Titchfield Park Dental Clinic Ltd

Titchfield Dental Clinic

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 20 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

Titchfield Dental practice is a private dental practice located in premises close to the centre of Mansfield Woodhouse. There is car parking available to the front of the practice and this includes disabled parking. The practice had six treatment rooms, three of which were on the ground floor.

The practice was first registered with the Care Quality Commission (CQC) in November 2014. The practice provides regulated dental services to both adults and children. The practice provides mostly private treatment (95%). Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are - Monday: 8:30am to 5pm; Tuesday: 8:30am to 6pm; Wednesday: 8am to 5pm; Thursday: 8:30am to 5pm; Friday: 8:30am to 1:30pm. The practice is open one Saturday per month 8:30am to 12:30pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Dentists at the practice provide an emergency out-of-hours service.

The principal dentist is the registered manager. 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'.

Summary of findings

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 three dentists; one dental hygienist, two dental therapists; four qualified dental nurses; two trainee dental nurses; two receptionists and a practice manager.

We received positive feedback from 14 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:

- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect.
- The practice was well equipped and provided a relaxed atmosphere for patients.
- Dentists identified the different treatment options, and discussed these with patients.
- Patients' confidentiality was maintained.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- 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.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- 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's protocols for the use of rubber dam for root canal treatment giving due regard to guidelines issued by the British Endodontic Society.

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 received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

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, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

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

The practice had infection control procedures to ensure that patients were protected from potential risks.

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 a dental professional 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).

The practice made referrals to other dental professionals when it was appropriate to do so. There were clear procedures for making referrals in a timely manner.

Are services caring?

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

Patient confidentiality was maintained and electronic dental care records were password protected.

Patients said staff were friendly, 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.

Summary of findings

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

The practice had good access for patients with restricted mobility, including three ground floor treatment rooms and level access. The practice had completed a disabled access audit to consider the needs of patients with restricted mobility.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, and the practice leaflet.

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

Are services well-led?

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

There 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.

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 dentists if they had any concerns.

Titchfield Dental Clinic

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 20 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 to send information to CQC. This included the complaints the practice had received in the previous 12 months; their latest statement of purpose; and the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with eight 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 14 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 May 2015 this being when a patient tripped in the waiting room. The records showed the staff had taken appropriate action to ensure this particular risk was reduced. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). 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 the practice was aware of how to make these on-line.

Records at the practice showed there had been two significant events in the 12 months up to the inspection visit. The last recorded significant event had occurred in March 2016 this related to a dental instrument which broke in a patient's mouth. The record showed this had been well managed and appropriate action was taken. Learning points were shared with staff following the event.

The practice received 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. These were received by the practice manager who shared them with staff when appropriate.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. The policies had been reviewed in October 2015. The policies identified how to respond to and escalate any safeguarding concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The relevant contact telephone numbers were on display in the staff room. The practice also had documentation and advice relating to recognising dental neglect in children.

The practice manager was the identified lead for safeguarding in the practice. They had received enhanced training in child protection to support them in fulfilling that role. We saw evidence that all staff had received safeguarding training to level two within the 12 months up to the inspection.

The practice had a policy to guide staff in the use and handling of chemicals in the practice. The policy identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The risk assessments identified the steps to take 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. The manufacturers' product data sheets were available to staff on-line.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 11 January 2017. 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 November 2015. 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. Staff said that only dentists handled sharp instruments such as needles.

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.) We saw the sharps bins were located in a raised position within the treatment rooms. The guidance indicated sharps bins should not be located on the floor, and should be out of reach of small children.

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 dentists and a review of patients' dental care records identified the dentists were not always using

rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society recommend that dentists should be using rubber dams. A rubber dam is a thin 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 supply of rubber dam kits in the practice. If dentists were unable to place the rubber dam in certain situations, the dentist would therefore use alternative measures to protect the airway. We saw this had not always been recorded in the dental care record.

Medical emergencies

The dental practice had equipment to deal with 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. Two dental nurses had completed a first aid at work course which was within date. The dental nurses were the designated first aiders for the dental practice.

There was an automated external defibrillator (AED) held in the practice. 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. The AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

Staff at the practice had completed basic life support and resuscitation training on 17 February 2016.

Additional emergency equipment available at the practice included: airways to support breathing and portable suction.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Staff recruitment

We looked at the staff recruitment files for three staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all members of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the practice manager and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in October 2015. As part of this policy environmental risk assessments had been completed. For example there were risk assessments for: the use of electrical equipment, moving and handling, mercury handling and radiation (X-rays).

Records showed that new fire extinguishers had been installed in 2014; the practice manager said the manufacturer recommended this type of extinguisher only needed to be serviced once every ten years. Records showed all staff had completed fire training in March 2016. The practice manager said the trainer would be returning to work with staff in the future and would be focussing on fire evacuation drills.

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.

