

## Nationwide Healthcare

# Normanton Road Family Dental Centre

### Inspection Report

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### Overall summary

We carried out an unannounced comprehensive inspection on 10 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

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

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

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

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

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

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

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

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

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

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

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

### **Background**

The practice is located on two floors of premises situated in the Normanton area of Derby to the south of the city centre. The practice provides mostly NHS dental treatments (90%). There is a pay and display car park approximately 200 yards from the practice. There are eight treatment rooms one of which is located on the ground floor.

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 are – Monday to Saturday: 9 am to 6 pm.

Access for urgent treatment outside of opening hours is by telephoning the NHS 111 telephone number.

The practice manager 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 is registered with the Care Quality Commission (CQC) as a partnership.

The practice has seven dentists; three qualified dental nurses; four trainee nurses; and two receptionists. Some dental nurses also worked on the reception desk.

We received feedback from 29 patients about the services provided. This was by speaking with patients and through comment cards left at the practice during the inspection.

## Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- Staff were not able to demonstrate they had learnt from accidents and significant events to reduce the likelihood of them being repeated.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The radiation protection file did not contain all of the information that it should.
- Patients said they had no problem getting an appointment that suited their needs.
- 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 the dentist involved them in discussions about treatment options and answered questions.
- Patients' confidentiality was protected.
- 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.
- The management of waste at the practice had not been monitored and evaluated.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the systems and processes for identifying, managing and monitoring risk; for example significant event management, infection control procedures, record-keeping.
- Review how consent is recorded within patient dental care records to ensure that the discussion outlining options and likely consequences are recorded.

# 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.

During the inspection we identified several documents such as: X-ray certification, and training records which were not available for inspection at the practice.

The practice was visibly clean.

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. 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.

X-ray machines were fitted with rectangular collimation to ensure that doses of radiation arising from exposures were kept as low as reasonably practicable

No action



### 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 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).

In relation to consent the discussion of options and likely consequences were not always clearly recorded in patient care records.

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 had systems in place for making referrals to other dental professional when it was clinically necessary.

No action



# Summary of findings

## 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.

Feedback from patients identified staff were friendly, and treated patients with care and concern. Patients also said they were treated with dignity and respect.

There were systems for patients to be able to express their views and opinions.

No action



## Are services responsive to people's needs?

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.

The practice had ground floor treatment rooms available which allowed easy access for patients with restricted mobility. A disabled access audit in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility. The practice had an induction hearing loop to assist patients who used a hearing aid.

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

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

No action



## Are services well-led?

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

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

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. Policies and procedures had been kept under review.

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 a senior colleague if they had any concerns.

No action



# Normanton Road Family Dental Centre

## 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 unannounced, comprehensive inspection on 10 October 2016. We received information of concern before this inspection in relation to: infection control, there not being enough dental instruments and dignity and respect. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

We reviewed policies, procedures and other documents. We received feedback from 29 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 accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. The practice had an accident book. Documentation showed the last recorded accident had occurred in May 2016 this being an inoculation injury to a member of staff. An inoculation injury is an injury caused by needles, blades or any other instrument that posed a risk of injury through cutting or pricking. The accident had been analysed and the practice policy for inoculation injuries had been followed. We noted there had been six such injuries in the year up to this inspection.

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

Records at the practice showed there had been two significant events in the twelve months leading up to this inspection. The last recorded event had occurred in October 2015 and related to an equipment malfunction. There had been six inoculation injuries to staff members in the twelve months up to this inspection. We saw that none had been recorded as a significant event. Minutes of staff meetings did not record that inoculation injuries had occurred or demonstrate any staff discussion or training. Following the inspection we were sent evidence that the sharps protocol had been re-written. We were sent photographic evidence that new posters relating to sharps had been put in place which gave staff guidance and reminded them of practice policy. We also received a copy of the team meeting minutes for 14 October 2016 where sharps and inoculation injuries had been discussed.

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 centrally by the provider analysed and sent out to the practice if relevant. The most recent alert had been received in September 2016 and related to the use of Glucogen (this is a hormone which helps to raise blood glucose levels). Appropriate action had been taken as a result.

