

Oracle Dental Limited

Argo Practices Shrewsbury

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 August 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

Argo Dental Practice has four dentists who work part time, two dental hygienists and one dental therapist, two qualified dental nurses who are registered with the General Dental Council (GDC) and two apprentice dental nurses, a practice manager, and two receptionists. The practice's opening hours are 9am to 5pm on Monday, 8am to 5pm on Tuesday and Friday, 8am to 6pm Wednesday and 8am to 8pm on a Thursday.

Argo Dental Practice provides private dental treatment for adults and children. The practice has four dental treatment rooms on the ground floor and a separate decontamination room for cleaning, sterilising and packing dental instruments. There was also a reception and 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 to tell us about their experience of the practice and during the inspection we spoke with patients. We

Summary of findings

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

Our key findings were

- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Feedback from patients was positive. Patients said they were treated with dignity and respect.
- The practice was visibly clean and well maintained.
- Infection control procedures were in place with infection prevention and control audits being undertaken on a six monthly basis. Staff had access to personal protective equipment such as gloves and aprons.
- There was appropriate equipment for staff to undertake their duties, and equipment was well maintained.
- Patients' confidentiality was maintained.
- Dentists identified treatment options and these were discussed with patients.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- Staff had been trained to deal with medical emergencies, although update training was required which had been booked for September 2016.
- The appointment system met the needs of patients and waiting times were kept to a minimum.
- Governance arrangements were in place for the smooth running of the practice and there was a structured plan in place to audit quality and safety beyond the mandatory audits for infection control and radiography.

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

- Review the practice's policy and procedures for accident reporting and develop a policy in relation to duty of Candour.
- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review availability of staff training to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review the suitability of the decontamination room in relation to the availability of separate hand wash facilities.
- Review the practice's risk assessment processes.
- Review the current legionella risk assessment and implement the required actions.
- Review compliance with the legal obligations under Ionising Radiation Regulations (IRR) 99 and Ionising Radiation (Medical Exposure) Regulation (IRMER) 2000.
- Review the practice's audit protocols of various aspects of the service and ensure audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

Staff were aware of the procedure to follow to report incidents, accidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Staff had received training in safeguarding vulnerable adults and children. Staff knew how to recognise signs of abuse and how to raise concerns. Staff were aware who held the lead role to offer support regarding safeguarding matters.

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). However, changes were required to the dosage strength of aspirin available which we were told would be addressed immediately. 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 although update training was overdue for some staff. This training had been booked for September 2016.

The practice did not receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts, however the registered manager confirmed that they would register to receive this information immediately.

Infection control audits were being undertaken on a six monthly basis in line with the recommendations of HTM 01-05. The practice had systems in place for waste disposal and on the day of inspection the practice was visibly clean and clutter free.

No
action


Are services effective?

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

Patients were assessed by a dental professional before treatment began. Patients and staff told us that explanations about treatment options and oral health were given to patients in a way they understood and risks, benefits, options and costs were explained. Patients' dental care records confirmed this. The dental care provided was evidence based and focussed on the needs of the patients. The practice used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice. The practice used oral screening tools to identify oral disease.

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Referrals were made in a timely way to ensure patients' oral health did not suffer.

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

No
action


Are services caring?

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

No
action


Summary of findings

Privacy and confidentiality were maintained for patients using the service on the day of the inspection. Staff treated patients with kindness and respect and were aware of the importance of confidentiality. Feedback from patients was overwhelmingly positive. Patients commented that staff were professional, friendly and helpful.

Are services responsive to people's needs?

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

The practice had ground floor treatment rooms and toilet which had been adapted to meet the needs of patients with a disability. However contact details for an external agency that could provide assistance with communication via British Sign Language were not available on the day of inspection, although we were told that this information would be sourced immediately.

The practice had developed a complaints procedure and information about how to make a complaint was available for patients to reference.

**No
action**


Are services well-led?

