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Duffield Road Dental Care

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 2 February 2017 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

Duffield Road Dental Care is located in premises situated in the northern outskirts of the city of Derby. there are two treatment rooms one of which is situated on the ground floor. The practice provides mostly private dental treatments (60%) There is a small car park for dental patients outside the practice and there is a dedicated disabled parking spot.

The practice provides regulated dental services to both adults and children. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours were – Monday: 9 am to 8 pm; Tuesday: 9 am to 5:30pm; Wednesday: 9 am to 2:30 pm; Thursday: 9 am to 5:30 pm and Friday: 9 am to 1 pm. The practice was also open alternate Saturdays: 9 am to 1 pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients can telephone the NHS 111 telephone number. An NHS out-of-hours dentistry service also operates in Derby.

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

Summary of findings

The practice has three dentists; four qualified dental nurses including the practice manager; and one receptionist.

Before the inspection we sent CQC 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 received responses from 43 patients through both comment cards and by speaking with them during the inspection. Those patients provided positive feedback about the services the practice provides. Among the themes we identified from patient feedback were that the reception staff were friendly, confidentiality was respected, appointments were convenient, dentists were caring and explained what was happening and the options for treatment and that the premises were clean and well equipped. Several patients said they had been coming to the practice for many years and were very satisfied.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- The systems to record accidents, significant events and complaints, learning points from these were recorded and used to make improvements.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- There were effective systems at the practice related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002.
- The practice had a consent policy including reference to the Mental Capacity Act 2005.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect and were able to get an appointment that suited their needs.
- Dental care records demonstrated that the dentists involved patients in discussions about treatment options.
- The practice offered a sedation service for patients. Sedation at the service carried out safely and was in line with the national guidance.
- Patients' confidentiality was protected within the practice.
- 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 about a colleague's practice.
- 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, medical oxygen and emergency medicines.

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

- Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and consider installing a hearing induction loop to assist patients and visitors who used a hearing aid.
- Review staff training to ensure that dental nursing staff who are assisting in conscious sedation have the appropriate training and skills to carry out the role giving due regard to guidelines published by The Intercollegiate Advisory Committee on Sedation in Dentistry in the document 'Standards for Conscious Sedation in the Provision of Dental Care 2015

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?

No action

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

There were systems for recording accidents, incidents and complaints.

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.

There were effective systems at the practice related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

The practice had emergency medicines and medical oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

When patients received sedation this was done safely with a consultant anaesthetist overseeing the procedure. Sedation was carried out in line with national guidance.

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 was visibly clean and 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?

No action

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

All patients were clinically assessed by a 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).

Discussions about treatment options were recorded in dental care records.

All staff were supported to meet the requirements of the General Dental Council (GDC) in relation to their continuing professional development (CPD).

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).

There was a consent policy which made reference to the Mental Capacity Act 2005.

Summary of findings

Are services caring?

No action

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.

Feedback from patients identified staff were friendly, and treated patients with care and concern. Patients also said they were treated with dignity and respect and had no concerns with regard to confidentiality at the practice.

There were systems for patients to be able to express their views and opinions and the practice encouraged patients to do so.

Are services responsive to people's needs?

No action

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

Patients who were in pain or in need of urgent treatment could usually get an appointment the same day. There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays

The practice had a ground floor treatment room which allowed easy access for patients with restricted mobility. The practice did not have an induction hearing loop to assist patients who used a hearing aid.

Interpreters were readily available for patients whose first language was not English.

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?

No action

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. Staff said they felt well supported and there were systems for peer review and clinical discussion.

The practice had a system for carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. The practice was able to demonstrate that learning and improvements had resulted from the audit process.

Policies and procedures were reviewed annually.

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

Duffield Road Dental Care

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 2 February 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked 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 reviewed the information we held about the practice and found there were no concerns.

We reviewed policies, procedures and other documents. We received feedback from 43 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 had systems for recording and investigating any accidents, significant events and complaints. The practice had an accident book to record any accidents to patients or staff. The last recorded accident had been in August 2016 when a staff member accidentally cut their finger. We saw that appropriate action had been taken with regard to all recorded accidents.

The practice had not needed to make any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they were aware how to make these reports.

The records identified there had been one significant event in the twelve months leading up to this inspection. There were forms in the practice for recording any significant events and recording learning points. The most recent significant event occurred in March 2016 and related to a patient becoming unwell in the practice. Appropriate action had been taken and the situation was dealt with as a medical emergency. This had been discussed in a staff meeting on 7 March 2016.

