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# The Ropewalk Dental and Implant Suite

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 10 May 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**

The Ropewalk is a small dental practice close to the centre of Nottingham. The practice is located on the ground floor, with one treatment room. The practice was first registered with the Care Quality Commission (CQC) in June 2011. The practice provides regulated dental services to both adults and children. The practice only provides private dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are - Monday and Tuesday: 9am to 5pm; Wednesday: 9am to 1pm; Thursday: 9am to 5pm; Friday 9am to 1pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively the Nottingham Emergency Dental Service offers a back-up when the dentist is unavailable through annual leave for example.

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

# Summary of findings

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

The practice has one dentist; two qualified dental nurses one of whom works on reception.

We received positive feedback from 20 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

**Our key findings were:**

- Feedback from patients provided about their experiences at the practice was positive. Patients said they were treated with dignity and respect.
- The dentist identified the treatment options, and discussed these with patients.
- Patients' confidentiality was maintained.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the practice system for staff appraisals to ensure there is documentary evidence that staff development and performance reviews had been completed.
- Review the availability of equipment 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.

# 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.

The practice made arrangements to receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts after the inspection.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available. However, the practice did not have an automated external defibrillator (AED). This situation was under review. Regular checks were being completed to ensure emergency equipment was in good working order.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance.

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.

All patients were clinically assessed by the dentist before any treatment began. The practice used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

**Are services caring?**

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

Patient confidentiality was maintained and dental care records were stored securely.

Patients said staff were welcoming, polite and professional. Feedback identified that the practice treated patients with dignity and respect.

Patients said they received good dental treatment and they were involved in discussions about their dental care.

Patients said they were able to express their views and opinions.

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

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

Patients said they were easily able to get an appointment. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice had good access for patients with restricted mobility, including ground floor treatment rooms and level access.

# Summary of findings

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays.

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.

Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

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

Patients were able to express their views and comments, and the practice listened to those views and acted upon them.

Staff said the practice was a friendly place to work, and they could speak with the dentist if they had any concerns.

# The Ropewalk Dental and Implant Suite

**Detailed findings**

## Background to this inspection

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

We carried out an announced, comprehensive inspection on 10 May 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the practice for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with three members of staff during the inspection.

We also reviewed the information we held about the practice and found there were no areas of concern.

We reviewed policies, procedures and other documents. We received feedback from 20 patients about the dental service.

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

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

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

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

The practice recorded and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in June 2009 this being a minor sharps injury to a member of staff. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had a policy for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) which had been updated in July 2015. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although they were aware how to make these on-line.

Records at the practice showed there had been no significant events in the 12 months up to the inspection visit. A dental nurse said the practice had no records of significant events as there had been nothing to record.

The practice had not made arrangements to receive Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Following the inspection the practice informed the Care Quality Commission (CQC) that they had signed up to receive MHRA alerts.

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

The practice had a safeguarding policy for children and guidelines from the General Dental Council (GDC) n safeguarding vulnerable adults. The safeguarding children policy had been reviewed in March 2016. The policy identified how to respond to and escalate any safeguarding concerns. Discussions with staff showed that they were aware of the safeguarding policy and knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The relevant contact telephone numbers were available in the safeguarding file.

The dentist was the identified lead for safeguarding in the practice. They had received enhanced training in child protection and safeguarding vulnerable adults to support them in fulfilling that role. Training for safeguarding both adults and children had been updated on 1 May 2016. We saw the practice had a safeguarding file which contained all of the relevant information should there be any concerns relating to safeguarding.

There was a policy and risk assessment to assess the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy had been reviewed and updated in May 2016. This policy directed staff to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. Data sheets from the manufacturer to inform staff what action to take if an accident occurred for example in the event of any spillage were available on a disc in the practice.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 20 November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in March 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. Practice policy was that only dentists handled sharp instruments.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) The bins were out of reach of small children as identified in the guidance.

Copies of the practice's sharps policy and how to deal with sharps injuries were displayed in the clinical areas of the practice.