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

There was a clear management structure at the practice. 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 systems were in place to ensure all staff who were unable to attend the meeting received an update about topics of discussion. However the minutes of meetings we saw did not record detailed information regarding topics of discussion. Minutes of meetings did not demonstrate, for example, that accidents, incidents, complaints, patient feedback or audits and the learning points from these had been discussed with staff.

Policies and procedures were available to staff to help the smooth running of the practice, however there was no duty of candour policy

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.

**No
action**


Argo Practices Shrewsbury

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 9 August 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 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

Some systems were in place to enable staff to report incidents and accidents. We saw that accident reporting books and significant event reporting forms were available. We saw that 24 accidents had been recorded since 2010 in the accident book. Staff spoken with were aware of the location of the accident book and the procedure to follow to report accidents. To maintain confidentiality accident reports were removed from the accident book and kept with either the patient records or the staff personnel file. However, once the report form had been removed from the accident book, there was no system in place to identify when the accident occurred or where the report form was kept. The practice was not monitoring accidents to identify trends and there was no documented evidence of learning points. The accident policy recorded that the practice should be completing an accident prevention log. We were told that this had not been completed. The practice manager was able to provide us with any accident forms requested and we saw that there had been four accidents within the last 12 months with the last accident being recorded in January 2016.

One significant event had been reported in June 2016 and we saw documentation that recorded details of the significant event and any follow up action. The practice manager had been appointed as the significant events lead and staff spoken with were aware who held this role. We looked at the minutes of practice meetings for 2016 and saw that neither accidents nor significant events had been discussed.

All staff we spoke with understood the Reporting of Injuries, Diseases and Dangerous Occurrences regulations (RIDDOR) and contact details were available to enable staff to report incidents under RIDDOR regulations if necessary. We were told that there had been no events at the practice that required reporting under RIDDOR.

The practice had not registered to receive national patient safety and medicines alerts from the Medicines and Healthcare products Regulatory Agency. We were told that the registered manager would register to receive these alerts.

Reliable safety systems and processes (including safeguarding)

Detailed child protection and safeguarding vulnerable adults policies had been implemented in June 2016. Details of how to report suspected abuse to the local organisations responsible for investigation were recorded on the policies. For example details of how to make a referral to the local NHS Safeguarding Team. Staff had signed a document to confirm that they had read and would work in accordance with the policies. The practice manager had been identified as the safeguarding lead and all staff spoken with were aware that they should speak to this person for advice or to report suspicions of abuse. We were told that there had been no safeguarding issues to report. We saw evidence that staff had completed the appropriate level of safeguarding training in June 2015.

There had been one sharps injury at the practice within the last five years. We saw the accident report form which recorded details of the accident, recommendations and any follow up action taken. For example the staff member was taken to the local accident and emergency department. The dental nurse we spoke with told us that dentists were responsible for handling and disposal of sharps. A sharps injury risk assessment had been completed. The risk assessment was reviewed on an annual basis. Sharps information was on display in treatment rooms and other locations where sharps bins were located.

We asked about the instruments which were used during root canal treatment. The dental nurse we spoke with explained that these instruments were single use only. We were told all dentists routinely used a rubber dam when providing root canal treatment to patients in line with guidance from the British Endodontic Society. A rubber dam is a thin, rectangular sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured.

Medical emergencies

There were systems in place to manage medical emergencies at the practice. Staff had all received training in basic life support although some staff had not completed this training within the last 12 months. The resuscitation council guidelines recommend that dental



Are services safe?

staff complete this training on at least an annual basis. We were told that update training was booked for 1 September 2016. 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. We noted that some items of emergency equipment was either missing or had expired. For example the oropharyngeal airways had expired, the adhesive defibrillator pads expire in August 2016 and there was no self-inflating bag with reservoir for a child. This equipment was ordered by the registered manager during our inspection of the practice. We saw records which confirmed that the oxygen and defibrillator were checked on a daily basis by the registered manager.

Emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice were available. However, the practice had 75mg of dispersible aspirin tablets available which would mean that the patient would need to take four tablets to reach the required dosage. The practice manager confirmed that the correct dosage of dispersible aspirin would be made available. All emergency medicines were appropriately stored and were regularly checked to ensure they were within date for safe use.

