The Dental Suite

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Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 27 August 2015 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 Dental Suite was registered in August 2013 to provide dental services to patients in West Bridgeford and the surrounding areas in the county of Nottinghamshire. The practice provides private dental treatment. Services provided include general dentistry, dental hygiene, porcelain veneers, teeth whitening, crowns and bridges, root canal treatment, cosmetic dentistry and dental implants. The practice has a combined reception and waiting area on the ground floor and treatment rooms on the ground and first floor. The practice is open Monday to Friday 8:30 am to 5:30 pm. Early mornings, evenings and Saturday appointments were by appointment only.

The practice has six dentists, one hygienists/ therapists, four dental nurses and a practice manager. Dental nurses also act as receptionists.

The provider 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'. 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.

We viewed 51 Care Quality Commission (CQC) comment cards that had been completed by patients, about the services provided. We saw that all 51 comment cards had positive comments. Patients said they were happy with

Summary of findings

the service provided. In addition, we spoke with two patients who said they were happy with the dental service they were receiving. Patients said they were treated well at the practice. Patients said they were able to ask questions, and the dentist explained the treatment options and costs.

Our key findings were:

- The practice had systems for recording accidents, significant events and complaints. Learning from complaints and significant incidents were recorded and learning was shared with staff.
- The practice had provided training in safeguarding and whistle blowing for all staff, and staff were aware of these procedures and the actions required.
- There were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies.
- Emergency medicines and life-saving equipment were readily available.
- The practice followed the relevant guidance (Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Patients were involved in making decisions about their treatment, and options were identified and explored with them.
- Patients' confidentiality was maintained.
- The practice sought feedback from staff and patients about the services they received.

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

- Update the Disability Discrimination Act assessment with particular reference to the raised chairs in the waiting room and the need for a pull cord/ alarm in the patients' toilet.
- Carry out a cleaning audit with particular reference to high dusting and cleaning extractor fans.
- Update the audit of sedation which noted whether or not sedation had been uneventful but did not give any detail of adverse events, analysis of causes or lessons learned.
- Carry out and record regular checks of the refrigerator temperature where medicines and other clinical items were stored.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice had procedures for reporting accidents and significant events and learning points were shared with staff in team meetings.

Staff had been trained 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.

The practice had procedures and equipment for dealing with medical emergencies and staff had been trained to deal with any such occurrence.

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

Infection control procedures followed published guidance to ensure that patients were protected from potential risks. Equipment used in the decontamination process was maintained by a reputable company and regular frequent checks were carried out to ensure equipment was working properly and safely.

X-rays were carried out safely in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use.

The practice carried out intravenous sedation for nervous patients. Sedation was completed in line with published guidance from the Resuscitation Council.

Are services effective?

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

Patients were assessed before treatment began. This included completing a health questionnaire or updating one for returning patients who had previously completed a health questionnaire.

The practice specialised in treating nervous patients or those with a phobia about visiting the dentist. They had devised a nervous patient programme to help those patients.

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients.

The use of alcohol and tobacco together with dietary advice was given to patients to help improve their oral health.

The practice had sufficient numbers of qualified and experienced staff to meet patients' needs.

There were clear procedures for referring patients to secondary care (hospital or other dental professionals).

Staff were aware of the need for valid consent, and patient records reflected this.

Are services caring?

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

Staff were aware of the need for confidentiality and worked in a way that protected patients.

Patients were treated with dignity and respect, and staff were open and welcoming to patients at the practice.

Summary of findings

Patients said they were happy with the dental care they received, and had confidence in the staff to meet their needs.

Patients said they felt involved in their care, and were able to express their views and opinions.

Are services responsive to people's needs?

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

The appointments system was accessible and met patients' needs.

The practice was well equipped and had been refurbished over the past two years. The waiting room was spacious and comfortable and this helped patients relax before their treatment.

The practice had taken steps to meet the needs of patients with restricted mobility, with level access, a ground floor treatment room and car parking available close to the front door.

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.

The practice had a complaints policy and procedure, and patients' complaints were treated seriously and addressed.

Are services well-led?

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

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

Patients' views and comments were collected at regular intervals and action was taken to make improvements and address issues.