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. The practice received these via e mail with the most recent received in January 2017 related to an issue with a medicine used to treat Hepatitis B.

The practice did not have a Duty of Candour policy. However, the practice manager was aware of the need to be open and honest and to offer apologies when things went wrong. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Discussions with the practice manager identified there had been no examples of apologies needing to be given due to errors in the practice. Discussions with the practice manager identified they knew when and how to notify CQC of incidents which caused harm.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children which had been reviewed in May 2016. The policy identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers and flow chart for protection agencies were available for staff both within the policy and in each treatment room. 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 practice manager said there had been no safeguarding referrals made by the practice.

The principal dentist and practice owner were the identified leads for safeguarding in the practice. They had received training in child protection and safeguarding vulnerable adults to level two in March 2016. We saw evidence that all staff had completed safeguarding training to level two during 2015 and 2016.

The practice had a statement for staff giving guidance on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were risk assessments for all products and there were copies of manufacturers' product data sheets. Data sheets provided information on how to deal will spillages or accidental contact with chemicals and advised what protective clothing to wear. The COSHH file had been reviewed in September 2016 and was located in the practice manager's office.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 15 January 2018. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a risk assessment for dealing with sharps injuries which was available in the practice manager's office. It was practice policy that only dentists' handles needles and needles were not re-sheathed. The practice used a recognised system for the safe management of sharps. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 where they were accessible to dentists

but not to patients. Sharps bins were signed and dated, the National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care' advise – sharps boxes should be replaced every three months even if not full. The fact that the boxes were signed and dated had allowed staff to identify when the three month expiry date had been reached.

Discussions with the principal dentist identified they were using rubber dams when providing root canal treatment to patients. Guidance from the British Endodontic Society is that rubber dams should be used whenever possible. A rubber dam is a thin, square 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 (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dams, the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We saw the practice had a supply of latex free rubber dam kits available.

Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and medical oxygen which were located in a secure central location. We checked the medicines and found they were all in date. There were systems in place to check expiry dates and monitor that equipment was safe and working correctly.

There was a first aid box which was located in the stock room. We saw evidence the contents were being checked regularly.

There was an automated external defibrillator (AED) at 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. We saw there were records to demonstrate the equipment was checked regularly to ensure it was working correctly.

All staff at the practice had completed basic life support and resuscitation training in January 2017. We saw certificates that had been issued to staff following this training.

Additional emergency equipment available at the practice included: airways to support breathing, manual resuscitators and oxygen masks for both adults and children.

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 five 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.

We saw that the records and information required by the regulations was present in the staff files. For example we saw that every member of staff had received a Disclosure and Barring Service (DBS) check. Practice policy was that each staff members' DBS status was checked on an annual basis during their appraisal to ensure there had been no changes. We discussed the records that should be held in the recruitment files with the principal dentist.

Monitoring health & safety and responding to risks

The practice had a risk based approach to health and safety with a comprehensive health and safety policy. The policy had been reviewed in May 2016 and identified the principal dentist as the lead person who had responsibility within the practice for different areas of health and safety. As part of this policy each area of the practice had been risk assessed to identify potential hazards and identify the measures taken to reduce or remove them.

Records showed that fire extinguishers had been serviced in May 2016. The practice had a fire risk assessment which had been completed by an external company. The risk assessment identified the steps to take to reduce the risk of fire. The risk assessment had been reviewed in July 2016. We saw there was an automatic fire alarm system installed with smoke detectors throughout the premises. Fire

evacuation notices were displayed for staff and patients outlining the action to take if a fire occurred. Records showed the practice held an annual fire drill with the last one completed on 2 February 2016.

The practice had a health and safety law poster on display in the kitchen. 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.

A Business Continuity Plan was available in the practice and a copy was held off site. This had last been reviewed and updated in March 2016. The plan identified the steps for staff to take should there be an event which threatened the continuity of the service. A list of emergency contacts formed part of the plan, and were displayed in the decontamination room for staff reference.

The practice offered a sedation service on an occasional basis. The sedationist was a consultant anaesthetist at the local hospital. When carrying out sedation, the sedationist brought their own equipment and medicines to be able to carry out the sedation safely.

The practice provided an intravenous sedation service (using a medicine introduced via a vein to help the patient relax). Sedation was carried out by the anaesthetist and the principal dentist supported by a dental nurse.