The practice had offered sedation in the past. However, with changes in the latest guidance the practice had ceased to offer sedation until all staff had been suitably trained. This was as identified in the guidance 'Standards for Conscious Sedation in the Provision of Dental care' 2015.

Infection control

Are services safe?

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 November 2015. The policy was available to staff working in the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures and documentation to evidence this.

Records showed that regular six monthly infection control audits had not been completed. The practice had been completing these audits on an annual basis. Following discussions with the practice manager the schedule of audits was changed to be six monthly going forward which was as recommended in the guidance HTM 01-05.

The practice had a clinical waste contract with a recognised company. We saw that clinical waste was collected on a regular basis. The 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 however this was not dated. The practice manager said they would contact the supplier to discuss, and follow their advice.

There was a decontamination room where dental instruments were cleaned and sterilised. There was a clear flow from dirty to clean areas to reduce the risk of cross contamination and infection. 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. A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice had one washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). However, this was not in use. The practice also had three ultrasonic baths. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's four autoclaves (devices for sterilising dental and medical instruments). The practice had two vacuum autoclaves, which were designed to sterilise wrapped instruments; and two specific autoclaves to sterilise a range of 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 the equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

We used the illuminated magnifying glass to check a random sample of dental instruments that had been cleaned and sterilised. We found the instruments to be clean and undamaged.

We saw 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 had a risk assessment for dealing with the risks posed by Legionella. This had been completed by an external contractor in October 2014 .Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance.

Equipment and medicines

Are services safe?

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 and was valid until July 2016.

The practice had all of the medicines needed for an emergency situation, as identified in the British National Formulary (BNF). Medicines were stored securely and there were sufficient stocks available for use. The practice had an emergency medicine called Glucagon. Glucagon is a hormone which helps to raise blood glucose levels when necessary in patients who have diabetes. This medicine should be stored in a refrigerator to preserve the use by date. If not stored in a refrigerator the use by date would be reduced. This was brought to the attention of the principal dentist and the practice manager who took appropriate action to ensure the Glucagon remained effective.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Radiography (X-rays)

The practice had a Radiation Protection file which contained all of the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). There was also a dental cone beam computer tomography (known as a CT) which is a specialised type of X-ray machine used when regular dental or facial X-rays were not sufficient. This machine was particularly useful for patients who were receiving dental implants.

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 a radiation protection supervisor (RPS) this being the principal dentist. 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 to be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and only by qualified staff.

Records showed the X-ray equipment had last been inspected in October 2014. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years to ensure it is safe and working correctly.

The practice used digital X-rays, which allowed the image to be viewed almost immediately, and relied on lower doses of radiation. This therefore reduced the risks to both the patients and staff.

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.

The practice had systems in place to regularly check the quality of the radiograph (X-ray image).

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. They contained information about the patients' assessments, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental professionals. The dental 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 electronically. This was done using an iPad and allowed the patient to provide an electronic signature. Details were then transferred directly into the patient's dental care records. The dentist was able to check 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 dentists 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.

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 the timescales for recalling patients; prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart); and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had a variety of information for patients in the waiting room. This was in leaflet form and through posters. Services offered at the practice were identified and there was information for parents about caring for their children's teeth.

The practice had two dental therapists. Dental therapists are dental professionals who work under direction from a dentist. The therapists would see children at the practice. Children were assessed on an individual basis to check their risk of dental decay. This resulted in children being offered fluoride application varnish and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This 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 three dentists; one dental hygienist, two dental therapists; four qualified dental nurses; two trainee dental nurses; two receptionists and a practice manager. 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), infection control, and safeguarding.

Records at the practice showed that appraisals had been completed for all staff. Staff completed a personal development plan after their appraisal to identify training needs for the coming year. The practice manager said appraisals were completed on an annual basis for all staff usually during July. We saw evidence that appraisals for staff had taken place. We also saw evidence of new members of staff having an induction programme.

Working with other services

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. The practice had a policy for making

Are services effective?

(for example, treatment is effective)

referrals to other services which had been reviewed in October 2015. The policy identified when and how to make referrals and had a section on making urgent referrals for patients who had oral cancer.

These referrals were tracked and we saw evidence that referrals had been made promptly.

Consent to care and treatment

The practice had a consent policy which had been reviewed in October 2015. The policy made reference to valid consent, informed consent and the ability to consent. The practice also had a policy regarding adults who lacked capacity and this made reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. All staff at the practice had completed training in the MCA.

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

Discussions with dentists identified they were aware of 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.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The reception desk was located within the waiting room. We asked how patient confidentiality was maintained at reception. Staff said 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 X-ray room. Staff said that all details of patients' individual treatment were discussed behind closed doors in the treatment rooms.

We observed staff members throughout the day. We particularly noted how staff spoke with patients and if they were polite, friendly and professional. We observed that staff were approachable and spoke to patients with dignity and respect. We saw that patient confidentiality was maintained at the practice. We asked two patients about confidentiality. Both said they had never had an issues or concern. Computer screens could not be overlooked at the reception desk. We saw that patients' dental care records were password protected and held securely.