The Dental Suite

Detailed findings

Background to this inspection

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

We carried out an announced, comprehensive inspection on 27 August 2015. The inspection team consisted of two Care Quality Commission (CQC) inspectors and a dentist specialist advisor. Before the inspection we reviewed information we held about the provider together with information that we asked them to send to us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with six members of staff, including the management team.

Prior to the inspection we asked the practice to send us information which we reviewed. This included the complaints they had received in the last 12 months, their latest statement of purpose, the details of their staff members, their qualifications and proof of registration with their professional bodies.

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

During the inspection we spoke with two dentists, the practice manager and two dental nurses. We reviewed policies, procedures and other documents. We reviewed 51CQC comment cards that we had left prior to the inspection, for patients to complete, about the services provided at the practice. We also spoke with two patients.

We informed stakeholders, for example NHS England area team and Healthwatch that we were inspecting the practice; however we did not receive any information of concern from them.

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 procedures for investigating, responding and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in May 2014. This had been a needle stick injury to a member of staff. This had prompted a raising of awareness among the staff about needle stick injuries and how to avoid them. We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice manager said that there had been no RIDDOR notifications made. We saw the minutes of staff meetings which showed that health and safety matters had been discussed, and learning points shared.

In respect of significant incidents, discussions with a dentist identified they understood the concepts of reporting and learning from those incidents. However, they were not aware that the practice had a specific policy for this. We saw evidence that significant incidents were discussed in staff meetings and the learning was shared with other practices within the company.

Records showed that a complaint that had been received by the practice which had led to a review and improvement in record keeping.

Responses to patients concerns or complaints had been recorded, and showed an open approach. We saw examples of correspondence to patients where the complaints were well-handled and resolved. This openness and transparency with people using services, and taking steps to inform patients when things go wrong is known as a duty of candour. The practice had a policy in place for dealing duty of candour.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) and informed health care establishments of any problems with medicines or healthcare equipment. The practice manager demonstrated how the alerts were received and information was shared with staff if and when relevant. Information was shared across all three practices within the company, and the practice manager took the lead in sharing information.

The practice also participated in the yellow card scheme for reporting any adverse reactions to medicines to the MHRA. This would allow the practice to share with other practitioners across the country any adverse medicine reaction with a patient or among patients.

Reliable safety systems and processes (including safeguarding)

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 safeguarding vulnerable adults and children policy. The policies had been updated in April 2015. The policies included details of how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The practice had an identified lead member of staff for safeguarding both vulnerable adults and children. Training records showed that the safeguarding lead had completed safeguarding to level three. All staff at the practice had undertaken training in safeguarding adults and children to level two with the training having been completed during July and August 2015.

The practice had a policy and procedure to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. As a result the practice had identified potentially hazardous substances that it used. Each substance was identified and risk assessed. Steps to reduce the risks included the use of personal protective equipment for staff and patients and safe and secure storage of hazardous materials. The practice had data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally swallowed.

Are services safe?

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 27 May 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

Discussions with dentists and examination of patients' notes identified the dentists were using rubber dams when completing root canal treatments in line with best practice guidelines from the British Endodontic Society. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth during treatment.

Medical emergencies

There were emergency medicines and oxygen to deal with any medical emergencies. The medicines were as recommended by the 'British National Formulary' (BNF). We checked the medicines and found them all to be in date. We saw the practice had a system in place for checking and recording expiry dates of medicines.

There was an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. All emergency equipment and medicines were stored centrally with all staff being able to access them if required. Records showed all staff had completed basic life support and resuscitation training on 12 June 2015. The training included the use of the practice's AED. The practice manager said this training was updated annually for all staff.

Having the emergency medicines, AED and oxygen available when required met with the Resuscitation Council UK guidelines.

Discussions with staff identified they understood what action to take in a medical emergency. They were able to describe those actions in relation to various medical emergencies including a cardiac arrest (heart attack).

There was a first aid box stored in a central location. Records showed the first aid box was being checked weekly. The practice had designated first aiders, who had been trained to an appropriate level.

Staff recruitment

The practice had a recruitment procedure for appointing new staff. We looked at the personnel 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 personnel files. This includes: a recent photograph; proof of identity; checking the prospective staff members' 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).