We saw that a first aid kit was available which contained equipment for use in treating minor injuries. We were told that equipment in the first aid box was checked on a monthly basis to ensure it was available and within its expiry date. However, there were no records available to demonstrate this. Within 24 hours of this inspection the registered manager forwarded a first aid kit check sheet which we were told would be completed on a monthly basis. The practice manager was the designated first aider and had completed first aid training in November 2014; update training would be required in November 2017.

Staff recruitment

We looked at the practice's employment policy that described the process to follow when employing new staff. This policy was implemented in June 2016 and had a date for review of June 2017. The policy included details of the interview processes and equal opportunities policy to follow. The policy did not record information regarding the pre-employment information to obtain such as disclosure and barring service checks (DBS).

We discussed the recruitment of staff and looked at four recruitment files in order to check that recruitment procedures had been followed. We saw that files did not contain all of the information as required in Schedule 3 of the Health and Social Care Act 2008. For example the practice had not obtained satisfactory information about any physical or mental health conditions which are relevant to the person's capability to properly perform tasks intrinsic to their employment and there was no documentary evidence in one file of satisfactory evidence of conduct in previous employment. The practice manager told us that they had obtained two verbal references for this member of staff but these had not been recorded on the recruitment file. Following this inspection we received a copy of an amended employment policy which included the checking of candidates' health or disabilities to enable special measures to be implemented ahead of commencement of employment.

Recruitment files contained other information such as contracts of employment, job descriptions and copies of policies and procedures such as data protection, confidentiality and health and safety.

We saw that disclosure and barring service checks (DBS) were in place and we were told that these had been completed for all staff. 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.

The practice planned for staff absences to ensure the service was uninterrupted. We were told that dentists had to book annual leave up to six weeks in advance and dental nurses four weeks. Unexpected leave would be covered either by part time staff who worked at the practice or by staff from one of four other local practices also owned by the provider. A weekly duty rota detailed where dental nursing staff would be working. For example, on reception or it recorded the name of the dentist or dental therapist they would be working with. We saw that separate duty rotas were available for the other four practices and these recorded the names of staff who would be available to cover leave if required. We were told that the 'group manager' was responsible for allocating staff to cover annual or sick leave. Agency staff would be used to cover dental nurses if required. The duty rota was on display in the staff room and all staff had access.



Are services safe?

We were told that all dentists and the dental therapist worked with a dental nurse. However dental hygienists normally worked without chairside support but support was available when requested.

Monitoring health & safety and responding to risks

Some arrangements were in place to monitor health and safety and deal with foreseeable emergencies. A health and safety poster was on display in the staff room. The practice had developed a health and safety policy in June 2016 and the practice manager was the named health and safety lead. All staff spoken with said that they could speak with the practice manager for health and safety advice if required.

The practice manager showed us a daily health and safety checklist that they completed. There was no written information to demonstrate the health and safety issues to be checked. The practice manager said that they walked around each room in the practice to ensure that there were not trip hazards, that lighting was working and that there were no other obvious health and safety issues. Following this inspection the practice manager sent an email which recorded the issues to review during the health and safety daily check.

Numerous risk assessments had been completed. For example, we saw risk assessments for lone working, sharps, dental nursing, use of ultrasonic tips, use of Bunsen burners and display screen equipment. All of these risk assessments had been reviewed on an annual basis and were dated June 2016. The dental nurse risk assessment had not been signed by all dental nurses at the practice as requested on the risk assessment.

We could not find evidence that a fire risk assessment had been completed; we were shown an example risk assessment produced by the British Dental Association. We were also shown an action plan which recorded actions to take such as six monthly fire drills, maintenance of fire safety equipment. However the practice manager was unable to find a completed fire risk assessment that related to this dental practice.

We discussed fire safety with the practice manager. We saw evidence that three fire drills had taken place during 2015 and one in 2016. The date of the fire drill was recorded along with the time taken to evacuate the practice. However the names of the staff members involved in the fire drill were not recorded. Within 24 hours of this

inspection the registered manager forwarded a newly developed fire drill log sheet, staff would be able to record relevant information such as the date, names of staff members present and the time taken to evacuate the building.