Involvement in decisions about care and treatment

We received feedback from 14 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 about the clinical and staffing aspects of the practice was very positive with patients saying the staff were approachable and patients were treated with respect. Several patients commented positively about the quality of the treatment they had received. Some patients said on the CQC comment cards that the dentists involved them in discussions and decisions about their dental care and treatment.

The practice offered mostly private treatments and the costs were clearly displayed in the practice and on the practice website.

We spoke with two dentists about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence in 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 dentists 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 patients' 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 premises close to the centre of Mansfield Woodhouse. The practice had its own large car park and this included disabled parking. The practice had six treatment rooms, three of which were on the ground floor.

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 was a sufficient supply of instruments to meet the needs of the practice.

We spoke with four patients during the inspection. Patients said they had no problem getting an appointment that suited them. Patients said reception staff were welcoming and friendly. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The computerised system automatically allocated different time slots for different treatments.

Tackling inequity and promoting equality

There was an equal opportunities policy which had been reviewed in October 2015.

The practice was situated over two floors. There were three ground floor treatment rooms, so patients in a wheelchair or with restricted mobility could access treatment at the practice. All treatment rooms were large enough to manoeuvre a wheelchair. The practice had purchased a slide board to help patients move from their wheelchair to the dental chair and back again.

The practice had good access to all forms of public transport being situated on a main road with bus stops and the local train station being located close by.

The practice had a ground floor toilet adapted for the use of patients with mobility problems. The toilet had support bars, grab handles and an emergency pull cord. Taps on the hand wash sink were lever operated.

The practice had completed an access audit in line with the Equality Act (2010). This identified the practice was fully compliant with legislation relating to access in the Equality Act. The practice had a portable hearing induction loop in reception to assist patients who used a hearing aid. The Equality Act required where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices. There was designated car parking for patients with restricted mobility close to the disabled access. A doorbell at this entrance allowed patients to summon staff assistance if required.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said that there had not been any need to use this service so far.

Access to the service

The practice's opening hours were: Monday: 8:30am to 5pm; Tuesday: 8:30am to 6pm; Wednesday: 8am to 5pm; Thursday: 8:30am to 5pm; Friday: 8:30am to 1:30pm. The practice was open one Saturday per month from 8:30am to 12:30pm.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Dentists at the practice provided an emergency out-of-hours service.

The practice routinely telephoned patients the day before their appointment to remind them their appointment was due.

Patients who were not registered with the practice who were in pain or required emergency treatment would also be seen the same day if they rang for an emergency appointment.

Concerns & complaints

The practice had a complaints procedure which had been reviewed in October 2015. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction.

Information about how to complain was contained in the practice leaflet and on the practice website.

From information received before the inspection we saw that there had been three formal complaints received in the 12 months prior to our inspection. We saw documentation which identified these complaints had

Are services responsive to people's needs?

(for example, to feedback?)

been dealt with in a timely manner. Learning points from complaints had been identified and shared with staff. We also saw that an apology and an explanation had been given to the patients concerned.

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 within the previous seven months. The practice manager identified that all policies were updated on an annual basis.

We spoke with staff who said they understood their role and could speak with either a dentist or the practice manager if they had any concerns. Staff said they understood the management structure at the practice. We spoke with two members of staff who said they were happy working at the practice, and they said the staff worked well as a 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

There was a practice manager in post who was a qualified dental nurse, and who also had a level three diploma in practice management.

We saw that staff meetings were scheduled for once a month throughout the year. The agenda covered areas such as: significant events, infection control, and health and safety. Staff meetings were minuted and minutes were available to all staff.

We spoke with several staff at the practice who told us there was a good team ethos at the practice. Staff said they could voice their views, and raise concerns, and were encouraged to do so at team meetings. Dentists were available to discuss any concerns and there was support available regarding clinical issues. Observations showed there was a friendly and welcoming attitude towards patients from staff throughout the practice. Discussions with different members of the team showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. A copy of the whistleblowing policy was on display on the staff room noticeboard.

Learning and improvement

We saw that audits were completed 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: an audit of referrals completed in April 2016, radiography (X-rays) and infection control.

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 a patient satisfaction survey which was completed on an annual basis. We saw the results were analysed and points raised by patients were discussed with the staff team. The practice kept a log of positive feedback received from patients. This gave the practice the opportunity to share positive comments with staff and to consider where and how it was succeeding.

Patients had requested later opening times, and had commented positively about the iPads used to collect patients' medical histories in reception.

The practice used the NHS Friends and Family (FFT) for children seen at practice. The responses within the boxes were analysed on a monthly basis. Feedback from patients by means of the FFT provided positive responses with respondents saying they would recommend the practice to their family and friends.