We found that the practice recruitment policy and the regulations had been followed.

A review of documentation showed the practice had an induction system; this was personalised for each new staff member dependant on their job role.

There were sufficient numbers of suitably qualified and skilled staff working at the practice. A system was in place to ensure that where absences occurred they could be covered, usually by colleagues.

Monitoring health & safety and responding to risks

The practice had a health and safety policy and environmental risk assessments. Both of which had been reviewed in August 2015. Risks to staff and patients had been identified and assessed, and the practice had introduced measures to reduce those risks. For example a fire evacuation procedure; local rules for the use of X-ray machines and a legionella risk assessment.

The practice also had other specific policies and procedures to manage other identified risks. For example: An infection prevention and control policy, which had been reviewed in April 2015. Processes were in place to monitor and reduce these risks so that staff and patients were safe. Staff told us that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested, and records in respect of these checks had been completed.

Infection control

Infection control within dental practices must follow the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices.' This document sets out clear

Are services safe?

guidance on the procedures that should be followed; records that should be kept; staff training; and equipment that should be available. Following HTM 01-05 would comply with best practice.

The practice had an infection control policy which had been reviewed in April 2015. The policy described how cleaning was completed at the premises including the surgeries and the general areas of the practice. The policy directed staff to complete certain tasks and identified what was required. The practice employed contract cleaners to clean the public areas of the practice such as the waiting room, reception and toilets. We found some areas where cleaning had been missed such as high dusting, and the provider said they would discuss this with the contract cleaners. Dental nurses had set responsibilities for cleaning and infection control in each individual surgery. The practice had systems for testing and auditing the infection control procedures. In addition we found the extractor fan in decontamination room was in need of cleaning.

The practice routinely carried out infection control audits on a six monthly basis. We saw copies of audits dated October 2014 and April 2015. No action required from either audit.

The practice used sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) The bins were attached securely to the wall, and were located out of reach of small children. The health and safety executive (HSE) had issued guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013.' We found that the management of sharps within the practice followed this guidance.

The practice had a clinical waste contract, and waste matter was collected on a regular basis. Clinical waste was stored securely while awaiting collection. The clinical waste contract also covered the collection of amalgam (dental fillings) which contained mercury and was therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids. Both spillage kits expired in June 2018.

The practice had a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had defined dirty and clean areas to reduce the risk of cross contamination and infection. There was a clear flow of instruments through the dirty to the clean area. Staff wore personal protective equipment during the process to protect themselves from injury. These included heavy duty gloves, aprons and protective eye wear. However, there was an unused vacuum autoclave (designed to sterilize hollow or porous dental instruments) in the decontamination room, which took up some of the available work space.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display for reference. The instruments were cleaned using an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. After the ultrasonic bath Instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments). The practice also has a DAC machine (a DAC machine is a machine for cleaning and sterilizing dental hand pieces.) The practice manager said the DAC machine was not in use at the time of the inspection, although there were plans to bring it into service. The DAC machine was also taking up work top space in the decontamination room.

The practice had one non-vacuum autoclave in use. This was designed to sterilise non wrapped or solid instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with a date of sterilisation and an expiry date. We looked at a random sample of sealed instruments in the treatment rooms and found six examples of pouched instruments that did not have an expiry date. We brought this to the attention of the practice manager and the provider. The provider said the guidance within HTM 01-05 was not clear with regard to these specific items. However, the practice decided to treat them as if they had been autoclaved and applied a relevant date stamp.

We checked the equipment used for cleaning and sterilising was maintained and serviced regularly in accordance with the manufacturer's instructions. There were daily, weekly and monthly records to demonstrate the

decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

Staff said they wore personal protective equipment when cleaning instruments and treating people who used the service. Our observations supported this.

We checked a random sample of bagged instruments under the illuminated magnifying glass. All of the instruments were clean and free from any debris or obvious contamination.

Staff files showed that staff had received inoculations against Hepatitis B and received regular blood tests to check the effectiveness of that inoculation. People (staff) who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise the risk of contracting blood borne infections. A needle stick injury is a puncture wound similar to one received by pricking with a needle.