We looked at the minutes of practice meeting minutes for 2015 and 2016, minutes of meetings were brief and there was no documentary evidence that health and safety had been discussed with staff at these meetings.

Records seen confirmed that fire safety equipment such as fire extinguishers; fire alarms, emergency lighting and smoke alarms were subject to routine maintenance by external professionals. A weekly fire safety checklist was completed. This included checks of the fire alarm and emergency lighting.

Details of all substances used at the practice which may pose a risk to health were recorded in a well organised COSHH file. An itemised list was available which was currently under review by the head dental nurse.

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.

An external cleaning company was responsible for undertaking all environmental cleaning of both clinical and non-clinical areas on four days per week and a dental nurse who worked at the practice was responsible for the remaining day each week. The practice followed the national colour coding scheme for cleaning materials and equipment in dental premises and signage was in place to identify which colour of cleaning equipment was specific for use in that area. One colour of mop and bucket were not available during the inspection (used to clean the small staff kitchen area) but these were ordered by the practice manager during the inspection. We were told that previously staff had cleaned the floor with a disposable cloth.

Systems were in place to reduce the risk and spread of infection within the practice. Staff had access to supplies of personal protective equipment (PPE) for themselves and for patients. Staff uniforms ensured that staff member's arms were bare below the elbow. Bare below the elbow working aims to improve the effectiveness of hand hygiene



Are services safe?

performed by health care workers. The practice had developed a comprehensive infection prevention and control policy. This was implemented in June 2016 and had a date for annual review. Infection prevention and control audits were completed on a six monthly basis. The last audit was undertaken in March 2016 with the previous audit in September 2015.

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. We saw that the decontamination room only had one sink which would be used by staff to wash their hands. Separate bowls were available for rinsing and scrubbing dental instruments. The practice manager informed us by email within 24 hours of our inspection visit that a quote was being obtained for the provision of a further hand wash sink in this room.

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. The practice used ultrasonic cleaners before undertaking a visual inspection using an illuminated magnifying glass. Instruments were then 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 been regularly serviced and maintained in accordance with the manufacturer's instructions and records were available to demonstrate this equipment was functioning correctly.

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) they 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 November 2014 and an interim assessment in September 2015. The only issues for action related to provision of legionella awareness training for the 'duty holder'. The practice manager told us that this training had been completed but we did not see any documentary evidence to demonstrate this.

We discussed clinical waste with the practice manager; we looked at waste transfer notices and the storage area for clinical and municipal waste. We were told that clinical waste was collected every few weeks. Clinical waste awaiting collection was stored in an area where members of the public could not access it. The segregation and storage of clinical waste was in line with current guidelines laid down by the Department of Health. Sharps bins were stored in appropriate locations which were out of the reach of children. Needle stick policies were on display in each treatment room.

Equipment and medicines

We saw that maintenance contracts were in place for essential equipment such as X-ray sets, fire safety equipment, the autoclave and compressors. Records seen demonstrated the dates on which the equipment had recently been serviced. All portable electrical appliances at the practice had received an annual portable appliance test (PAT) in July 2016.

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.

Radiography (X-rays)

We were shown a radiation protection file which did not contain all information in line with the Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). We did not see any evidence of notification to the Health and Safety Executive (HSE). Employers planning to carry out work with ionising radiation are required to notify HSE and retain



Are services safe?

documentation of this. The file recorded details of the Radiation Protection Advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The four dentists who worked at the practice were identified as Radiation Protection Supervisors (RPS) this helped to ensure that equipment was operated safely and by qualified staff only.

The practice had three dental X-ray machines in use and one which required repair and was out of use. Copies of the critical examination packs for each of the X-ray sets along with the maintenance logs were available for review. The maintenance logs were within the current recommended interval of three years.

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. We saw that rectangular collimators were not available on any of the X-ray machines that we saw. A rectangular collimator reduces the amount of radiation to the patient by

decreasing the amount of radiation scatter. We received notification from the registered manager that this equipment had been purchased the day following our inspection visit.