Discussions with dentists showed they were not clear about the yellow card system. This being a system operated through the 'British National Formulary' (BNF) and allowed health care professionals to report any serious medicine interactions or adverse reactions suffered by patients. Following the inspection the practice manager sent CQC evidence that all dentists had received an e mail informing them of the details of the yellow card scheme.

We saw examples in the complaints file that patients had been told when they were affected by something that goes wrong, given an apology and informed of any actions taken as a result. The provider knew when and how to notify CQC of incidents which caused harm.

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

The practice had policies for safeguarding vulnerable adults and children. The policies had been reviewed and updated in December 2015. The policies identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers and a flow chart were available for staff. 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 if and when necessary.

The principal dentist was the identified lead for safeguarding in the practice. They had received enhanced training in child protection to level two in September 2016 to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two during June 2015. The practice manager said this training was being rebooked for staff that needed refresher training.

The practice had a records relating to the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The records formed part of the health and safety policy and had been reviewed and updated in December 2015. This identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were electronic copies of manufacturers' product data sheets which were kept on a computer disc. Data sheets provided information on how to deal with spillages or accidental contact with chemicals and advised what protective clothing to wear.

# Are services safe?

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 22 November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a recapping needles policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in January 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. Practice policy was amended following this inspection so that only dentists handled sharp instruments. We saw there were devices in each clinical area for the safe removal and disposal of needles and sharps.

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 on the back of work surfaces in clinical areas which followed the guidance which indicated sharps bins should not be located on the floor, and should be out of reach of small children. Following the inspection we were sent photographic evidence that sharps bins had been wall mounted in clinical areas.

Discussions with dentists identified the dentists 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 dam 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 rubber dam kits in the practice.

## Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and

found they were all within their use by date. There were systems in place to check the use by dates of medicines and equipment to monitor that medicines and equipment were safe and working correctly.

There was a first aid box which was located centrally with the emergency medicines. Two members of staff had completed a first aid at work course. We saw certificates dated 18 February 2016 which evidenced the staff members had completed the training.

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.

All staff at the practice had completed basic life support and resuscitation training on 25 October 2015. We saw that arrangements had been made for all staff to receive refresher training in the coming weeks.

Additional emergency equipment available at the practice included: airways to support breathing, oxygen masks for adults and children 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 six 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. The practice was routinely taking references for new



# Are services safe?

members of staff and was keeping a record of interview notes. 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 December 2015. The policy identified the practice manager as the lead person who had responsibility within the practice for health and safety. As part of this policy, environmental risk assessments had been completed. For example there were risk assessments for: fire, use of the autoclaves, and working with biological agents.

Records showed that fire extinguishers had been serviced in August 2015. The practice had a fire risk assessment which had been reviewed in January 2016. Records showed the practice held a fire drill twice a year, with the last one completed on 26 July 2016. Records showed that fire safety was a regular agenda item at staff meetings. The fire evacuation procedure was displayed prominently on the upper floors of the premises. The practice had an automatic fire detection system which was being upgraded during this inspection visit.

The practice had a health and safety law poster on display behind the reception desk. 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 this had been reviewed and updated on 1 December 2015. A copy was held off site. This identified the steps for staff to take should there be an event which threatened the continuity of the service.

## **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.

Before the inspection the Care Quality Commission (CQC) received information of concern relating to infection control. Specifically that there were not enough dental instruments and the systems and processes involved in cleaning dental instruments were not always followed.

We saw there was an adequate supply of dental instruments, and there were sufficient instruments to meet the needs of the practice. Dentists demonstrated there were additional supplies of dental instruments in the stock area of the practice. When asked all of the dentists said there was not a problem with the number of dental instruments available.

The practice had an infection control policy which had been reviewed in December 2015. A copy of the policy was available to staff in the policy folder. 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.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last audit was completed on 8 September 2016.

Throughout the practice there were posters stating: 'It's OK to ask our staff if they have cleaned their hands and put on fresh gloves and masks.'

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored away from patient areas while awaiting collection. We saw the stored waste was more than could be accommodated by the waste bin and loose bags were stored beside the bin. The waste bin was not locked and therefore clinical waste was not secure. The practice manager telephoned to arrange an early collection to take away the full clinical waste bags during the inspection. Following the inspection we were sent evidence that a second storage bin had been ordered and was due for delivery the following week. The practice manager said this would solve the identified problem.