Staff said sedation was most often used to support patients during surgical procedures such as fitting an implant. In April 2015, the Royal College of Surgeons and the Royal College of Anaesthetists published guidance on 'Standards for Conscious Sedation in the Provision of Dental care.' We saw the practice were working towards meeting the newer standards. The practice was meeting the standards set out in the previous guidance: Conscious Sedation in the Provision of Dental Care (Department of Health 2003). Patients were assessed at an initial appointment which allowed time for them to consider the risks and benefits of the sedation procedure as explained by the principal dentist. This also gave the opportunity for patients to withdraw if they so wished. Patients were provided with written guidance for before and after the sedation. The practice required that an escort come with the patient on the day that sedation was scheduled. This was to safeguard the patient afterwards and on their way home. The escort was formally briefed by the practice staff on their duties. The sedationist was supported by trained staff and resuscitation equipment was available. We noted that dental nurses had not completed immediate life support training. Dental nurses involved in sedation should have completed this training. The principal dentist said arrangements would be made for nurses to complete an immediate life support training course. Sedation was achieved with a single medicine called Propofol.

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 was available to staff in the practice manager's office. 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. The head nurse was the lead for infection control at the practice. We saw that they had received additional training to help them carry out that role.

Following a staff training course regular six monthly infection control audits had been introduced during 2016. Before this audits had been completed annually. The dates of the last three audits were: June 2015, May 2016 and December 2016. This was as recommended in the guidance HTM 01-05. The latest audit had scored 99% and an action plan was not necessary.

The practice had a clinical waste contract, and waste matter was collected regularly. 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 and a bodily fluids spillage kit both of which were in date.

There was one decontamination room where dental instruments were cleaned and sterilised and then bagged, date stamped and stored. 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. The practice was latex free to avoid any risk to staff or patients who might have a latex allergy.

A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice had an ultrasonic cleaner. An ultrasonic cleaner is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a solvent solution. After cleaning, instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had two autoclaves which were designed to sterilise dental 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. However, the records relating to the ultrasonic cleaner demonstrated that this piece of equipment was not functioning correctly. We discussed this with the principal dentist and arrangements were made to take the ultrasonic cleaner out of commission until it had been checked and serviced.

There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received boosters when required. Records showed that blood tests to check the effectiveness of the inoculation had been taken. 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 risks associated with Legionella had been assessed. This assessment had been completed by an external contractor in April 2016 and was due for renewal in April 2018. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had taken steps to reduce the risks associated with Legionella with regular flushing of dental water lines as identified in the relevant guidance. We saw documentary evidence to identify that staff had been trained and quarterly dip slides had been completed. Dip slides are a means of testing the microbial content (bacteria) in a liquid through dipping a sterile carrier into that liquid and monitoring any bacterial growth. Discussions with staff and a review of the records showed that a positive dip slide in August 2016 had not been followed up with a second dip slide to demonstrate measures taken had been effective. The head nurse said the dip slide would be repeated as a matter of urgency.

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 had been completed on electrical equipment at the practice in July 2016 and was identified for renewal in July 2017. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in September 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced and validated in September 2016.

The practice kept a log of prescription numbers to monitor the security of the prescription pads and maintain an audit trail. Prescription pads were not pre-stamped which added to their security and the stamp was held securely.

Radiography (X-rays)

There was a Radiation Protection file which contained the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth).

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. 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 be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Are services safe?

The practice had critical examination documentation for the X-ray machines. Critical examinations are completed when X-ray machines are installed to document they have been installed and are working correctly.

Records showed the X-ray equipment had been inspected in January 2015 and September 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence confirmed the HSE had been informed in 2004.

Both X-ray machines were fitted with rectangular collimation therefore the Ionising Radiation Regulations (Medical Exposure) Regulations 2000 (Regulation 7) were being followed. Rectangular collimation is a specialised metal barrier attached to the head of the X-ray machine.

The barrier has a hole in the middle used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient receives and the size of the area affected.

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.

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.

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. Dental care records contained information about the assessment, diagnosis, and treatment. The care records showed a thorough examination had been completed, and identified any risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form on an electronic tablet which put information directly into their electronic dental records. Returning patients updated their information which was reviewed with the dentist in the treatment room. The patients' medical histories included any health conditions, medicines being taken, whether the patient might be pregnant or 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. The dentists were using BPE for all patients other than children younger than seven years.

