

## Steeple Grange Smiles Limited

# Steeplegrange Smiles

## Inspection Report

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### Overall summary

We carried out an announced comprehensive inspection on 29 April 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**

Steeple Grange Smiles is part of the Oasis Dental Care group of dental practices. The practice is located over two floors of premises close to the village of Wirksworth. The practice was first registered with the Care Quality Commission (CQC) in April 2011. The practice provides regulated dental services to both adults and children. The practice provides mostly private dental treatment (95%). There is a small NHS contract to provide services for minor oral surgery and orthodontics, and a service to a small number of children. Services provided include general dentistry, dental hygiene, crowns and bridges, root canal treatment and sedation.

The practice's opening hours are: Monday: 8:30 am to 5:15 pm; Tuesday 8:45 am to 7:15 pm; Wednesday: 8:30 am to 7:15 pm; Thursday: 8:30 am to 5:15 pm; Friday 8 am to 5:15 pm and Saturday: by appointment one Saturday every month.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message, which directs the patient to a dentist. Alternatively patients could ring the Derby or Chesterfield emergency dental service.

The practice manager is registered with the Care Quality Commission (CQC) as an individual. Like registered

# Summary of findings

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.

The practice has ten dentists; three dental hygienists; ten qualified dental nurses; two receptionists; a practice manager and one administrator primarily to deal with referrals.

We received positive feedback from 34 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

## **Our key findings were:**

- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect.
- Dentists identified the treatment options, and discussed these with patients.
- Patients' confidentiality was maintained.
- There were systems in place to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The practice carried out intravenous sedation for nervous patients or those requiring minor oral surgery.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the infection control arrangements in the minor oral surgery room with regard to the spittoon. Giving due regard to the guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05).
- Review the practice policy with regard to Equality and Diversity and consider installing a hearing loop as a reasonable addition as identified in the Equality Act (2010).

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Are services safe?**

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

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

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

Staff had been trained to carry out intravenous sedation. The practice was equipped and staffed to do so safely and in line with published guidance.

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?**

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

All patients were clinically assessed by a dental professional before any treatment began. The practice used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, wisdom tooth removal and the non-prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

The practice received referrals from other dental professionals and there were clear procedures for receiving referrals and dealing with them in a timely manner.

### **Are services caring?**

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

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

Patients said staff were friendly, polite and professional. Feedback identified that the practice treated patients with dignity and respect.

Patients said they received good dental treatment and they were involved in discussions about their dental care.

Patients said they were able to express their views and opinions.

# Summary of findings

## **Are services responsive to people's needs?**

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

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

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

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

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

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

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

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

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

Patients were able to express their views and comments, and the practice listened to those views and acted upon them. Regular feedback was given to patients following surveys to gather patients' views.

Staff said the practice was a friendly place to work, and they could speak with the dentists if they had any concerns.

# Steeplegrange Smiles

## 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 29 April 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked the for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies. We spoke with eight members of staff during the inspection.

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

We reviewed policies, procedures and other documents. We received feedback from 34 patients about the dental service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

# Are services safe?

## Our findings

### Reporting, learning and improvement from incidents

The practice recorded and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in January 2015 this being a minor sharps injury to a member of staff. There were no recorded learning points from this accident. 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 a policy for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) which had been updated in July 2015. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although they were aware how to make these on-line.

Records at the practice showed there had been no significant events in the 12 months up to the inspection visit. The last recorded significant event had occurred in January 2014 when a member of the public had become unwell in the practice. The record showed this had been well managed and was discussed at a staff meeting following the event.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. Alerts were received by the practice manager and forwarded to individual dentists and discussed in a staff meeting.

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

The practice had separate policies for safeguarding vulnerable adults and children. Both policies had been reviewed in April 2016. Both policies identified how to respond to and escalate any safeguarding concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when

necessary. A flow chart and the relevant contact telephone numbers were on display in the staff room together with a flow chart with the key contacts to share information with regard to poor oral health concerns. Copies of the safeguarding policies with key telephone numbers were also in the patient information folder in the waiting room.

The practice manager was the identified lead for safeguarding in the practice. They had received enhanced training in child protection to support them in fulfilling that role. We saw the practice had a safeguarding file which contained all of the relevant information should there be any concerns relating to safeguarding.

Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children. We saw that some staff were booked on further safeguarding training during 2016. We saw evidence that all staff completed on-line training annually with regard to safeguarding to act as a refresher.

There was a policy and risk assessment to assess the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy had been reviewed and updated in August 2015. This policy directed staff to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer to inform staff what action to take if an accident occurred for example in the event of any spillage.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 31 March 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in July 2015. There was also a sharps risk assessment next to the sharps bin in each treatment room. 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.

# 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.) The bins were wall mounted in the treatment rooms. The guidance indicated sharps bins should not be located on the floor, and should be out of reach of small children.

