Durgan and Ashworth Dental Care Limited

Mydentist - High Street West - Glossop

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 5 September 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 in ground floor premises in the town of Glossop in north Derbyshire. There is road side parking close to the dental practice. There are three treatment rooms one of which was 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 had three dental chairs registered with the Care Quality Commission which meant up to three dentists could work at any one time seeing patients. The practice provides mostly NHS dental treatments.

The practice's opening hours are – Monday to Friday: 8 am to 8 pm. The practice is closed at weekends.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 telephone number. This information is also displayed on the practice front door.

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 an organisation.

The practice has six dentists; one dental hygienist; five qualified dental nurses; two trainee nurses; four receptionists and one practice manager.

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

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- 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.
- There were systems to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- 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.

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.

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.

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

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.

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).

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.

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.

Summary of findings

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.

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.

The practice had a ground floor treatment room 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.

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

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

Are services well-led?

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.

The practice had a robust 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.

Mydentist - High Street West - Glossop

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 5 September 2016. 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.

The practice manager sent additional information in the form of key policies, staffing information, the business continuity plan and maintenance details. This allowed the inspection team to begin analysing the information before the site visit.

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

We reviewed policies, procedures and other documents. We received feedback from ten 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. Documentation showed the last recorded accident had occurred in August 2016 this being a minor injury to a member of staff. This had been caused when a patient moved during treatment. The accident had been analysed and learning points recorded. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had not made any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they would be made through head office.

Records at the practice showed there had been one significant event during the past year. The last recorded event had occurred in July 2016 and related to a patient becoming unwell in the practice. This was not related to their dental treatment. The record showed all significant events had been analysed and discussed at staff meetings. We saw that incidents with both positive and negative outcomes were recorded and 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 by the practice manage analysed and discussed in staff meetings as appropriate. MHRA alerts were also monitored by head office and information was passed on to the practice manager as appropriate. The most recent alert had been received in July 2016 and related to child safety plugs for electric sockets. Appropriate action had been taken as a result.

Reliable safety systems and processes (including safeguarding)

The practice had comprehensive policies for safeguarding vulnerable adults and for safeguarding children. Both policies were due for review on 1 October 2016. The policies identified how to respond to and escalate any safeguarding concerns that staff might have. The relevant contact telephone numbers and a flow chart were available for staff and were contained within both policies and on display in the staff 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. Hoverer, if children were referred to the community service the practice also monitored to check they had attended and took appropriate action if they had not.

The practice manager was the identified lead for safeguarding in the practice. They had received enhanced training in child protection to level two in December 2015 to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two during 2015 and were due for an update in 2016.

The practice had risk assessments to give staff guidance on Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were hard copies of manufacturers' product data sheets and every computer in the practice had a link to on-line COSHH data sheets. Data sheets provided information on how to deal with spillages or accidental contact with chemicals and advised what protective clothing to wear. The practice manager had completed COSHH training in 2013.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 1 April 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. Practice policy was that only dentists handled sharp instruments. We saw there were devices in each clinical area for the safe removal and disposal of needles and sharps. A dental nurse had recently experienced a needle stick injury and we saw this had been managed in line with the policy. The dental nurse also gave a presentation to the staff team so they could learn from the incident.

Are services safe?

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 wall mounted 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.

Discussions with dentists and a review of patients' dental care records identified the dentists were using rubber dams when providing root canal treatment to patients. This was in line with guidance from the British Endodontic Society. 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 including latex free rubber dams. The head dental nurse described the practice as being latex safe with latex free gloves and rubber dams available throughout 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 in date. There were robust systems in place to check expiry dates and monitor that equipment was safe and working correctly. Before the inspection we were sent documentation which identified that regular checks of the equipment were being completed.

There were two first aid boxes in the practice one behind reception and one in the staff room. Two members of staff had completed a first aid at work course. We saw certificates to evidence the staff members had completed the training which was valid until 2018.

The practice had 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 in October 2015, and we saw this was booked again for Friday 9 September 2016.

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

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

Staff recruitment

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

We found that all members of staff had received a DBS check. The practice was routinely taking references for new members of staff and were 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 handbook which was given to each member of staff as part of their induction. The latest version of the handbook was dated December 2015.

