

## Wall Heath Dental Practice

# Wall Heath Dental Practice

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 15 June 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

#### **Our findings were:**

##### **Are services safe?**

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

##### **Are services effective?**

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

##### **Are services caring?**

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

##### **Are services responsive?**

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

##### **Are services well-led?**

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

#### **Background**

Wall Heath Dental Practice has two dentists who own the practice, two part time hygienists, five qualified dental nurses who are registered with the General Dental Council (GDC); two of which mainly work on reception and one trainee dental nurse. The practice's opening hours are 8.30am to 5.15pm on Tuesday, Wednesday and Friday, 8.30am to 5pm on Monday and 9.30am to 6pm on Thursday. The practice closes for lunch each day, however there is a receptionist available unless the practice is closed for a meeting.

Wall Health Dental Practice provides mainly private and a small amount of NHS dental treatment for adults and children. The practice has two dental treatment rooms; both on the ground floor. There is a separate decontamination room for cleaning, sterilising and packing dental instruments. There is also a reception with adjoining waiting area.

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

# Summary of findings

to tell us about their experience of the practice and during the inspection we spoke with two patients. Overall we received feedback from 51 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 and infection prevention and control audits were being undertaken on a six monthly basis as detailed in the Department of Health's guidance on decontamination (HTM 01-05).
- 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 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 was professional, caring and helpful.

# 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).

The practice had medicines and equipment in place in line with national guidance, and these were stored together in a central location. Staff had all completed basic life support training.

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. 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.

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.

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.

### **Are services caring?**

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

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.

Feedback from patients was positive. Patients said staff were friendly, attentive and caring. Patients were happy with the service and treatment received.

### **Are services responsive to people's needs?**

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

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.

# Summary of findings

A portable ramp was available for use by patients with restricted mobility to gain access to the practice; the dental practice was located on the ground floor. The practice had access to an interpreting service to assist patients for whom English was not their first language.

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.

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.

# Wall Heath Dental Practice

## Detailed findings

### Background to this inspection

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

This inspection took place on 15 June 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 four 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.

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 March 2016. Accident reports recorded learning points. We saw that accidents and incidents were a standard agenda item on each monthly practice meeting. Discussions were held regarding accidents to decide upon action to take to reduce the risk of the accident occurring again. For example a member of staff banged their head on the leaflet holder whilst undertaking cleaning duties. A discussion was held regarding moving the leaflet holder to another location or other action to reduce the risk of this type of accident occurring again.

The practice had a notifications policy which recorded the type of information to report to the Care Quality Commission (CQC), it also contained information regarding significant events and the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR). RIDDOR information produced by the Health and Safety Executive was available for staff. 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 all staff had a copy of and a copy was also kept in the office.

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. We saw the minutes of the February and March 2016 practice meetings which demonstrated this. 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 forwarded to the registered manager for discussion at a practice meeting.

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

The practice had a policy in place regarding child protection and safeguarding vulnerable adults. There was also a separate policy regarding adults who lack capacity. These policies were reviewed on an annual basis. Details of how to report suspected abuse to the local authority responsible for investigation were available including their contact details. Staff were aware who in the practice held the lead role regarding safeguarding and confirmed that they could speak with this person at any time for help and advice. Staff said that they had all of the information that they needed to identify and report suspected abuse. For example there was a child protection referral flow chart and all staff had undertaken the appropriate level of safeguarding training. We were told that all staff would also be undertaking on-line training regarding safeguarding on 21 July 2016. Staff said that safeguarding was discussed at each practice meeting and we saw that safeguarding was a standard agenda item for each meeting.

Staff spoken with were aware that they should report safeguarding referrals to the Care Quality Commission and the practice's notifications policy and health and safety in the workplace policy confirmed this.

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. A poster was on display in the decontamination room describing the action to take in the event of an inoculation injury. Staff spoken with had an in-depth knowledge of the action to take. Sharps boxes were located 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

# Are services safe?

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 were recorded. We saw that oropharyngeal airways had expired but new supplies had been ordered a few days before our inspection. The practice did not have a self-inflating bag for a child and clear face masks for the self-inflating bag. These items were ordered during the inspection and we were shown a copy of a purchase confirmation email to demonstrate this.

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 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. Both of the dentists were the designated first aiders and had completed first aid training to enable them to fulfil this role.