Copies of the practice's sharps policy and how to deal with sharps injuries were displayed in the clinical areas of the practice.

Discussions with dentists and a review of patients' dental care records identified the dentists were using rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We saw the practice had a plentiful supply of rubber dam kits with both latex and non-latex being available to avoid the possibility of a latex allergy reaction in a patient.

For additional safety dentists had parachute chains available to use. A parachute chain is a chain which attaches to dental instruments on one end and to a ring on the dentists' finger at the other.

## 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. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

The practice had a designated recovery room for patients who had received sedation. This room had piped oxygen available, and equipment for measuring blood glucose levels and blood pressure.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Four staff members had completed an emergency first aid at work course and were the designated first aiders for the dental practice. A poster in the recovery room identified which staff were trained first aiders.

There was an automated external defibrillator (AED) held in the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of

the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

Staff at the practice had completed basic life support and resuscitation training on 23 November 2015. Immediate life support training on 10 August 2015 was provided for ten members of staff involved in sedation at the practice.

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

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies. Staff said that at monthly staff meetings different emergency scenarios were discussed, giving staff the opportunity to explore how those scenarios would be managed.

## Staff recruitment

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

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

## Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments; both had been updated in June 2015. Risks to staff and patients had been identified and assessed. For example there were risk assessments for: slips, trips and falls; manual handling and radiography.



# Are services safe?

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been updated in August 2015. The fire extinguishers had been serviced in August 2015. Staff training records showed staff had completed fire awareness training within the 12 months before the inspection. Five staff had also completed enhanced fire marshal training.

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 provided an intravenous sedation service (using a medicine introduced via a vein to help the patient relax). Staff said sedation was most often used to support patients during surgical procedures such as tooth removal. The practice recently had an inspection by SAAD (a charity dedicated to the advancement of knowledge in pain and anxiety control for dentistry). The report from the SAAD visit identified there were no concerns with regard to sedation at the practice. In April 2015, the Royal College of Surgeons and the Royal College of Anaesthetists published guidance on 'Standards for Conscious Sedation in the Provision of Dental care.' We saw the practice were working towards meeting the newer standards. However, the practice was meeting the standards set out in the previous guidance: Conscious Sedation in the Provision of Dental Care (Department of Health 2003). Patients were assessed at an initial appointment which allowed time for them to consider the risks and benefits of the sedation procedure as explained by the oral surgeon. This also gave the opportunity for patients to withdraw if they so wished. Patients were provided with written guidance for before and after the sedation. The practice required that an escort come with the patient on the day that sedation was scheduled. This was to safeguard the patient afterwards and on their way home. The escort was formally briefed by the practice staff on their duties, and were required to remain in the practice throughout the sedation procedure. The sedationist was supported by trained staff and resuscitation equipment was available. Staff had completed immediate life support training. Sedation was achieved with a single medicine called Midazolam. A reversal agent called Flumazenil was available if required.

Afterwards patients were able to recover with supervision in a purpose built recovery room. There was piped oxygen available in the recovery room. The patients' vital signs were monitored throughout the procedure and recovery.

We noted the room used for sedation only had one sink and no spittoon. This meant that patients would spit blood into the hand washing sink, which posed an infection control risk. We discussed this with the practice manager who said they would look at ways of addressing this issue.

## 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 February 2016. The policy was available to staff working in the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit in 9 March 2016 scored 99%.

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 both mercury and bodily fluids. Both spillage kits were in date.

There was a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room was secure with a keypad on the door to ensure only staff had access. The decontamination room had been split into two separate rooms with a dirty and clean area. There was a clear flow between them to



# Are services safe?

reduce the risk of cross contamination and infection. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We saw that instruments were being cleaned and sterilised at the practice. A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice had two washer disinfectors (machines for cleaning dental instruments similar to a domestic dish washer). After cleaning, the instruments were rinsed and examined using an illuminated magnifying glass. All instruments were dried and placed in pouches. Finally the instruments were sterilised in one of the practice's three autoclaves (devices for sterilising dental and medical instruments). The practice had two vacuum autoclaves, which were designed to sterilise wrapped instruments, in addition there was a Statim autoclave which ran on a shorter cycle and could sterilise instruments quicker. All instruments were dated with a use by date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

We examined a sample of dental instruments that had been cleaned and sterilised, using the illuminated magnifying glass. We found the instruments to be clean and undamaged.

The practice had a policy for dealing with blood borne viruses which had been reviewed in June 2015. There were records to demonstrate that staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had a Legionella risk assessment which had been updated in November 2014. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks

associated with Legionella and had taken steps to reduce them with regular water tests, which were recorded. In addition three monthly dip tests were carried out on the water lines to monitor the growth of bacteria.