Appropriate signage was on doors where X-ray machines were located.

We saw evidence that all of the dentists were up to date with the required continuing professional development on radiation safety. One of the dental nurses had also undertaken training to enable them to take radiographs. Local rules were available in each of the treatment rooms where X-ray machines were located for all staff to reference if needed. Emergency cut-off switches were located outside of the treatment room.

We saw a recent X-ray audit completed in May 2016. The audit did not record the type of radiograph taken or the name of the dentist who had taken the radiograph. It was therefore difficult to highlight any improvements required by individual dentists. Following this inspection the registered manager sent us a copy of a newly developed detailed radiography audit which staff would be able to record the required information.

Are services effective?

(for example, treatment is effective)

No action



Our findings

Monitoring and improving outcomes for patients

We spoke with dentists about oral health assessments. We were told that following completion or update of medical history records, an examination of the patient's teeth, gums and soft tissues was completed. During this assessment dentists looked for any signs of mouth cancer. We saw details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (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). Following the clinical assessment the diagnosis was then discussed with the patient and treatment options explained in detail.

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 lower wisdom teeth removal. NICE guidance was also used to determine recall intervals for patients. Each dentist took risk factors such as, oral cancer, dental decay, gum disease and patient past history of maintaining oral health into consideration to determine the likelihood of patients experiencing dental disease and therefore the timescale for dental recall. Patient care records demonstrated that risk factors had been documented and discussed with patients. The decision to take an X-ray was made according to clinical need and 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 oral health promotion with a dental nurse. We were told that the dentists, hygienists and therapists gave information to patients about maintaining oral hygiene. Disclosing tablets were given to children and fluoride varnish was applied to children's teeth when necessary. High concentration fluoride toothpaste was prescribed to patients at high risk of dental caries. During appointments the dental professional explained tooth brushing and interdental cleaning techniques to patients in a way they understood. We were told that this included instruction using a scale model of the mouth.

We discussed medical history forms with staff and were told that these were completed by patients on a six monthly basis. We saw that medical history forms included questions about smoking and alcohol consumption. Following review of the medical history forms patients were given advice appropriate to their individual needs such as, smoking cessation and alcohol consumption advice. Where patients were identified with a high risk of dental caries, advice was also given regarding dietary intake.

We were told that free samples of toothpaste and toothbrushes were available upon request. The practice also had a range of dental hygiene products for patients to purchase.

Staffing

Practice staff included a practice manager, four part time dentists, two dental hygienists and a dental therapist, two qualified dental nurses, two apprentice dental nurses and two receptionists. The practice owner, who was not present during this inspection, also owned other dental practices. Some of the functions such as human resources were overseen by a group manager.

We discussed staff training with the practice manager and with staff. Staff told us that they were encouraged to attend training courses and supported to develop their skills. One staff member told us that they had initially started working at the practice as an apprentice receptionist but had been encouraged to start a dental nursing course which they were enjoying.

Staff spoken with said that they received all necessary training to enable them to perform their job confidently. Records showed professional registration with the GDC was up to date for all relevant staff.

We saw evidence in staff recruitment files that staff had undertaken safeguarding and infection control training. We were told that basic life support training was booked for all staff to attend on 1 September 2016. The practice manager had attended training regarding the Mental Capacity Act and was booked on to update training in 2017.

Appraisal systems were in place and we saw records to confirm that annual appraisal took place. Staff told us that they were able to raise any issues or concerns or request

Are services effective?

(for example, treatment is effective)

No action 

training during their appraisal meeting. Staff also said that the practice manager was approachable and they could speak with them at any time and would not need to wait for their appraisal meeting to discuss issues.

Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves. For example referrals were made for patients who required complex treatments, sedation or oral surgery. Systems were in place to ensure referrals were received in a timely manner; staff telephoned referral practice's to ensure that referral information had been received and acted upon.