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 spillage kits for mercury and bodily fluids. Both spillage kits were within their use by date.



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There was one decontamination room where instruments were cleaned and sterilised. 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 had latex free gloves available to avoid any risk to staff or patients who might have a latex allergy.

The practice had a washer disinfectant however; this was not plumbed in and therefore was not in use, a washer disinfectant is a machine for cleaning dental instruments similar to a domestic dish washer. As a result the practice used manual cleaning to clean dental instruments. We saw a long handled brush as identified in the guidance (HTM 01-05) was used for manual cleaning. However, the water temperature was not being routinely measured. HTM01-05 identifies that water temperature should not exceed 45 degrees centigrade during manual cleaning as higher temperatures bind protein to the instruments. Following the inspection CQC were sent evidence that all staff had received additional training regarding the decontamination protocol. The decontamination policy had also been reviewed and shared with staff.

After cleaning instruments were rinsed and examined using an illuminated magnifying glass. We saw this was not working during the inspection, but a new one was purchased and installed before the end of the day. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had three autoclaves. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

During the inspection we identified there were no signs giving instruction to staff on the correct procedure for manual cleaning. Following the inspection we were sent photographic evidence that the signage had been put in place in the decontamination room.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained. However, we did establish that dental hand pieces were only being oiled daily rather than every time they were used, which would extend their life time.

The practice had a policy for dealing with blood borne viruses. There were records to demonstrate that clinical 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 August 2015. However, during the inspection we saw no evidence the practice had implemented the recommendations that lead staff should complete Legionella awareness training. Following the inspection we were sent copies of training certificates for two dentists showing they had completed this training on 20 October 2016. 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

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 in October 2015. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in March 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced in August 2015.

The practice had all of the medicines needed for an emergency situation, as recommended in the British National Formulary (BNF).

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

## 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. During the inspection we identified certain information was missing from the records. This documentation had been held at the

## Are services safe?

organisation's head office and was therefore not available in the practice during the inspection. Following the inspection we were sent copies of staff training records in relation to radiography and a list of staff authorised to operate the X-ray equipment and their relevant qualifications, a log of the X-ray machinery on site, critical examination documents, servicing details and copies of the local rules for each machine.

The practice had nine 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. However, it was not clear that the local rules were specific to each piece of equipment. Following the inspection the practice sent copies of specific local rules for each X-ray machine. 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 dentists at the practice. 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.

Following the inspection the practice sent us photographic evidence that all intraoral X-ray machines were fitted with rectangular collimation in line with current guidance. 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.

Following the inspection the practice sent critical examination documentation for all of the X-ray machines. This documentation had been held at the organisation's head office and was not available during the inspection. Critical examinations are completed when X-ray machines are installed to document they have been installed and are working correctly.

Records showed that five X-ray machines had been inspected in March 2016. We saw that four machines were installed within the two years before this inspection and therefore did not require inspection. 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. Following the inspection the practice sent us documentary evidence that the HSE had been notified on 4 June 2002 that X-rays were being taken at the premises. This was following the change of ownership of the practice.

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.

# 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 and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified with risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form. 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 the dentist used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentist 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. A poster in the waiting rooms explained the NICE guidelines in respect of recalls.

### Health promotion & prevention

The practice had two waiting rooms, one on each floor of the building. There were posters and leaflets relating to good oral health and hygiene on display. There were posters and information relating to oral cancer on display in the downstairs waiting room. A flat screen television was available in the waiting room. This gave positive dental health messages on 'Smile TV.' The providers own information programme. We saw how the television could provide information in a variety of languages if required.

Children seen at the practice were offered fluoride varnish application 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 has been produced to support dental teams in improving patients' oral and general health. Discussions with the dentist showed some did not have a good knowledge and understanding of the 'Delivering Better Oral Health' toolkit. Following the inspection the practice manager sent evidence that all dentists had undergone a refresher session with regard to the '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. We saw that dentists had received training in smoking cessation and were aware of other local services that could support patients to give up smoking.