The practice was flushing the dental unit water lines used in the treatment rooms. This was done for two minutes at the start of the day, and for 30 seconds between patients, and again at the end of the day. A concentrated chemical was used for the continuous decontamination of dental unit water lines to reduce the risk of Legionella bacterium developing. This followed the published guidance for reducing risks of Legionella.

## 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 on 18 September 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures. The boiler and annual landlord's gas safety check was due in May 2016, and we saw that an appointment had been booked to carry out the service.

The practice had all of the medicines needed for an emergency situation, as identified in the current guidance. Medicines were stored securely and there were sufficient stocks available for use. Medicines used at the practice were stored and disposed of in line with published guidance.

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

## Radiography (X-rays)

The practice had four intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw. The practice also had a cephalometric radiograph machine. This was a machine which produced an image of the skull which the orthodontist used as a treatment planning tool. The image produced allowed the relationships between the dental and skeletal structures to be analysed. There was also a dental cone beam computer

## Are services safe?

tomography (known as a CT) which is a specialised type of X-ray machine used when regular dental or facial X-rays were not sufficient. This machine was particularly useful for patients who were receiving dental implants.

During the inspection we noted the practice did not have a protocol for the use of the CT. As a result staff who could operate the machinery had not been formally identified, and neither had the training they had completed. Following the inspection we received a written protocol which addressed all of the issues identified during the inspection.

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 radiation protection supervisors (RPS) this being one of the dentists. 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 last been inspected in December 2014. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The cone beam CT equipment was installed and tested in 2015.

The practice used digital X-ray images; these rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional X-rays. This makes them safer for both 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. They 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 risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form, or updated their details. The dentist then checked the medical history with the patient before treatment began. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of 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 a large waiting room with information for patients on display. There was assorted literature about the services offered at the practice. The practice had a patient information file containing information about the staff, their qualifications and specialisms and the various treatments and services on offer at the practice.

Two dentists explained that children seen at the practice were assessed on an individual basis to check their risk of dental decay. This resulted in children being offered fluoride application varnish and fluoride toothpaste if they were identified as being at risk. This was in accordance with

the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health.

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, dentists had particularly highlighted the risk of dental disease and oral cancer.

### Staffing

The practice had ten dentists; three dental hygienists; ten dental nurses; two receptionists; a practice manager and one administrative assistant. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

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

Records at the practice showed that appraisals had been completed for all staff. Appraisals were completed on an annual basis for all staff usually during March and April. The cycle for 2016 was due and the practice manager showed the process was about to start. We saw evidence that appraisals for staff had taken place. We also saw evidence of new members of staff having an induction programme. We spoke with two members of staff who said they had received an annual appraisal.

### Working with other services

The practice was a referral practice taking referrals from other dentists in the local area. Referrals received were for example: sedation, periodontal (gum disease), implants, minor oral surgery and orthodontics. Each time a referral was received the practice opened a new file which

# Are services effective?

(for example, treatment is effective)

contained the referral letter and all relevant information including X-rays and the patient's medical history. All notes related to the patient's individual treatment were stored within this file.

The practice hosted open evenings throughout the year where dentists who referred to the practice were invited to attend for an information sharing events. Past events had covered periodontal disease (gum disease), implants, and a general referral evening where dentists spoke about their specialisms.

Much of the administrative assistant's workload revolved around referrals, with keeping track of progress with referrals made and received.

The practice tended to make referrals to local hospitals for example where patients had suspected oral cancer. These referrals were tracked and we saw evidence that referrals had been made promptly.

## **Consent to care and treatment**

The practice had a consent policy which had been reviewed in July 2015. The policy made reference to valid

consent, and assessing a patient's capacity with regard to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. An easy read version of the MCA was available for staff, which was easier to understand, and covered the important points of the Act.

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

The practice consent policy made reference to Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. Discussions with dentists showed they were aware of and understood the use of Gillick to assess competency for young persons.

# Are services caring?

## Our findings

### **Respect, dignity, compassion & empathy**

Throughout the inspection we observed staff speaking with patients. We saw that staff were friendly, polite and professional. Our observations showed that patients were treated with dignity and respect.

The reception desk was located away from the waiting room. We asked how patient confidentiality was maintained with reception staff. Staff said if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen, such as an unused treatment room, or the manager's office. Staff said that all details of patients' individual treatment were discussed in the privacy of the treatment room.

We observed staff speaking with several patients throughout the day. This was at the reception desk and when dental nurses brought patients to the treatment room. We saw that patient confidentiality was maintained at the practice. We asked two patients about confidentiality. Both said they had no concerns or issues. Computer screens could not be overlooked at the reception desk. We saw that patients' dental care records were password protected and held securely.

We observed a young child selecting their first toothbrush. Staff were supportive and offered the parent advice. Staff spoke with the child in a friendly and appropriate manner.

