staff spoken with were knowledgeable about how to handle a complaint. Staff told us that any complaints received would be acknowledged and the information sent to one of the dental partners. Guidance was available regarding the action to take when a complaint was received, for example completion of a complaint log sheet and standard acknowledgement letter.

We were told that six complaints had been received at the practice within the last 12 months. We saw that detailed information was available about each complaint including details of any action taken to address issued identified, follow up action and learning points to try and reduce the risk of the complaint reoccurring. We saw that duty of candour information was available. Staff spoken with said that they always offered an apology; they were open and honest and took action to sort out any problems. Complaints were discussed at practice meetings and learning points identified. Staff discussed a recent complaint with us and told us the action taken to mitigate the risk of this type of complaint re-occurring. This included staff training, discussion at a practice meeting.

Complaints on file had been responded to within a timely manner and staff were aware of the timescales for responding to complaints. We saw that written responses had been sent to complainants which included apologies or other appropriate action as necessary.

We saw that a complaint audit was undertaken on an annual basis, this included information regarding the number of complaints received, details of any trends and details of any underperformance issues identified. This enabled appropriate action to be taken to learn from complaints received.

Are services well-led?

Our findings

Governance arrangements

The practice had purchased a system which helped with setting up and monitoring systems to aid compliance. This included a variety of policies and procedures to support the management of the service. These were readily available for staff to reference in the staff handbook. All staff had been given a copy of the staff handbook. We were told that policies were reviewed and updated regularly by the external company. We saw that version numbers were recorded on the bottom of policies to identify which was the most current version available. Policies available included health and safety, complaints, safeguarding, and infection control. Staff had signed a document to confirm that they had received a copy of the employee handbook.

Systems were in place for monitoring and improving the quality of services provided for patients. Comprehensive risk assessments were in place to mitigate risks to staff, patients and visitors to the practice. These included risk assessments for fire, health and safety and a general practice risk assessment. These helped to ensure that risks were identified, understood and managed appropriately.

We saw a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

Staff at the practice had the General Dental Council's (GDC) nine principles to meeting the GDC standards available. This was to offer guidance and remind them of the key steps to good practice. A copy of the principles was displayed in the waiting room. Other information on display included a copy of the complaint policy, NHS and private charges and details of staff including their GDC registration numbers.

We saw that staff meetings were scheduled for once a month throughout the year. A standard agenda was in place and staff were able to discuss any other issues at the end of each meeting. All staff were given a copy of any policy which was discussed during the staff meeting. Staff said that this was a useful reminder. Staff meetings were minuted, although minutes seen were brief and did not give any detail of discussions held. We were told that detailed minutes would be recorded for all future meetings.

The practice had clear lines of responsibility and accountability. Staff said they understood their role and could speak with any of the dentists if they had any concerns. The management team consisted of two dentists who were part owners of the practice, one of which was the registered manager. Staff said they understood the management structure at the practice and also who held lead roles within the practice. Staff told us that the registered manager was approachable and helpful. They said that they were confident to raise issues or concerns and felt that they were listened to and issues were acted upon appropriately.

The practice had a whistleblowing policy. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with a dental nurse who was able to give a clear account of what the procedures were for, and when and how to use them. The policy was available in the staff handbook.

The culture of the practice was open and supportive. Staff told us that they worked well as a team, provided support for each other and were praised by the management team for a job well done. There was an effective management structure in place to ensure that responsibilities of staff were clear. Staff were aware of who held lead roles within the practice such as complaints management, safeguarding and infection control. Staff said that the practice manager and assistant practice manager worked at the practice on alternate days to ensure staff always had a member of management staff on the premises to provide advice and support. Complaints systems encouraged candour, openness and honesty. Duty of candour information was on display in the waiting room for patients to see.

Staff told us that the culture of the practice was open and supportive. We were told that there were open lines of communication and staff were able to speak with a member of the management team at any time. Staff said that they felt valued and supported. They were able to raise concerns and make suggestions for improvement. Staff

Are services well-led?

told us that everyone had a sense of responsibility for the running of the practice. We observed staff to be friendly and helpful and they regularly obtained confirmation that patients understood the information given to them.

Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw that a radiography audit was completed on a six monthly basis and a complaints, hand hygiene and record card audit were completed annually. The practice also undertook Infection Prevention Society (IPS) infection control audits on an annual basis; however the Department of Health's guidance on decontamination (HTM 01-05) recommends IPS self-assessment audits every six months. Following the inspection we received email confirmation that IPS audits would now be undertaken on a six monthly basis. One of the dental partners was the lead for clinical audit. Action plans had been developed following clinical audit and we discussed some of the improvements made to date which included improved clarity and more detail in patient care records.

One of the dental partners was a member of a peer review group of local dentists. We were told that these dentists met on a quarterly basis and held discussions regarding clinical topics and disseminated any learning.

Staff working at the practice were supported to maintain their continuous professional development (CPD) as required by the General Dental Council (GDC). Annual appraisal meetings were held and personal development plans were available for all staff. Staff confirmed that they were encouraged and supported to undertake training.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. Patients had various avenues available to them to provide feedback, for example; a suggestions box and the friends and family test (FFT) box in the waiting room. The friends and family test is a national programme to allow patients to provide feedback on the services provided. The responses within the boxes were analysed on a monthly basis. The most recent data showed that 95% of patients who responded (43) would recommend the dentist.

Patients were able to contact the practice via their website to leave comments or ask questions. A copy of the complaint policy was available on the practice website. The policy recorded contact details such as NHS England and the General Dental Council. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice.

Satisfaction surveys were given to patients on an annual basis; we were told that 20 responses had been received in 2015 and the aim was to increase this number for the 2016 survey. We were told that the results of the survey were displayed in the waiting room for a few months following the survey. These were not on display at the time of our inspection. Staff confirmed that the results of satisfaction surveys were discussed with them at staff meetings.

We were told that a staff satisfaction survey had been completed in 2015; there were no issues for action and staff were generally satisfied. Staff we spoke with told us that they felt valued and supported. Staff appeared confident and were well informed. We were told that dentists were helpful and approachable and staff said that they enjoyed working at the practice.