### Staffing

The practice had seven dentists; three qualified dental nurses; four trainee nurses; and two receptionists. Some dental nurses also worked on the reception desk. Following 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. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, and safeguarding.

Records at the practice showed that all staff had an annual appraisal. As part of the appraisal process staff completed a review of their own learning objectives and these were

# Are services effective?

## (for example, treatment is effective)

discussed during the process. We also saw evidence of new members of staff having an in-depth induction programme with regular review meetings scheduled with the practice manager.

### **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, orthodontic practices and to the Intermediate minor oral surgery service (IMOS).

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. This was usually through the IMOS service. Children or patients with special needs who required more specialist dental care would be referred to the community dental service.

The practice also did not offer orthodontics (where badly positioned teeth are repositioned to give a better appearance and improved function). Children who required multiple extractions were referred to community services.

Where there was suspected oral cancer the referral was fast tracked to the local Queens Medical Centre (QMC). These referrals were made in-line with the recommended two week window for urgent suspected cancer referrals.

The practice referral system was monitored through a tracking system on the computer. Patients were routinely offered a copy of the referral letter for their records and information.

### **Consent to care and treatment**

The practice had a consent policy which made explored the issue consent and offered guidance to staff. The Mental Capacity Act was explored within the policy and this included making best interest decisions as identified in the MCA. 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.

Dentists had a general understanding of the MCA but had not received any specific training. Following the inspection we were informed the dentists had arranged to attend MCA training in November 2016.

We saw how consent was recorded in the patients' dental care records. As most patients received NHS treatment the FP17 DC form which was the standard NHS consent form used to record consent, provide the patient with the treatment plan and identify the costs involved. The practice kept a supply of specific consent forms for different treatments, and a specific consent form for private treatment. During discussions dentists were able to describe the consent process and described the discussions detailing the options and identifying the likely consequences. However, we noted a number of examples where consent had not been well recorded in dental care records. We saw examples where the discussion outlining options and likely consequences around consent were not clearly recorded. Therefore it was not obvious within the records that patients had been able to give informed consent.

We saw that models and leaflets were available to assist dentists in explaining the treatment options to patients.

The consent policy made reference to obtaining consent from children under the age of 18. We talked with dental staff about this and identified they were aware of Gillick competency however, their knowledge and understanding identified they required further training. Following the inspection we were sent evidence that dentists had been updated with regard to 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**

During the inspection we observed staff speaking with patients. We saw that staff were polite, and had a professional approach. 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 were necessary to discuss a confidential matter, there were areas of the practice where this could happen such as an empty treatment room.

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 password protected.

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

We received positive feedback from 29 patients about the services provided. This was through CQC comment cards left at the practice during the inspection, and by speaking to patients in the practice during the inspection.

The practice offered mostly NHS treatments (90%) and the costs were clearly displayed in the practice, in waiting rooms and in reception. The fees for private treatment were available on request.

We spoke with the dentist about how patients had their diagnosis and dental treatment discussed with them. We saw limited recording in the patient care records of how the treatment options and costs were explained and recorded. Patients were given a written copy of the treatment plan which included the costs. We noted that patients' dental care records identified the diagnosis and treatment options discussed with patients.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice was located on two floors of premises situated in Derby to the south of the city centre. There was a pay and display car park 200 yards from the practice.

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

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To facilitate this, the practice had a sit and wait system from 9 am to 11 am and from 2 pm to 4 pm.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. However, we saw that new patients were allocated ten minutes for their initial consultation which would make the appointment rushed.

### Tackling inequity and promoting equality

The practice had an equal opportunities policy and an equality and diversity policy. Both of which had been reviewed in December 2015. Staff had completed training for treating patients with dignity and respect as part of their induction with refresher training dated

There were two treatment rooms situated on the ground floor although only one was in use. This allowed patients with restricted mobility easy access treatment at the practice. The treatment room was large enough for patients to manoeuvre a wheelchair or push chair. Access for patients using a wheelchair or with a pushchair was via a ramped access at the main door of the practice.

The practice had one ground floor toilet for patients to use. This was fitted with bars to assist patients with restricted mobility. However, there was no emergency alarm for patients to summon assistance if needed. The toilet was fitted with a lever operated tap and hot air hand dryer.