Discussions with a dental nurse and a review of patients' dental care records identified the dentist was using rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin

# Are services safe?

rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We saw the practice had a plentiful supply of rubber dam kits with a non-latex product being used to avoid the possibility of a latex allergy reaction in a patient.

**Medical emergencies**

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. All three staff members had completed an emergency first aid at work course and were the designated first aiders for the dental practice.

The practice did not have an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Following the inspection the practice sent a copy of the practice risk assessment for the AED. The risk assessment identified the nearest AED to use in an emergency was less than three minutes away. The risk assessment also identified the practice was keeping the need for an AED under review.

Staff at the practice had completed basic life support and resuscitation training on 4 May 2016.

Additional emergency equipment available at the practice included: airways to support breathing, portable suction, and manual resuscitation equipment (a bag valve mask).

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies. Staff said that at monthly staff meetings different emergency scenarios were discussed, giving staff the opportunity to explore how those scenarios would be managed.

**Staff recruitment**

We looked at the staff recruitment files for all three members of staff all three staff members had been in post for many years and pre-dated the practice being registered under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw all members of staff had received a Disclosure and Barring Service (DBS). A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We discussed the records that should be held in the recruitment files with the dentist and saw the practice recruitment policy and the regulations had been followed.

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

The practice had both a health and safety policy and environmental risk assessments; both had been updated in February 2016. Risks to staff and patients had been identified and assessed. For example there were risk assessments for: slips, trips and falls; lone working; violence to staff and equipment.

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been reviewed in March 2016. The fire extinguishers had also been serviced in March 2016.

The practice had a health and safety law poster on display in the staff room. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

**Infection control**

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy which had been reviewed in March 2016. The policy was available to

# Are services safe?

staff working in the practice. The dental nurse had set responsibility for cleaning and infection control in the treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed the practice had not been completing regular six monthly infection control audits as identified in the guidance HTM 01-05. We discussed this with the principal dentist who provided evidence that audits had been completed by an external company in the past, although not on a six monthly basis. Following the inspection a comprehensive infection control audit was completed and sent to the Care Quality Commission (CQC). The provider identified that six monthly audits were scheduled going forward.

The practice had a policy for the disposal of healthcare (clinical) waste which had been reviewed in March 2016. The practice had a contract with a company to collect waste matter on a regular basis. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury. We saw this was out of date, but the practice sent evidence after the inspection this had been replaced.

The practice split the decontamination processes into two. Dental instruments were cleaned in the treatment room and they were sterilised in the small decontamination room. There was a clear split between the two areas with dirty and clean areas to discourage the risk of cross infection and contamination. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We saw that instruments were being cleaned and sterilised at the practice. Processes were as outlined in the published guidance (HTM 01-05).

The practice was using an ultrasonic bath which was located in the treatment room. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. After the ultrasonic bath Instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in the practice's autoclave (a device for sterilising dental and medical instruments).

The practice had one vacuum autoclave, which was designed to sterilise wrapped instruments. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

We examined a sample of dental instruments that had been cleaned and sterilised, using the illuminated magnifying glass. We found the instruments to be clean and undamaged.

The practice had a policy for dealing with blood borne viruses which had been reviewed in June 2015. There were records to demonstrate that staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice did not have any stored water. As a result there was no Legionella risk assessment. Legionella is a bacterium found in the environment which can contaminate water systems in buildings.

The practice was flushing the dental unit water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of bacteria developing.

**Equipment and medicines**

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice 1n March 2016. Fire extinguishers were checked and serviced by an external company and staff had been

# Are services safe?

trained in the use of equipment and evacuation procedures. The boiler and annual landlord's gas safety check was due in May 2016, and we saw that an appointment had been booked to carry out the service.

The practice had all of the medicines needed for an emergency situation, as identified in the current guidance: The British National Formulary (BNF) guidance for medical emergencies in dental practice. This was with the exception of Midazolam a medicine used in an emergency for patients having an epileptic seizure. Staff said they did not have the confidence to administer this medicine and would therefore telephone 999 and rely on the paramedic team.