We saw the dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the 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 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

There were leaflets and posters to demonstrate good oral hygiene techniques and provide patients with information and guidance. There were free samples of toothpaste for patients available in the practice.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. The use of fluoride varnish was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. There were copies of this document available in the practice. Discussions with staff showed they had a good knowledge and understanding of 'delivering better oral health' toolkit.

We saw several examples in patients' dental care records that the dentist had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, the dentist had particularly highlighted the risk of dental disease and oral cancer. The dental care records contained an oral cancer risk assessment. In some dental care records we saw the risk assessments for caries (tooth decay) and periodontal disease (gum disease) were also recorded.

We noted that with regard to smoking cessation another local agency offering this service was identified in the practice. Patients were signposted to this service. This was in line with NICE guidelines: Oral health promotion: general dental practice (NG30).

The practice produced a quarterly newsletter which gave positive messages about oral health. The January 2017 newsletter focussed on sugar and provided information about the amount of sugar in different food and highlighted the steps taken by the dental profession to tackle the issue of sugar and tooth decay.

Staffing

The practice had three dentists; four qualified dental nurses including the practice manager; and one receptionist. 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.

Records within the practice showed there were sufficient numbers of staff to meet the needs of patients attending the practice for treatment.

We looked at staff training records for clinical staff to identify that they 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.

Are services effective?

(for example, treatment is effective)

Training records for clinical staff were clear and we saw copies of training certificates and CPD details for relevant staff during the inspection. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, and safeguarding.

Records at the practice showed that all staff had received an annual appraisal. This was completed with the principal dentist and practice manager. We saw evidence of new members of staff having an in-depth induction programme which included a probationary assessment to ensure that learning and knowledge had been embedded.

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. We saw the practice referred to other local dental services and to the local hospital.

Children or patients with special needs who required more specialist dental care were referred to the community dental service. The practice made also referrals for NHS orthodontic treatment (where badly positioned teeth are repositioned to give a better appearance and improved function)

Referrals were made to the Maxillofacial department at the local hospital or a local practice with a contract for minor oral surgery for difficult wisdom tooth removal and other more complicated minor oral surgery. For patients with suspicious lesions (suspected cancer) referrals were sent through to the hospital. We saw this was within the two week window for urgent referrals.

Consent to care and treatment

The practice had a patient consent policy which had been reviewed in May 2016. There was also a policy for the Mental Capacity Act 2005 (MCA) which had been reviewed in February 2017. 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. Discussions with the practice manager showed an understanding on the MCA and how it might apply to dentistry.

The practice used the standard NHS FP17DC form to record NHS patients' consent. This form recorded both consent and provided a treatment plan. The dentists discussed the treatment plan with the patients and explained the treatment process. This allowed the patient to give their informed consent. A hard copy of the consent form was given to the patient. Private patients were treated in a similar way though the practice's own treatment plan was used and signed.

We saw how consent was recorded in the patients' dental care records. An audit in 2016 had identified that verbal consent was not always being recorded as having been obtained. As a result a prompt had been introduced and this had seen a marked improvement. Dentists had recorded the discussions held with patients and this led them to make informed choices about their treatment and give valid consent.

We talked with dental staff about their awareness 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. We saw that staff had an understanding of Gillick competency. Records showed that most staff had completed training in legal and ethical issues which included Gillick competency.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed staff speaking with patients. We saw that staff were polite, and had a friendly and welcoming manner. We saw that staff spoke with patients with due regard to dignity and respect.

The reception desk was located within the waiting room. We asked reception staff how patient confidentiality was maintained at reception. Staff said that details of patients' individual treatment were never discussed at the reception desk. In addition if it was necessary to discuss a confidential matter, there were areas of the practice where this could happen such as the practice manager's office.

We saw examples that showed patient confidentiality was maintained at the practice. For example we saw that computer screens could not be overlooked at the reception desk. Patients' dental care records were held securely and were computer password protected. Patients told us they did not have any concerns about their confidentiality being breached in the practice.

Involvement in decisions about care and treatment

We received positive feedback from 43 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection, and by speaking to patients in the practice during the inspection. Among the themes we identified from patient feedback were that the reception staff were friendly, confidentiality was respected, appointments were convenient, dentists were caring and explained what was happening and the options for treatment and that the premises were clean and well equipped. Several patients said they had been coming to the practice for many years and were very satisfied.