The practice had completed an access audit in line with the Equality Act (2010) this had been reviewed and updated in December 2015. The practice could accommodate patients with restricted mobility; with level or ramped access from the street to the ground floor treatment rooms. The

practice had 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 had access to a recognised company to provide telephone interpreters. Additionally NHS England provided information on accessing interpreters and this included the use of sign language. Several staff members spoke languages other than English and staff said communicating with patients did not usually pose a problem.

### Access to the service

The practice's opening hours were – Monday to Saturday: 9 am to 6 pm. This allowed patients who were in full time employment or full time education the opportunity to access the service.

Access for urgent treatment outside of opening hours was by telephoning the NHS 111 number.

The practice operated a text message reminder service with patients who had appointments with the dental therapist. Patients received a text reminder three working days before their appointment was due. Staff also telephoned patients the day before their appointment.

The practice had a website at: [www.normantonroaddental.co.uk](http://www.normantonroaddental.co.uk). This allowed patients to access the latest information or check opening times or treatment options on-line. In addition information about the practice was available on the NHS Choices website: [www.nhs.uk](http://www.nhs.uk).

### Concerns & complaints

The practice had a complaints procedure which had been issued reviewed in December 2015. The procedure explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the complaint resolution policy.

Information about how to complain was displayed within the practice and was available in the practice leaflet.

There had been one verbal complaint received in the 12 months prior to our inspection. The documentation

# Are services responsive to people's needs?

(for example, to feedback?)

showed the complaint had been handled appropriately and an apology and an explanation had been given to the patient who returned to the practice and had their complaint addressed.



# 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 during December 2015. The practice manager identified that all policies were updated on an annual basis.

We spoke with staff who said they understood the structure of the practice and the wider organisation. Staff said if they had any concerns they would raise these with either the practice manager or one of the dentists. We spoke with two members of staff who said they liked working at the practice and they felt well supported within the practice.

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 in all area apart from the recording of the options and discussion around consent.

### Leadership, openness and transparency

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

Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing and underachieving policy which had been reviewed in December 2015. The whistleblowing policy 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.

The practice manager sent us a copy of the duty of candour policy following the inspection. This was dated 17 October 2016. The policy made reference to the General Dental Council's (GDC) 'standards for the dental team'. The policy led the practice to be open and honest in their dealings with patients and to offer an apology and explanation when things had gone wrong.

### 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: a review of fluoride application varnish completed in April and June 2016 and for review again in December 2016. An antibiotic prescribing audit had been completed between May and July 2016. The patient satisfaction survey was audited in May 2016 and was scheduled for re-audit in November 2016. This identified that patients were overwhelmingly satisfied with the service they received. An audit of radiographs (X-rays) had been completed in June 2016 and a second cycle completed in July 2016. This identified mostly high scores on the audit, although there were some action points identified which were shared with the relevant staff. A record keeping audit had been complete in July 2016, which had produced action points for improvements.

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) and safeguarding had been completed by all relevant staff.

Following the inspection the Care Quality Commission (CQC) were sent a duty of candour policy dated 17 October 2016 which had been produced from the General Dental Council's (GDC) guidance. This information led the practice to be open and honest in their dealings with patients and to offer an apology and an explanation when things had gone wrong.

A copy of the General Dental Council's (GDC) nine principles and the provider's own vision, mission and values were on display in the practice.

### 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

## Are services well-led?

was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. The latest information in the practice showed 301 patients responded. Feedback was overwhelmingly positive with 99% of patients who responded saying they would recommend the practice to family and friends. A poster in the waiting room gave patients feedback in relation to comments generated through the FFT box.

The latest figures displayed on the NHS Choices website identified that 352 patients had responded and 99% would recommend the practice to their friends and family. There had also been 11 patient reviews recorded on the NHS

Choices website in the year up to this inspection. Reviews were mixed with seven positive and four negative reviews. There had been 26 reviews posted prior to this, again being a mixture of positive and negative comments. Although there were more positive comments over all. We noted the practice had responded to the patient comments on the NHS Choices website.

The practice operated its own satisfaction survey on an on-going basis. The format of the survey was being altered to best fit the patient experience at the practice. The results of the last patient satisfaction survey were dated May 2016.