## **Staff recruitment**

We discussed the recruitment of staff and looked at three recruitment files in order to check that recruitment procedures had been followed. We saw that files contained a front sheet which recorded information such as dates of interview, references obtained, induction, disclosure and

barring service check (DBS) and job offer. Information regarding appraisal dates, training and details of when staff continuing professional development logs had been checked were also recorded. 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 and they were signed up for an annual update service which confirmed the status of the DBS check each year. 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. The registered manager confirmed that dentists booked their annual leave up to a year in advance wherever possible and staff were requested to try and book leave during this time. However, a dental nurse told us that there was some flexibility regarding this and the dentists always tried to accommodate staff annual leave wherever possible. We were told that there were usually enough dental nurses to provide cover during times of annual leave or unexpected sick leave. A local practice provided emergency cover at any time that both dentists were not available and this was a reciprocal arrangement.

We discussed staffing levels with the registered manager. We were told that there was enough staff to support dentists and hygienists during patient treatment and to ensure that the reception area was not left unmanned at any time. Two of the dental nurses mainly worked on reception but other nurses were expected to help out on reception as needed. We were told that for four and a half days each week an additional dental nurse was on duty to undertake decontamination, administration or assist with reception. A weekly duty rota detailed where dental nursing staff would be working.

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

The practice had arrangements in place to monitor health and safety and deal with foreseeable emergencies. We saw that the practice had developed a health and safety folder which contained numerous risk assessments such as a



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practice risk log, fire, manual handling, control of substances hazardous to health (COSHH) and hepatitis B non-responder risk assessments. Various health and safety policies were also available including policies regarding accidents, radiation safety, equipment and infection control. These policies were reviewed on an annual basis. A health and safety poster was on display in the staff room.

We discussed fire safety with the registered manager and looked at the practice's fire safety risk assessment and associated documentation. We saw that an annual fire management schedule had been developed. This recorded actions that needed to be taken at certain times of the year to maintain fire safety. For example fire drills were to be undertaken in March and September and training in March. The fire risk assessment was updated in May 2015 and following this inspection we were informed that a further update had taken place in June 2016. We saw that appropriate fire signage was on display around the practice. Fire safety equipment such as fire extinguishers and a fire blanket were available. Records were available to demonstrate that this equipment was subject to routine maintenance and checks by external professionals. A certificate of conformity had been provided by the external company who undertook the maintenance of fire safety equipment. This was dated June 2016. Documentary evidence was available to confirm that fire drills took place on a six monthly basis with the last fire drill recorded as taking place in March 2016.

## **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 cleaning of non-clinical areas of the practice and dental nurses cleaned clinical areas. We noted that staff were following the national colour coding scheme for cleaning materials and equipment in dental premises. Records were kept to demonstrate cleaning undertaken.

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 a 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. Staff spoken with were aware who held the lead role for infection prevention and control 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.

Infection prevention and control audits were completed on a six monthly basis in line with the Department of Health's guidance on decontamination (HTM 01-05).

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. 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 placed in a washer disinfectant and a visual inspection was undertaken using an illuminated magnifying glass before instruments were sterilised in an autoclave. 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 current HTM 01-05 guidelines. All the equipment used in the decontamination process had



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been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly. Services safe

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. A risk assessment regarding Legionella had been carried out by an external agency in March 2016 and was due again in March 2018. We saw evidence that routine temperature monitoring checks were being completed as identified in the risk assessment and annual water samples sent for testing.

We discussed the disposal of sharps, clinical waste and looked at waste transfer notices and the storage area for clinical and municipal waste. 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). We saw that clinical waste was stored in an area that was accessible to members of the public who were entering the rear of the practice. Clinical waste bins were locked but were not secured to the wall or floor. Following this inspection we received email confirmation that the registered manager had spoken with their waste disposal contractor who had advised some action to take to secure the bins. The area was unable to be locked as it was a fire escape route. The practice had decided to take the advice of the waste contractor. Sharps bins were located appropriately out of the reach of children.

## Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, dental chairs, fire safety equipment and the autoclaves. Records seen demonstrated the dates on which the equipment had most recently been serviced. For example one of the dental chairs was serviced in November 2015 and the other in February 2016, the autoclaves were serviced in January and March 2016. All portable electrical appliances at the practice had received a quarterly visual check. A risk assessment was in place which identified the timescales for a full check to be undertaken by an external professional. We noted that equipment had been tested in line with the

timescales identified in the risk assessment. The practice had guidance produced by the health and safety executive regarding portable appliance testing and they were working in accordance with this document.