Consent to care and treatment

The practice demonstrated a good understanding of the processes involved in obtaining full, valid and informed consent for an adult. Staff confirmed that treatment options were discussed with each patient. Patients were given verbal and written information to support them to make decisions about treatment. Detailed information was given to patients regarding fixed braces. We were shown

entries in dental care records where treatment options were discussed with patients. Any risks involved in treatment were also recorded. Patients were requested to sign a treatment plan once a decision about treatment had been made. There was evidence in records that consent was obtained.

A consent policy had been implemented which was last reviewed in June 2015. This policy did not make reference to the MCA. Following this inspection the registered manager sent us a copy of an amended consent policy which referred to the MCA including best interest decisions. We saw that consent was reviewed as part of a recent record card audit on a six monthly basis.

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 were aware of the MCA and best interest decisions, staff had completed training regarding the MCA. There were no recent examples of patients where a mental capacity assessment or best interest decision was needed.



Are services caring?

Our findings

Respect, dignity, compassion & empathy

We were told that privacy and confidentiality were maintained at all times for patients who used the service. Treatment rooms were situated off the waiting area. We saw that doors were closed at all times when patients were with the dentist. Conversations between patient and dentist could not be heard from outside the treatment rooms which protected patient's privacy. We were told that music was played in the waiting area, although a patient had requested that it be turned off on the day of our inspection. Playing music may help aid confidentiality as people in the waiting room would be less likely to hear conversations held at the reception desk. A dental nurse told us that some dentists also played music in the treatment rooms and this helped to distract and relax anxious patients.

Patients' clinical records were stored electronically. Computers were password protected and backed up on a daily basis 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.

Patients provided positive feedback about the practice on comment cards completed prior to our inspection and during our discussions with them on the day of 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. Clear treatment plans were given to patients which detailed treatment and costs. We saw evidence in the records we looked at that the dentists recorded the information they had provided to patients about their treatment and the options open to them. Patients commented they felt involved in their treatment and said that they received full explanations before agreeing to commence their treatment.

Are services responsive to people with hearing loss?

(for example, to feedback?)

No action



Our findings

Responding to and meeting patients' needs

The practice provided private dental treatment and offered some private dental treatment plans. The practice's website gave information about opening times, how to book appointments, details of the staff team and the services provided. This included information regarding the range of treatments offered to patients and gave a brief explanation of treatments. There was no information regarding any treatment costs.

The practice was open throughout lunchtime each day and was open late in the evening until 6pm on a Wednesday and 8pm on a Thursday. The practice opened at 8am four days per week. This helped to ensure that those patients with work commitments during Monday to Friday were still able to receive an appointment with a dentist.

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. There were vacant appointment slots to accommodate urgent appointments. 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. We were told that some of the dentists at Argo Shrewsbury also worked at the Argo Telford practice and patients in dental pain could also attend that practice to see the dentist. Feedback confirmed that patients were rarely kept waiting beyond their appointment time.

Tackling inequity and promoting equality

The practice had policies on equal opportunities to support staff in understanding and meeting the needs of patients. There was a hearing induction loop for use by people who were hard of hearing. However there were no contact details for any external company to provide assistance with communication via the use of British sign language. The practice manager confirmed that they would ensure that these details were obtained immediately.

We asked about communication with patients for whom English was not a first language. We were told that all of the

patients at the practice were able to communicate in English. However the practice manager confirmed that they had the contact details for a translation service which they would use if required.

This practice was suitable for wheelchair users, having ground floor treatment rooms with level access to the front of the building, and a disabled toilet.

Access to the service

The practice was open from 9am to 5pm on Monday and Friday, 8am to 5pm Tuesday, 8am to 6pm Wednesday and 8am to 8pm on a Thursday. The opening hours were displayed in the practice and on the practice's website. The practice was open during lunchtime each day and the practice was part of the Shropshire on-call rota. The telephone answering machine gave emergency contact details for patients with dental pain when the practice was closed during the evening, weekends and bank holidays. The message informed patients that there would be a call out charge during these times.

Patients were able to make appointments over the telephone, in person or via the practice website. Staff we spoke with told us that during the holiday period there may be a wait to see the dentist but usually patients could see a named dentist for a routine appointment within three weeks of their contact with the practice.