Medicines were stored securely and there were sufficient stocks available for use. Medicines used at the practice were stored and disposed of in line with published guidance. However, the practice had Glucagon an emergency medicine used to treat people with diabetes who had low blood sugar. This medicine can be either stored in a refrigerator or at room temperature. If stored at room temperature the use by date was reduced. The practice Glucagon was stored at room temperature and was replaced following the inspection due to the reduced use by date. The principal dentist said that the new stock would be stored in the refrigerator in future.

**Radiography (X-rays)**

The practice had one intraoral X-ray machine located in the main treatment room (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw.

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had radiation protection supervisors (RPS) this being one of the dentists. The provider had appointed an external 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 Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Records showed the X-ray equipment had last been inspected in April 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years.

All patients were required to complete a medical history form and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. We saw that the Faculty of General Dental Practice (FGDP UK) guidelines: 'selection criteria for dental radiography' (2013) were being followed.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The practice held paper dental care records for each patient. They contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by the dentist. The care records showed a thorough examination had been completed, and identified risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form, or updated their details. The dentist then checked the medical history with the patient before treatment began. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentist used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums. In addition other screenings tools such as: bleeding on probing (BOP) and the six point pocket charting for recording and assessing periodontal (gum) disease.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients. For example some patients had been assessed as requiring three monthly appointments and were seen accordingly.

**Health promotion & prevention**

The practice had a large waiting room with some information for patients on display. There was assorted literature about the services offered at the practice.

The dentist explained that the practice saw very few children at the practice. The practice used the government document: 'Delivering better oral health: an evidence based toolkit for prevention' to guide their practice. This document had been produced to support dental teams in improving patients' oral and general health.

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, dentists had particularly highlighted the risk of dental disease and oral cancer.

**Staffing**

The practice had one dentist; two qualified dental nurses one of whom worked on reception. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We looked at staff training records and these identified that staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays) and safeguarding.

The practice had a small staff team with only three members. Records showed the last recorded staff appraisals were in 2013. Appraisals would usually be completed on an annual basis. Staff said that with such a small team development meetings and discussions around training needs tended to be more informal. It was clear that the staff supported each other and were a close knit team. However, there were no current records to identify staff performance had been appraised

**Working with other services**

The practice had templates for making referrals to other dental services when the needs of the patient indicated. For example referrals were made to local hospitals where patients had suspected oral cancer. The practice did not offer conscious sedation (using a medicine to help the

# Are services effective?

## (for example, treatment is effective)

patient relax). However, if a patient required this service, due to being very nervous or because of complex treatment; there were systems in place to refer to other dental professionals who did offer this service.

**Consent to care and treatment**

The practice had a consent policy which had been reviewed in July 2015. However, the policy did not clearly identify all of the issues involved in the consent process. Following the inspection the principal dentist sent us an updated copy of the consent policy which fully addressed the areas needed.

This included the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves; and Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Consent was recorded in the patients' dental care records. The dentist discussed the treatment plan, and explained the process, which allowed the patient to give their informed consent.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

Throughout the inspection we observed staff speaking with patients. We saw that staff were friendly, polite and professional. Our observations showed that patients were treated with dignity and respect.

The reception desk was located in the waiting room. We asked how patient confidentiality was maintained within reception. Staff said and we saw that computer screens could not be overlooked at the reception desk and if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen, such as an unused treatment room, or the dentist's office. Staff said that all details of patients' individual treatment were discussed in the privacy of the treatment room.

We observed staff greeting patients when they entered the practice. Patients were given a warm welcome and we saw staff speaking politely with several patients throughout the day. We saw that patient confidentiality was maintained at the practice. We spoke with two patients who said they were well treated and staff were quick to put them at ease. We saw that patients' dental care records were held securely.