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.

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.

Prescription pads were securely stored and records kept of the name of the patient and the medicine prescribed. However there was no log of each prescription number issued. Following this inspection a new prescription log was developed which recorded prescription number, patient code, what was prescribed and the signature of the prescriber.

## 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 two 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

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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 which contained a clear individual analysis of the quality of the X-rays which had been taken and action plans developed as 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 both dentists about oral health assessments and dental care records which were available for each patient. The dentists discussed the examination of the patient's teeth, gums and soft tissues. Dental care records showed that the dentists regularly checked gum health by use of the basic periodontal examination (BPE). (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). Scores over a certain amount would trigger further, more detailed testing and treatment or referral to one of the dental hygienists at the practice.

Following the clinical assessment the diagnosis was then discussed with the patient and treatment options, advantages and disadvantages explained in detail. We were told that treatment plans were printed, signed by the patient and a copy kept on patient dental care records. 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.

Dentists were aware of the Faculty of General Dental Practice (FGDP) guidelines regarding clinical examination and record keeping and record keeping audits seen demonstrated their compliance with these guidelines.

FGDP guidelines recommend that patients with a low risk of dental caries had a radiograph taken every 18 – 24 months. However the decision to take an X-ray was made in line with a risk assessment undertaken at the practice. This identified those patients with low risk of dental caries had a radiograph every three to five years.

### 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). High concentration fluoride toothpastes were prescribed when required. Fluoride varnish was also applied to children's teeth if required.

During appointments 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. Patients we spoke with confirmed this. Where gum problems were identified patients were referred to one of the dental hygienists who worked at the practice. We saw entries in dental care records that detailed patients' oral health and details of discussions that had taken place regarding improving oral health. Information leaflets were available in the waiting room regarding treatments available but also regarding the effects of smoking and alcohol on oral health and about gum disease.

Free samples of denture adhesives and toothpaste were available on reception and in treatment rooms. The practice sold a range of dental hygiene products to maintain healthy teeth and gums; these were available in the reception area.

### Staffing

Practice staff included two dentists who owned the practice, two part time hygienists, five qualified dental nurses who were registered with the General Dental Council (GDC); two of which mainly work on reception and one trainee dental nurse. Staff spoken with said that they enjoyed their work, were well supported and all said that staff worked 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.

Appraisal meetings were held on an annual basis with a six monthly review. Appraisal systems contain information on General Dental Council (GDC) standards, job satisfaction and CPD records. We saw that personal development plans (PDP) had been developed as part of the appraisal process. This recorded information on current goals and goals from previous appraisal whether achieved or ongoing. Staff told us that they were able to discuss issues or concerns, working practices or training requirements.

# Are services effective?

(for example, treatment is effective)

Staff said that they were provided with on-line training, in-house training and by external providers. Staff confirmed that they received regular training including infection prevention and control, safeguarding and basic life support.

We saw that systems were in place to ensure that staff met their continuing professional development (CPD) requirements. CPD is a compulsory requirement of registration as a general dental professional. We saw that CPD logs recorded the total training time required and details of training completed. We were told that support would be given to staff who were falling behind their CPD requirements. Staff spoken with said that they received all necessary training to enable them to perform their job confidently and confirmed that they were able to ask to undertake any training which was always considered. 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. We were told that all referrals were sent with a copy of a radiograph. Patients were given a copy of a referral notice which confirmed where they had been referred to and the reasons for the referral. The practice had not developed a system to check whether the patient had received their referral appointment. We were told that patients were asked to contact the practice if they had not heard from the referral service. The practice had received one complaint regarding referrals. The patient was unhappy with the costs of the private referral. We were told that the referral notice had been changed to now record the likely costs of any treatment.

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. Information was faxed through and the original referral put in the post. A telephone call was made to confirm that an urgent referral was being sent.

## **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. This had been reviewed on an annual basis. Treatment plans seen had been signed by patients who gave their written consent for treatment.

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. Patients were given time to gather further information; consider treatment options and support to help them make decisions about treatment. Patient care records seen evidenced that the practice had a robust consent process in place.

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. We were told that the practice undertook some visits to a local care home. The care home would complete a brief assessment and where it was identified that capacity was not present a capacity assessment form was used. The dentist spoken with clearly understood best interest decisions and confirmed that decisions would always be made in the best interest of the patient. The practice had developed a policy regarding adults who lack capacity and the actions staff should take.