Are services safe?

The practice manager was the lead person who had responsibility within the practice for different areas of health and safety. The health and safety handbook identified that environmental risk assessments had been completed. The practice had a work tracker to ensure risk assessments were updated. For example there were risk assessments for: fire, infection control and hazardous substances.

Records showed that fire extinguishers had been serviced in March 2016. The practice had a fire risk assessment which was reviewed annually, with the last review in April 2016. We saw there was an automatic fire detection system installed within the premises as well as emergency lighting. Records showed the practice held a fire drill twice a year, with the last one completed on 27 July 2016. Two members of staff were identified as fire marshals and had received training specific to this role. The training was valid until 2018 for one staff member and 2019 for the other.

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

The practice had a business continuity plan which had been updated in January 2016 and reviewed in March 2016. The plan gave detailed information on how threats to the service would be dealt with and managed to ensure continuity of the service. For example: if there was loss of electricity, heating, computers, or telephones. The plan guided staff in the steps to take to minimise the disruption to patients.

Infection control

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

The practice had an infection control policy which had been reviewed in December 2015. 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 29 April 2016 and scored 97%. The practice had produced an action plan to address the issues identified in the infection control audit.

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

There was one decontamination room. This was where dental 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 was latex free to avoid any potential latex allergy. As a result latex free gloves were available

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

The practice had one washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). This was a new machine and was waiting to be plumbed in. As an alternative the practice had one ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. After cleaning instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's two autoclaves (a device for sterilising dental and medical instruments). The practice had two steam autoclaves which were designed to sterilise unwrapped or solid dental instruments. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

Are services safe?

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.

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 April 2015. 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. Low use water outlets (taps) were being flushed regularly and records kept.

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 August 2016 with the certificate valid for three years. There was a Landlords gas safety certificate dated 24 June 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in August 2016. Records showed the autoclaves had also been serviced in August 2016.

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.

The practice had three 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 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.

Records showed the X-ray equipment had been inspected in May 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 of if there was a change of ownership. Documentary evidence dated 29 May 2009 confirmed this had been completed when Mydentist acquired 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.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held 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 which was repeated every two years. A form was used to capture any changes at visits within the two year window. If there were any significant changes patients were asked to complete a new 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 wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had one waiting room and posters and leaflets relating to good oral health and hygiene were on display. There was a flat screen television in the waiting room which provided the patients with information about the practice and services available.

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 they had a good knowledge and understanding of 'delivering better oral health' toolkit. We saw a copy of this document in the practice. Advice given included: brushing twice a day, using interdental brushes or floss and avoiding alcohol and tobacco.

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.

Staffing

The practice had six dentists; one dental hygienist; five qualified dental nurses; two trainee nurses; four receptionists and one practice manager. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

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

Records at the practice showed that all staff had an annual appraisal. As part of the appraisal process there was a goal setting process and a review of their own learning objectives and these were discussed during the process. We also saw evidence of new members of staff having an in-depth induction programme.

Working with other services

Are services effective?

(for example, treatment is effective)

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 department.

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. This was usually to a private dental service or to hospital. Children were referred to the community dental service if the practice was unable to meet their specific needs.

The practice referral system was monitored through a tracking system at reception. All referrals were recorded in a log and telephone calls were made to ensure referral letters had been received and check progress. Copies of all correspondence were scanned into the patients' dental care records.

Consent to care and treatment

The practice had a consent policy which had been reviewed in December 2015. The policy made reference to the Children's Act 1989 and the Mental Capacity Act 2005 (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. The policy outlined the issues relating to adults who lacked capacity. 'Best interest' decisions that could be taken on behalf of a person who lacked capacity where identified and there was detailed guidance to support staff.

We saw how consent was recorded in the patients' dental care records. The records showed the dentist had discussed the treatment plan with the patients, which allowed patients to give their informed consent. Both verbal and written consent were recorded within the dental care records. As most patients received NHS treatment the FP17 DC form which was the standard NHS consent form was used to record consent. Dentists gave examples of patients where consent was not straight forward, and explained the steps taken to ensure valid consent was received and recorded.