The needle stick injury policy was displayed in the decontamination room. A member of staff was able to describe what action they would take if they had a needle stick injury and this reflected the practice policy.

Records showed a risk assessment process for Legionella had been updated in April 2015. The Legionella risk assessments had been updated in July 2015. This was to ensure the risks of Legionella bacteria developing in water systems had been identified and measures taken to reduce the risk of patients and staff developing Legionnaires' disease. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The records showed the practice was flushing their water lines in the treatment rooms. Records showed waterlines were flushed for two minutes at the beginning and end of each session, and for 30 seconds between patients. This was in keeping with HTM 01-05 guidelines. These measures would reduce the risk of Legionella or any other harmful bacteria from developing in the water systems.

Equipment and medicines

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines. Portable appliance testing (PAT) took place on electrical equipment. With the last PAT tests having been completed in December 2014. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures. Records showed the fire extinguishers had been serviced annually with the last service in June 2015.

Medicines used at the practice were stored and disposed of in line with published guidance. There were sufficient stocks available for use. Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Emergency medicines, oxygen and an automated external defibrillator (AED) were available, and located centrally and securely for use in an emergency.

Radiography (X-rays)

X-ray equipment was located in each treatment room. 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 displayed in each area where X-rays were carried out.

The practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth) and one extra-oral (panoral) X-ray machine (extra oral X-rays show the whole mouth, and the full set of teeth.)

The practice had a radiation protection file which contained documentation to demonstrate the X-ray equipment had been maintained at the intervals recommended by the manufacturer. Records showed that the dates X-ray equipment was tested, serviced and if necessary repaired. The latest records showed X-ray machines had been serviced in March 2015.

The local rules identified the practice had a radiation protection supervisor (the registered manager) and a radiation protection agency, as identified in the Ionising Radiation Regulations 1999 (IRR 99). Their role was to ensure the equipment was operated safely and by qualified staff only. Staff members authorised to carry out X-ray procedures were clearly identified. The measures in place protected people who required X-rays to be taken as part of their treatment.

We discussed the use of X-rays with a dentist. This identified the practice monitored the quality of its X-ray images and had records to demonstrate this. This ensured the X-rays were of the required standard and reduced the risk of patients being subjected to further unnecessary

Are services safe?

X-rays. Patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where female patients might be pregnant. Patients' notes showed that information related to X-rays was recorded in line with current guidance from the Faculty of General Dental Practice (UK) (FGDP-UK). This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings.

Sedation services

Intravenous sedation services were provided in order to facilitate the treatment nervous and phobic patients. Two dentists were trained to perform sedation and on the day we were able to talk at length to one of them. During sedation practice the dentist was supported by at least two sedation trained dental nurses. The SAAD checklist was used as an aid to assessing services. SAAD is a dental charity dedicated to the advancement of knowledge in pain and anxiety control for dentistry. Systems and processes were in line with current guidelines and equipment and medicines in accordance with the Resuscitation Council Guidelines were readily available. These included a reversal agent should it be required. The sedation medicines were secured when not in use.

We saw that consent processes were robust and that this was reflected in the clinical notes. Assessment for suitability for sedation was conducted at a separate visit in advance of the treatment. This allowed time for the patient to understand information and withdraw consent if they so wished. Assessments included height, weight, blood pressure, heart rate and oxygen saturation as well as a detailed medical history. The assessment was repeated on the day of treatment to ensure that sedation remained appropriate for the patient.