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

We received feedback from 34 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback was wholly positive with patients saying the staff were friendly, and patients were treated with respect. Some patients said in the CQC comment cards that they were involved in discussions and decisions about their dental care and treatment.

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

We spoke with two dentists and the visiting consultant oral surgeon, about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence on the patient care records of how the treatment options and costs were explained and recorded before treatment started. Patients were given a written copy of the treatment plan which included the costs.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice was located in a building close to the village of Wirksworth. There was car parking available to the front of the practice and this included disabled parking. There were two ground floor treatment rooms.

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.

We spoke with two patients during the inspection. Patients said that getting an appointment had been easy, and staff had been responsive to the patients' needs. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day. Emergency treatment slots were available at the practice to see patients who were in pain.

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

Nervous patients were invited to visit the practice to familiarise themselves with the environment and the sounds in order to help them to cope with any necessary treatment.

### Tackling inequity and promoting equality

There was an equality, diversity and human rights policy which had been reviewed in November 2015.

The practice was situated over two floors. There were two ground floor treatment rooms, so patients in a wheelchair or with restricted mobility could access treatment at the practice. There was level access for patients in wheelchairs or with young children in pushchairs.

The practice had good access to all forms of public transport with a bus stop located close by.

The practice had a ground floor toilet for the use of patients, and this had grab rails to assist those with restricted mobility.

The practice had completed an access audit in line with the Equality Act (2010) this had taken the form of a risk

assessment. Details of the steps taken to improve access for all patients, including the use of hand rails and ramps were identified. The practice did not have a portable hearing induction loop. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices. The practice manager said this would be reviewed.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said that there were very few patients who could not speak English, and if language was a barrier the patient usually brought someone to interpret for them which avoided the need for the interpreting service.

### Access to the service

The practice's opening hours were: Monday: 8:30 am to 5:15 pm; Tuesday 8:45 am to 7:15 pm; Wednesday: 8:30 am to 7:15 pm; Thursday: 8:30 am to 5:15 pm; Friday 8 am to 5:15 pm and Saturday: by appointment one Saturday every month.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message, which directs the patient to a dentist. Alternatively patients could ring the Derby or Chesterfield emergency dental service.

Two days before their appointment was due patients were sent a text message reminder. For patients who did not use the text reminder service staff telephoned patients to remind them their appointment was due.

### Concerns & complaints

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

Information about how to complain was contained in the patient information file in the practice waiting room and on the practice website.

From information received before the inspection we saw that there had been one formal complaint received in the 12 months prior to our inspection. We saw documentation which identified complaints had been dealt with in a timely

# Are services responsive to people's needs?

(for example, to feedback?)

manner. Learning points from complaints had been identified and shared with staff. We also saw that apologies and explanations had been given in line with the practice policy related to a duty of candour.



# 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 on an annual basis. The organisation had a management plan which included the review and updating of policies and procedures.

Staff said they understood their role and could speak with any of the dentists if they had any concerns. Staff said they understood the management structure at the practice. We spoke with three members of staff who said they were happy working at the practice, and there was good communication within the staff team.

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

### Leadership, openness and transparency

The practice was part of a large corporate organisation. The management structure provided by the provider gave the practice the support. The practice manager had several years' management experience and a business studies qualification.

We saw that staff meetings were scheduled for once a month throughout the year. The agenda covered areas such as: information governance and significant events. A core training event was also highlighted which could be the review of a particular policy. Staff meetings were minuted and minutes were available to all staff.

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

Staff at the practice had access to the General Dental Council's (GDC) nine principles to meeting the GDC

standards available. This was to offer guidance and remind them of the key steps to good practice. A copy of the principals was contained in the patient information file in the waiting room.

The practice had a whistleblowing policy which was had been reviewed in February 2016. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with a dental nurse who was able to give a clear account of what the procedures were for, and when and how to use them. The policy was available on any computer in the practice.

### Learning and improvement

We saw there was audits were completed throughout the year. This was for both clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved, particularly in respect of the clinical areas. Examples of completed audits included: Radiography (X-rays) had been completed in March 2016; Medical history audit in May 2015; Hand washing audit completed in February 2016 and safeguarding adults training in March 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 need to complete 150 hours over the same period.

We saw that there were a number of staff training events taking place both internally and externally. The provider paid for all employed staff to attend training and actively supported staff to achieve their CPD targets.

The practice manager maintained an over view of CPD achievement for staff at the practice.

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

The practice had its own patient satisfaction survey which patients could complete in the practice. In addition patients could leave feedback through the website. Feedback was analysed both in the practice and at head

## Are services well-led?

office. An example of a patient comment resulting in action was: a patient pointed out that fresh lilies in the waiting room were difficult for asthmatic patients. As a result the practice no longer bought lilies for the waiting room.