The consent policy made detailed reference to obtaining consent from children aged 16 to 17. We talked with dental staff about this and identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed a number of times when staff spoke with patients. We saw that staff were polite, friendly and had a caring and 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. The practice manager said that space was limited but if this was necessary arrangements could be made.

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 password protected and held securely.

Involvement in decisions about care and treatment

We received positive feedback from ten 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.

The practice offered mostly NHS treatments and the costs were clearly displayed in the practice, in treatment rooms and in reception. The fees for private treatment were also on display in the waiting room.

We spoke with dentists about how patients had their diagnosis and dental treatment discussed with them. The dentist 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. 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. I 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. There were posters in the practice explaining the NICE guidelines in respect of recalls for appointments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was located in premises in the centre of Glossop in north Derbyshire. There was road side parking close to the dental practice.

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. To facilitate this the practice made a specific appointment slots available for patients who were in pain. During the course of the inspection we saw a patient who was experiencing pain who had been seen at short notice.

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

Tackling inequity and promoting equality

The practice had an equality and diversity policy which had been reviewed in December 2015. This policy outlined the organisation's position with regard to treating all patients equally and providing opportunities for all patients to access services.

Patient areas were spread over two floors of the practice. Here was one treatment room situated on the ground floor. 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. There was a small ramp to the front door of the practice to assist wheel chair users and parents with pushchairs to gain access to the practice.

The practice had one ground floor toilet which had been adapted to meet the needs of patients with restricted mobility. The toilet was fitted with support bars and grab handles.

The practice had completed an access statement in line with the Equality Act (2010) this had been kept under review. The practice could accommodate patients with restricted mobility; with level access from the street to the ground floor treatment room. 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 NHS England who provided information on accessing interpreters and this included the use of sign language. Staff said the practice had some patients who used sign language and in response a member of staff had completed a sign language course. We saw the staff member's certificate which was dated 2 March 2015.

Access to the service

The practice's opening hours were – Monday to Friday: 8 am to 8 pm. The practice was closed at weekends.

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 number.

The practice operated a text message reminder service, and patients received a text reminder 48 hours before their appointment was due.

Concerns & complaints

The practice had a complaints procedures which had been reviewed in August 2016. The procedure explained how to complain and identified time scales for complaints to be responded to. The procedure included other agencies to contact if the complaint was not resolved to the patients satisfaction including NHS England, the independent complaints service and the Parliamentary Health Ombudsman.

Information about how to complain was displayed in the reception area.

From information received before the inspection we saw that there had been two formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patients. We also saw evidence that complaints had been discussed in staff meetings and learning shared with staff.

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 the year up to this inspection. 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. Staff said if they had any concerns they would raise these with either the practice manager or a dentist. We spoke with three members of staff who said they liked working at the practice and there was a close working team. Staff said they were proud to work at the practice, and there was a supportive approach from management 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 we saw contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

There was a practice manager who had been working as the practice manager since 2012.

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: significant events, infection control, and health and safety. Staff meetings were minuted and minutes were available to all staff. When there were learning points to be shared with staff we saw evidence these had been discussed and shared as appropriate.

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

Staff were aware of the duty of candour which directed staff to be open and to offer apologies when things had gone wrong.

The practice had a whistleblowing policy which had been reviewed in July 2016. The whistleblowing policy identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. The organisation had a whistle blowing telephone number which was available to all staff to raise issues internally if they had not been raised with the person's line manager. This was both internally and with identified external agencies. A copy of the policy was available on the notice board in the staff room.

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, the last of which was completed in April 2016. An audit of the use of prescriptions had been completed in July 2016 and audits of dental care records were dated July and September 2016. A radiography (X-ray) audit had been completed in April 2016.

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.

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. The latest information on the showed 20 patients had responded and 95% said they would recommend the practice to their family and friends. A poster in the waiting room provided feedback to patients on a monthly basis.

There had been no patient reviews in the year up to this inspection. However, two reviews prior to this time had both been positive. We noted the practice had responded to both patient comments on the NHS Choices website.

Are services well-led?

The practice operated its own satisfaction survey on an on-going basis. We saw the most recent audit had been in October 2015 and had been analysed in December 2015. The findings were positive and discussed with staff.

Within the practice there were forms which gave patients the opportunity to provide feedback about the practice using the QR reader app on their smartphones.