**Involvement in decisions about care and treatment**

We received feedback from 20 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback was wholly positive with patients saying the staff were friendly, and patients were treated with respect. Some patients said in the CQC comment cards that they were involved in discussions and decisions about their dental care and treatment.

The practice offered private treatments and the costs were clearly displayed in the practice. Costs were also contained in the practice leaflet and on the practice website.

We spoke with one dentist about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence on the patient care records of how the treatment options and costs were explained and recorded before treatment started. Patients were given a written copy of the treatment plan which included the costs.

Where necessary the dentist gave patients information about preventing dental decay and gum disease. We saw several examples of this in patients' dental care records. Dentists had highlighted the particular risks associated with smoking and diet, and this was recorded in the dental care records. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The practice was located in a building close to the centre of Nottingham. There was metered roadside car parking available to the front of the practice. There were two ground floor treatment rooms.

The practice had separate staff and patient areas, to assist with confidentiality and security.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

We spoke with two patients during the inspection. Patients said that getting an appointment had been easy, and staff had been responsive to the patients' needs. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours. There were emergency slots at lunch time or the patient was offered an appointment at the end of the working day.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist.

**Tackling inequity and promoting equality**

The practice was situated on the ground floor. There were two treatment rooms, although only one was in use. Patients in a wheelchair or with restricted mobility could access treatment at the practice. There was level access for patients in wheelchairs or with young children in pushchairs throughout the practice.

The practice had good access to all forms of public transport with tram and bus stops located close by.

The practice had a toilet for the use of patients, and this had grab rails and an emergency pull cord to assist those with restricted mobility.

The practice had completed an access audit in line with the Equality Act (2010) this had been reviewed in March 2016. Details of the steps taken to improve access for all patients were identified. The practice did not have a portable hearing induction loop. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices. The dentist said this would be reviewed.

The practice had access to a recognised company to provide interpreters. Staff said that there were very few patients who could not speak English and therefore interpreting was not an issue.

**Access to the service**

The practice's opening hours are: Monday and Tuesday: 9am to 5pm; Wednesday: 9am to 1pm; Thursday: 9am to 5pm; Friday 9am to 1pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively the Nottingham Emergency Dental Service offers a back-up when the dentist is unavailable through annual leave for example.

One week before their appointment was due patients were sent a text message reminder that their appointment was due.

**Concerns & complaints**

The practice had a complaints procedure which had been reviewed in March 2016. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction.

From information received before the inspection we saw that there had been no formal complaints received in the 12 months prior to our inspection.

# Are services well-led?

## Our findings

**Governance arrangements**

We saw a number of policies and procedures at the practice and saw they had been reviewed and where relevant updated on an annual basis.

Staff said they understood their role and could speak with the dentist if they had any concerns. Staff said they understood the management structure at the practice. We spoke with one member of staff who said they were happy working at the practice, and there was good communication within the staff team.

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**

We saw that formal staff meetings took place on an occasional basis throughout the year. The agenda covered areas such as: information governance and significant events. A core training event was also highlighted which could be the review of a particular policy. Staff meetings were minuted and minutes were available to all staff.

We spoke with all of the staff at the practice who told us everyone got on well, and worked well together as a team. Staff said they could voice their views, and raise concerns. The dentist was available to discuss any concerns or clinical issues. Observations showed there was a friendly and welcoming attitude towards patients from staff throughout the practice. Discussions with staff showed there was a good understanding and knowledge of policies and procedures.

The practice had a whistleblowing policy which was had been reviewed in March 2016. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies.

**Learning and improvement**

We saw the practice completed audits throughout the year. This was for both clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved, particularly in respect of the clinical areas. Examples of completed audits included: Radiography (X-rays) had been completed in March 2016; a record card audit March 2015, and a pain and anxiety control audit March 2015.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period.

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

The practice had its own patient satisfaction survey which patients had last completed in March 2016. The results had been analysed and discussed with the staff team.

Patients requested both early morning appointments and weekend opening. In response the practice has made 8:30am and Saturday appointments available on request.