# 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. We saw that policies were in place which detailed what information staff were able to give to patients. Reception staff were aware of actions to take to maintain confidentiality. Staff discussed an issue which resulted in a significant event form being completed regarding a child attending for treatment without a parent. We were told that the treatment was refused until a parent was present. 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 and in paper format. 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. Paper records were securely stored in a cabinet behind the reception desk. 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 have a discussion 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. The practice website recorded some of the actions that they take to reduce anxiety. This included discussion only appointments; longer appointment times to allow staff time to provide reassurance to the patient during treatment or inhalation sedation. Staff said that they took their time to chat to patients and tried to make them feel at ease. New patients

were requested to complete a questionnaire regarding dental anxiety to enable dental staff to review and assess patient's levels of dental anxiety to enable appropriate care to be provided.

We observed staff were friendly, helpful, discreet and respectful to patients when interacting with them on the telephone and in the reception area. 49 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. We observed a member of reception staff telephoning a patient who had attended for treatment on the morning of our inspection. The receptionist told us that this was an anxious patient and they always telephoned these patients to ensure that they were alright and to confirm any further treatment arrangements.

### **Involvement in decisions about care and treatment**

The practice provided patients with information to enable them to make informed choices. The registered manager told us that a computer printout was given to patients which detailed the treatment options available, any risks and benefits of treatment and costs involved. Patients we spoke with confirmed this. Patients said that they were always given information to enable them to make an informed choice. They were given time to consider their options and staff always made sure that they fully understood how much treatment would cost, what was involved and how long it would take. One patient we spoke with discussed a recent treatment and confirmed that the dentist had given them enough information to be able to choose and requested that they went away and did further research before making a choice. Staff said that detailed explanations were given to patients and they always made sure that patients understood the information given. Patient care records demonstrated that the dentists recorded the information they had provided to patients about their treatment and the options open to them.

The practice website and leaflets in the waiting area provided information about treatments available at the practice.

The dentist we spoke with demonstrated a good understanding of Gillick competency. Gillick competency is

# Are services caring?

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 mostly private with some NHS treatment. A leaflet detailing private fees was available on the reception desk and an NHS treatment fee poster was clearly displayed in the waiting area. The practice's website recorded details of the three different fee structures for patients which was NHS, private and Denplan (a private dental plan). Examples of private, Denplan and NHS fees were listed as a guide for patients. The practice's website provided a wealth of information for patients such as details of the staff team, the services provided, opening times and contact details including email address. Dental links to websites that provide useful information were also available. For example patients were able to access the General Dental Council, NHS Dental Health Information and Care Quality Commission websites via these links.

An information folder was available at the reception desk. This folder contained useful information for patients such as a copy of the last Care Quality Commission inspection report, a guide to NHS dental services, the Statement of Purpose, dental protection insurance certificates, copies of certificates of registration with the General Dental Council and the practice leaflet. Some relevant policies and procedures were available such as quality assurance, customer care, complaints and clinical governance.

We discussed emergency appointments with the receptionist and were told that four emergency appointments were available each day. When the emergency appointments were full, patients were either given a cancellation or asked to come and sit and wait to see the dentist. Staff told us that patients in dental pain were always able to get an appointment within 24 hours of their initial contact with the practice. Patients were usually able to get a routine appointment within one week. Feedback confirmed that patients were rarely kept waiting beyond their appointment time. The practice had undertaken a waiting time audit in January 2016 and had identified that 10% of patients were waiting beyond 12 minutes. We were told that this audit would be completed again and action taken to address issues identified.

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 which had been reviewed on an annual basis with the last review taking place in October 2015.

The practice had access to a shared car park at the rear of the practice. There was no disabled car parking space. A portable ramp was available to gain access to the front or rear of the practice. We were told that pop up notes on patient's computer records alerted staff to patients with any special needs such as the use of the portable ramp. This dental practice was located on the ground floor of a building on a busy high street. Patients who required the use of a wheelchair would have access to all patient areas at the practice. There was also a toilet which had been adapted to meet the needs of patients with restricted mobility.

We asked about communication with patients for whom English was not a first language and for those patients with hearing or sight difficulties. We were told the majority of patients were able to communicate in English but a translation service was available for use if required. We were told that there was no hearing loop for use by patients with hearing aids. However, arrangements could be made with an external company to provide assistance with communication via the use of British sign language as required. There was also a large portable magnifying viewer for use by patients with sight difficulties and practice information could be made available in large print and other languages.