Detailed information leaflets on pre sedation preparation, the conduct of sedation and post-operative instructions and the need for a chaperone were given to patients. A pulse oximeter was used to monitor the patient during sedation and blood pressure, heart rate and oxygen saturation levels are recorded. A pulse oximeter is a non-invasive way of measuring a person's oxygen saturation. Most commonly this would be a sensor placed on a thin part of the patient's body, usually a fingertip or ear lobe. It was the sedationist's responsibility to monitor and discharge the patient when recovery was complete. This occurred in the surgery as a separate recovery room was not available and appointment lengths were tailored to allow this. All staff were appropriately trained and maintained continuous professional development (CPD) in accordance with current guidelines. All staff involved in sedation had received training in dealing with emergencies. However, in house training, practising scenarios and confirming skills with local equipment were not taking place or recorded. An audit had started in 2014. This noted whether or not sedation had been uneventful but did not give any detail of adverse events, analysis of causes or lessons learned.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice assessed the patients at the start of each consultation. The assessment included a review of their soft tissues, their risk of developing decay which could lead to a crumbling of a tooth, a periodontal check (the supporting structures of the teeth and diseases and conditions that affect them) and taking a medical history at each visit. Medical histories included any health conditions, current medicines being taken and whether the patient had any allergies. If an X-ray was to be taken and the patient was female and of child bearing age, the possibility of being pregnant was also discussed. For returning patients the medical history focussed on any changes to their medical status.

The practice specialised in treating nervous patients or those with a phobia about visiting the dentist. They had devised a nervous patient programme, and one of the providers was a dental phobia certified dentist. If required sedation was available for nervous patients or those with a dental phobia.

We spoke with two dentists, and one dental nurse who said that each individual patient had their diagnosis discussed with them. Treatment options and costs were explained before treatment started. This was confirmed in several of the Care Quality Commission (CQC) comment cards, and in face to face discussions with patients. Where relevant, information about preventing dental decay was given to improve the outcome for the patient. The patient notes were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Discussions with two dentists showed they were aware of NICE guidelines, particularly in respect of recalls of patients, anti-biotic prescribing and wisdom tooth removal. These being the most current guidelines being followed. A review of the records identified that the dentist were following NICE guidelines in their treatment of patients.

Each treatment room had a large flat screen monitor so dentists could show patients their X-rays, photographs, or their treatment plan. This assisted the dentists in explaining treatment and diagnosis to the patients.

Public Health England had produced an updated document in 2014: 'Delivering better oral health: an evidence based toolkit for prevention'. Following the guidance within this document would be evidence of up to date thinking in relation to oral healthcare. Discussions with dentists showed they were aware of the 'Delivering better oral health 'document and used it in their practice.

We reviewed 51 Care Quality Commission (CQC) comment cards. All 51 contained positive comments. Only one made an additional negative comment, with reference to waiting times. Patients said they were very happy with the care and treatment they received. Dental staff kept patients informed, and they were able to ask questions.

Health promotion & prevention

We saw a range of literature in the waiting room and reception area about the services offered at the practice. There were free samples of toothpaste available for patients to take away.

A dental nurse said that patients were given advice on tooth brushing, and the use of Fluoride. The practice offered orthodontic treatment and patients were encouraged to maintain the oral health during orthodontic treatment.

The practice had a consultation room where clinical staff could speak with patients and review notes, X-rays or treatment plans. The consultation room was more comfortable than the treatment room, and provided a relaxing environment to hold discussions. This included health promotion discussions with the computer available to provide visual information.

We saw examples in patients' notes that advice on smoking cessation, alcohol and diet had been discussed. With regard to smoking dentists had highlighted the risk of periodontal disease and oral cancer. With regard to alcohol the patients' consumption was recorded (number of units of alcohol per week) although further discussion would be based on risk.

Staffing

The practice has six dentists, one hygienists/ therapists, four dental nurses and a practice manager. Dental nurses also act as receptionists. Prior to the inspection we

Are services effective?

(for example, treatment is effective)

checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We reviewed staff training records and saw staff were encouraged to maintain their continuing professional development (CPD) to maintain their skill levels. CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended.

The practice monitored staff training and training updates and refresher courses were provided. For example the practice had identified that training in basic life support was required, and had made this available to all staff.

The practice appraised the performance of its staff with annual appraisals. We saw evidence in staff personal files that appraisals had been taking place. We spoke with two members of staff who said they had an annual appraisal with the practice manager.

Staff said they felt well supported and that there was a strong team ethos at the practice.

Working with other services

The practice had systems in place to refer patients to other practices or specialists if the treatment required was not provided by the practice. For example referral for specialist treatments at the dental hospital if the problem required more specialist attention. However, staff said that those referrals often required the practice to chase them, as the hospital had lost paperwork or there had been delays in referrals being actioned at secondary care (hospitals and clinics particularly). The practice then monitored patients after their treatment to ensure they had received satisfactory treatment and had the necessary after care after treatment at the practice.