The practice offered mostly private dental treatments (60%) and the costs of private treatments were clearly displayed in the waiting room. If patients were receiving treatment they were given a treatment plan which included the costs.

We spoke with dentists about how patients had their diagnosis and dental treatment discussed with them. Some dentists but not all demonstrated in the patient care records how the treatment options and costs were explained and recorded. Patients were given a written copy of the treatment plan which included the costs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

There were two treatment rooms one on the ground floor to allow patients with restricted mobility access to treatment. Car parking including disabled parking was available in the practice car park to the front of the premises.

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.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. The practice made specific appointment slots available for patients who were in pain or required emergency treatment.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The appointment book also identified where patients were being seen in an emergency.

Tackling inequity and promoting equality

The practice had an equality and diversity policy which made reference to the Equality Act (2010) and gave staff guidance on treating patients without prejudice or discrimination. The policy had been reviewed in May 2016.

The ground floor treatment room was accessible for wheelchair users. The ground floor treatment room was large enough for patients to manoeuvre a wheelchair into the room.

The practice had one ground floor toilet for patients to use. This was compliant with the Equality Act (2010).

The practice did not have a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

The practice used a recognised company to provide interpreter services for patients who could not speak English. The practice also used the on-line google translate service.

Access to the service

The practice's opening hours were – Monday: 9 am to 8 pm; Tuesday: 9 am to 5:30pm; Wednesday: 9 am to 2:30 pm; Thursday: 9 am to 5:30 pm and Friday: 9 am to 1 pm. The practice was also open alternate Saturdays: 9 am to 1 pm.

The practice had a website: www.duffieldroaddental.com. This allowed patients to access the latest information or check opening times or treatment options on-line.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 telephone number. An NHS out-of-hours dentistry service also operated locally and the contact details were recorded on the answerphone message.

The practice operated a text message reminder service for patients who had appointments with the dentist 48 hours before their appointment was due.

Concerns & complaints

The practice had a complaints policy which explained how to complain and identified time scales for complaints to be responded to. The policy had been reviewed in May 2016. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the complaints policy.

Information about how to complain was displayed in the patient information file in the waiting room.

From information reviewed in the practice we saw that there had been two formal complaints received in the 12 months prior to our inspection. One complaint related to materials provided by a third party rather than the dentist. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient when required.

Are services well-led?

Our findings

Governance arrangements

We saw a number of policies and procedures at the practice these had been reviewed at various times in the twelve months up to this inspection.

We spoke with staff who said they understood the structure of the practice. Staff said if they had any concerns they would raise these with either the practice owner or the practice manager. We spoke with four members of staff who said they liked working at the practice.

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

Leadership, openness and transparency

We saw that full staff meetings at this practice were scheduled for every six to eight weeks throughout the year. Staff meetings were minuted and minutes were available to all staff.

Discussions with staff identified they felt valued and part of a team. Staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

At the time of the inspection the practice did not have a policy relating to the duty of candour. However, we were sent a copy of the newly written policy the following day. This directed staff to be open, honest and to offer apologies when things had gone wrong. Discussions with staff showed they understood the principles behind the duty of candour. There had been no examples where the duty of candour policy had been used.

The practice had a whistleblowing policy which had been reviewed in May 2016 identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. This was both internally and with identified external agencies. A copy of the policy was available in the practice manager's office.

Learning and improvement

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Regular six monthly infection control audits and audits of radiography (X-rays) were completed every six months. The radiography audits checked the quality of the X-rays including the justification (reason) for taking the X-ray and the clinical findings which had been recorded in the dental care records. The practice had audited their dental care records for each clinician and this highlighted that verbal consent was not always recorded as having been received in the dental care records. As a result this had been discussed in October 2016 and the issue had been addressed by introducing a prompt.

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 are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

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

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. Information in the practice showed nine patients responded in December 2016. 100% of patients provided positive feedback with all patients who responded saying they would recommend the practice to family and friends. A poster in the waiting room provided patients with a response to FFT feedback.

The latest information on the NHS Choices website showed 18 patients had responded and 100% said they would recommend the practice to their family and friends. There were eight patient reviews recorded on the NHS Choices website, three within the 12 months before this inspection. Six were positive reviews. We noted the practice had not responded to the patient comments on the NHS Choices website.

Are services well-led?

The practice operated its own patient satisfaction survey. The latest survey had been between October 2016 and November 2016. Analysis of the results showed 30 patients had responded and action had been taken in response to comments received.