### Access to the service

The practice's opening hours are 8.30am to 5.15pm on Tuesday, Wednesday and Friday, 8.30am to 5pm on Monday and 9.30am to 6pm on Thursday. 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 for lunch each day. The telephone answering machine also gave emergency contact details for patients with dental pain when the practice was closed during the evening,



# Are services responsive to people's needs?

(for example, to feedback?)

weekends and bank holidays. A buddy arrangement was in place when the practice was closed due to both dentists being on leave so patients in dental pain could be seen by a dentist from a local practice.

Patients were able to make appointments over the telephone, in person or by email. 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.

Patients were sent letters, email and text message reminders of booked appointments. Phone calls were also made to patients who were unable to receive text messages.

## 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 acknowledgement letter.

We were told that two complaints had been received at the practice within the last 12 months. A complaints file was available which contained a log sheet which recorded details of all complaints received. The file also contained other information such as a complaint handling procedure and contact details for external agencies that patients could complaint to if they were unhappy with the outcome of the investigation undertaken at the dental practice.

We saw that information was available about each complaint including details of any action taken to address issues identified, follow up action and learning points to try and reduce the risk of the complaint reoccurring. Complaints were discussed at practice meetings and learning points identified. We saw that action had been taken to address issues identified. For example the likely cost of treatment was now recorded on referral letters.

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.

# Are services well-led?

## Our findings

### Governance arrangements

The practice had policies and procedures in place to support the management of the service, and these were readily available for the staff to reference in the staff handbook. All staff had been given a copy of the staff handbook. These covered a wide range of topics, for example infection control, health and safety, complaints and safeguarding. Staff told us that all policies were reviewed each year and these were discussed at practice meetings. Staff were given a copy of the amended policy and signed documentation to confirm that they had read the amended policy.

A practice information folder was available on reception for patients to review. This contained information such as Denplan membership certificates, an annual statement on prevention and control of infection, fire certificate of conformity and the Information Commissioners Office certificate (The Data Protection Act 1998 requires every organisation that processes personal information to register with the Information Commissioner's Office (ICO)).

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

Monthly practice meetings were held and standard agenda items were discussed such as safeguarding, complaints and accidents or incidents. In addition to this any other issues relevant to the practice were discussed. Separate monthly meetings were also held for dental nurses and separate meetings for reception staff. Staff said that they were able to speak out during meetings and were encouraged to feedback any ideas for change at the

practice. Staff said that there was an inclusive atmosphere and they were always made aware of any changes at the practice. Staff confirmed that there were clear lines of responsibility and dentists were approachable and helpful.

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 dentists were very well organised, 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. We discussed the whistleblowing policy with a dental nurse who was able to give a clear account of what the procedure was for, and when and how to use it. The policy was available in the staff handbook.

Staff said that they felt valued and supported. They were able to raise concerns and make suggestions for improvement. We observed staff to be friendly and helpful.

### Learning and improvement

The practice had a structured plan in place to audit quality and safety. We saw the audits that had been completed to date during 2016, this included hand hygiene, instrument cleanliness, patient recall, sedation, radiography and data protection. Other audits were also completed on a regular basis and the practice undertook a six monthly infection control audit in line with the Department of Health's guidance on decontamination (HTM 01-05).

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

# Are services well-led?

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; Denplan satisfaction surveys, 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.

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, Denplan for private patients and the Parliamentary and Health Service Ombudsman. This enabled patients to contact these bodies if they were not satisfied with the outcome of the investigation conducted by the practice.

We were told that a staff satisfaction survey had been completed as part of the appraisal process. Denplan conducted surveys every three years. The practice newsletter for October 2014 gives some feedback about the results of the Denplan survey undertaken in May 2014

which was reported as positive. We were told that the practice also undertook in-house surveys every 18 months, although we did not see the results of these surveys. However, prior to our inspection we received some brief feedback regarding a survey undertaken in February 2016 regarding data protection. Positive comments were recorded by patients who stated that privacy and confidentiality was respected at all times and professional care and attention was given to patient information. Staff said that the results of staff surveys, friends and family test and other patient feedback was discussed at practice meetings. Staff discussed actions taken as a result of patient feedback such as the widening of the entrance to the car park, entrance to the rear of the practice and low level door bells at the front and rear entrance to the practice.

The practice had kept details of compliments received. Patients had praised the staff and the service received stating that staff made patients feel at ease, they were attentive, caring and professional.