The practice had a dentist with a 'special interest' in endodontics (a branch of dentistry dealing with the cause, diagnosis, prevention and treatment of diseases of the dental pulp – the central part of a tooth). As a result they dealt with most endodontic referrals to the practice, and for complex cases there was a practice that specialised in endodontics who were available for support and back up.

Patients being referred for oral surgery would be referred to Nottingham Hospital (Queens Medical Centre). We saw examples of urgent two week referrals, when there were suspected cancer for example. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines.

The practice had a letter to be sent to health visitors informing them if and when a child aged less than five years had failed to attend for a dental appointment after being referred. This allowed the health visitor to liaise with the family and find out why the child had missed the appointment.

Consent to care and treatment

The practice had a policy for consent to care and treatment. We saw evidence that patients were given treatment options and consent forms which they signed to signify their consent with the agreed treatment. Discussions with dentists showed they were aware of and understood the use of Gillick competency in young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical treatment without the need for parental permission or knowledge. The consent policy provided information about Gillick competencies.

The consent policy also had a description of competence or capacity and how this affected valid consent. The policy linked this to the Mental Capacity Act 2005 (MCA). Staff training records showed staff had attended training with regard to the MCA 2005. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we observed how the staff spoke with patients and whether they treated patients with dignity and respect. The reception desk was an open desk, and conversations could be heard in the waiting room. Reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area, particularly when other patients were present. They said that a private area was available for use, with either the back office or an unused treatment room available.

We observed a number of patients being spoken with at the reception desk and found that confidentiality was being maintained. We saw that patient records, both paper and electronic were held securely either under lock and key or password protected on the computer.

We viewed 51 Care quality Commission (CQC) comment cards that had been completed by patients. All 51 had positive comments about the staff and the services provided. Only one comment card had a slightly less positive comment, and this was about waiting times. We also spoke with two patients who said they were very happy with the service provided. Several patients on both comment cards and in person spoke about the approachability of the staff. There were also several comments where patients said they had been treated with respect and dignity.

Staff were sensitive to the needs of their patients and there was a strong focus on reducing anxiety and supporting people to feel comfortable in the surroundings. For example, staff were clear about the importance of the emotional support needed for patients who were very nervous or phobic of dental treatment. Staff and patients told us all consultations and treatments were carried out in the privacy of a surgery and we observed this to be the case. We observed the treatment room door was closed during consultations and that conversations taking place in these rooms could not be overheard.

Involvement in decisions about care and treatment

We spoke with two patients on the day of the visit. Both made positive comments about the dentists they saw. They said they were totally satisfied with the dental treatment they received. The patients spoke positively about the staff, and said they had never felt the need to complain. Both patients said that treatment was explained clearly to them including the cost. Both patients said they felt involved in the decisions taken, and were able to ask questions and discuss with the dentists the treatment options.

CQC comment cards completed by patients included comments about how treatment was always explained in a way the patients could understand. Eighteen comment cards made specific reference to staff explaining treatment options, and having the opportunity to ask questions.

The practice information leaflet and the practice website clearly described the range of services offered to patients, the complaints procedure and information about patient confidentiality. The practice offered private treatments and the costs were clearly displayed and fee information was also available on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had an appointment system which patients said met their needs. Where treatment was urgent patients would be seen the same day if possible. Six comment cards we received made reference to the appointment system and patients being happy with the service.

Many of the patients seen at the practice were people of working age and older people. Practice opening times could accommodate the needs of patients with late or early appointments, and Saturday opening, although these were by appointment. New patients were asked to complete a medical and dental health questionnaire. This allowed the practice to gather important information about the patient's previous dental and medical history.

The practice was well equipped and had been refurbished over the past two years. The waiting room was spacious and comfortable and this helped patients relax before their treatment.

Tackling inequity and promoting equality

The practice had considered the needs of patients who may have difficulty accessing services due to mobility or physical issues. The practice had a concrete ramp to the front door providing step free access to assist patients with mobility issues, using wheelchairs or mobility scooters and parents with prams or pushchairs. The practice had an assisted ground floor toilet, which was accessible for patients. However, there was no alarm cord should a patient get into difficulty in the toilet.