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.

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. Patients were given information on how to make a complaint. We saw that a copy of the complaints policy was on display in the waiting area. Patients were also able to complain through the practice website if they preferred. We were told that patients were able to raise concerns either in writing or verbally. The practice manager confirmed that they made contact with complainants by letter and by telephone. Complainants were offered a meeting with the practice manager in order to discuss their concerns.

Are services responsive to people's views? (for example, to feedback?)

No action



We were told that three complaints had been received at the practice within the last 12 months. We looked at the practice's complaint folder and saw that detailed information was recorded regarding these complaints including the outcome of any investigation.

Staff spoken with were knowledgeable about how to handle a complaint. Staff confirmed that any complaints received would be sent to the registered manager who was the complaints lead.



Are services well-led?

Our findings

Governance arrangements

Systems were in place for monitoring and improving the quality of services provided for patients. Risk assessments were in place to mitigate risks to staff, patients and visitors to the practice.

The practice had policies and procedures in place to support the management of the service, and these were readily available for staff to reference. However, the practice had not developed a duty of candour policy. Staff had been given a number of policies during their induction to the practice. Staff had also signed a document to confirm that they had read these policies and the employee handbook. We were told that when these policies were reviewed they were discussed at staff meetings. We looked at the minutes of staff meetings for 2015 and 2016 and could not see any documentary evidence to demonstrate that discussions had been held regarding policies.

Leadership, openness and transparency

The practice owner did not work at this practice but was available by phone and would visit the practice if required. The registered manager who was also the practice manager worked at the practice on a daily basis. Staff were aware of their roles and responsibilities and were also aware that the registered manager held the majority of lead roles within the practice. Staff told us that the registered manager was approachable and helpful.

Staff told us that they worked well as a team, provided support for each other and were always praised for a job well done. 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 culture of the practice was open and supportive. However we noted that dentists did not always attend practice meetings. We were told that they were able to inform the registered manager of any areas for discussion at these meetings. Minutes of meetings, although brief were available for review. These minutes did not record any learning outcomes or details of discussions held regarding complaints, accidents, incidents or the practice's policies and procedures.

Complaints systems encouraged candour, openness and honesty. However, the practice had not developed a duty of candour policy and there was no information on display for patients to see. The registered manager confirmed that they would develop this policy and discuss this with staff.

Learning and improvement

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 available for all staff.

All dentists we spoke with had an understanding of the latest GDC standards for the dental team.

The practice had a plan in place to audit quality and safety and was carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. We saw that infection control audits were completed on a six monthly basis. Other audits included radiography, health and safety, waste and record cards. Although we noted that hygienists and dental therapists were not carrying out record card audits to monitor the quality of their record keeping. Although we noted that the hygienist and dental therapist were not completing record card audits.

We saw that staff meetings were held and were usually minuted. However, the minutes of meetings seen for 2016 were not detailed. Minutes of meetings did not demonstrate that learning from complaints, accidents, audits or the findings from satisfaction surveys were discussed with staff.

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

The practice had systems in place to seek and act on feedback from patients including those who had cause to complain. Patients had various avenues available to them to provide feedback, for example; there were comments/compliments slips available for completion in the waiting area. Satisfaction surveys were given to patients on a continual basis; patients were able to contact the practice via their website to leave comments or ask questions. We looked at the results of the satisfaction surveys for 2016. We saw that these forms were not dated. Positive feedback was recorded on the surveys seen. We were told that it was difficult to obtain feedback from patients as they generally

No action



Are services well-led?

stated that they were happy with the service and did not wish to fill in a survey. The registered manager told us that they discussed the results of satisfaction surveys and comments slips with staff as appropriate. However the minutes of staff meetings seen did not demonstrate that patient feedback had been discussed. The registered manager said that recently only informal discussions had been held and minuted as it had been difficult to involve all part time staff at these meetings.

Staff we spoke with told us that they felt supported and involved at the practice. Staff said that they would speak with the registered manager if they had any issues they wanted to discuss. We were told that the registered manager was open and approachable and always available to provide advice and guidance.