The practice had provided raised chairs for patients who had difficulty rising, for example elderly patients. However, the design of the chairs, with a single central leg and wide seat meant the chairs did not offer a firm base from which to stand.

The practice had good access by all forms of public transport. Car parking was either street parking or there was a small area for disabled patients to park at the side of the practice.

For patients with restricted mobility who could not manage the staircase, a ground floor surgery was available for treatment.

Staff members told us that longer appointment times were available for patients who required extra time or support, such as patients who were particularly nervous or anxious.

Access to the service

The practice was open Monday to Friday 8:30 am to 5:30 pm. Early mornings, evenings and Saturday appointments were by appointment only.

The arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays were clearly displayed in the waiting room area and in the practice leaflet. By telephoning the practice number the caller would hear a recorded message giving the arrangements for that day for emergency treatment and cover.

Concerns & complaints

The Dental Suite had a complaints procedure that explained the process to follow when making a complaint. The timescales and the person responsible for handling the complaint were also identified. Details of how to raise complaints were included in the practice leaflet and accessible in the reception area. However, they were not available on the practice website. Staff said they were aware of the procedure to follow if they received a complaint.

From information received prior to the inspection we saw that three complaints had been received in the past twelve months. The records of all three complaints showed there was an outcome and where appropriate learning for the individual clinician or the practice as a whole. The documentation identified the practice had followed its own policy with regard to timescales, written responses and review.

Care Quality Commission (CQC) comment cards reflected that patients were satisfied with the dental services provided.

Are services well-led?

Our findings

Governance arrangements

The practice monitored and improved the service provided for patients. For example the practice

reviewed feedback from patients, and held regular staff meetings. We saw staff meeting minutes where feedback from patients and safety issues had been discussed. The practice had governance arrangements in place. This was demonstrated by several audits which we reviewed. For example: audits of patients' notes and regular review and updates of policies and procedures. Risk assessments had also been reviewed, and the practice was well organised with specific files containing information, policies and audits. In all cases we found information to be up to date and having been reviewed where necessary within the past twelve months. Discussions with staff identified they were aware of their roles and responsibilities within the practice.

There were systems for clinical and non-clinical audits taking place within the practice. These included audits of patient records, oral health assessments and X-ray quality. Health and safety related audits and risk assessments were also in place.

We noted the temperature of the clinical refrigerator was not being checked or recorded. We discussed this with the practice manager and a procedure was set up immediately.

Leadership, openness and transparency

The practice stated its core purpose (as part of its ethos) was: 'A dedication to the highest quality of customer service as well as delivering dental care to the highest standard by a by a qualified and experienced team.' This was displayed in the staff room, and staff were aware of this core purpose.

Staff told us that they could speak with the practice manager or a dentist if they had any concerns. Several staff members said they felt part of a team, well supported and knew what their role and responsibilities were.

Responses to patients concerns or complaints had been recorded, and showed an open approach. We saw examples of correspondence to patients where the practice had apologised for any distress or concern caused.

Staff were aware of how to raise concerns about their place of work under whistle blowing legislation. We saw that the practice had a whistle blowing policy, and all staff had access to the policy.

Learning and improvement

In its statement of purpose The Dental Suite stated its objective was: "We strive to be acknowledged by our patients, suppliers and regulators as a leader in our sector. This will be achieved by ensuring that we recruit and train highly professional staff whose ambitions are to exceed patient expectations."

We found staff were aware of the practice values and were able to demonstrate that they worked towards these.

The practice manager showed us an analysis of feedback from patients, which demonstrated how the information had been used to learn and improve the service delivered.

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

Staff said that patients could give feedback at any time they visited. There was a comments box in the waiting room, and questionnaires for patients. Staff said patients were encouraged to complete these forms and provide feedback. The practice manager showed us that feedback from patients was reviewed on a three monthly basis.

The patients we spoke with said they were aware of the comment box in the waiting room and the questionnaires. However, only one of them had completed a questionnaire.

The practice analysed the complaints it had received, and was able to demonstrate learning from complaints. Information was shared at staff meetings.