

Nationwide Healthcare Seven Dental

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 17 October 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

The practice is located on two floors of premises in the Hyson Green area of Nottingham. The practice provides mostly NHS dental treatments (95%). There are a number of free car parks in the area including the park and ride at the nearby tram stop. There are 17 treatment rooms 14 of which are located on the ground floor.

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

The practice's opening hours are – Monday to Saturday: 9 am to 6 pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the 111 NHS service.

The practice manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Summary of findings

The practice has 15 dentists; eight qualified dental nurses; ten trainee nurses; and one practice manager. Dental nurses also worked on the reception desk when required. In addition two oral surgeons visited the practice on a sessional basis several times a month.

We received positive feedback from 32 patients about the services provided. This was by speaking with patients and through comment cards left at the practice prior to the inspection.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients. A large pool of staff identified that staff shortages were easily covered.
- Patients commented they had no problem getting an appointment that suited their needs.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect; and the dentist involved them in discussions about treatment options and answered questions.
- Patients' confidentiality was protected.
- There were systems to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

The practice was visibly clean.

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

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 and inspected to make sure it was safe for use.

No action



Are services effective?

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

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

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

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

No action



Are services caring?

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

Patient confidentiality was maintained and dental care records were stored securely.

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

No action



Summary of findings

There were systems for patients to be 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.

Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice had 14 ground floor treatment rooms which allowed easy access for patients with restricted mobility or mothers with prams or pushchairs.

A formal disabled access audit in line with the Equality Act (2010) had not been completed to consider the needs of patients with restricted mobility.

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

There were systems and processes to support patients to make formal complaints.

No action



Are services well-led?

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

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

The practice had a system for carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. Policies and procedures had been kept under review.

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

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

No action



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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 17 October 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

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

We reviewed policies, procedures and other documents. We received feedback from 32 patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems for recording and investigating accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed there had been one recorded accident in the twelve months up to this inspection. This being a minor injury to a member of staff. We saw that learning points had been identified and shared with staff.

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

The significant event folder contained guidance for staff on identifying a significant event and keeping suitable records about any such event. Records at the practice showed that significant events had been identified and logged by each treatment room or area within the practice. There had been over 100 significant events logged during 2016. These were for positive interactions such as a dentist receiving chocolates from a patient through to faulty equipment and patients leaving property in the practice. The last recorded event had occurred in October 2016 and related to a broken light fitting. The record showed all significant events had been analysed and discussed at staff meetings.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. These were received by the principal dentist analysed and discussed in staff meetings as appropriate. The most recent alert had been received in October 2016 and related to a type of Automatic External Defibrillator (AED) which had failed to deliver a shock. The practice also received Central Alerting System (CAS) alerts which related to medicines.

A review of the information in the complaints folder identified that patients were told when they had been affected by something that had gone wrong. They had received an apology and been informed of the actions taken as a result. The practice manager was aware of when and how to notify CQC of incidents which cause harm.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. The policies had been reviewed and updated in September 2016. The policies identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers and a flow chart were available for staff in the policies and on display in the staff room and behind reception. The contact details for ChildLine and a poster about staying safe on-line which was aimed at children was on display in the waiting rooms. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The practice manager said there had been no safeguarding referrals made by the practice.

The principal dentist was the identified lead for safeguarding in the practice. They had received enhanced training in child protection to level two on 20 June October 2015 to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two during June 2015.

The practice had guidance relating to the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. This identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were hard copies of manufacturers' product data sheets in the COSHH file together with risk assessments for each product. Data sheets provided information on how to deal with spillages or accidental contact with chemicals and advised what protective clothing to wear. Detailed information related to COSHH products was also held on a computer disc available in the practice.

The practice had an up to date Employers' liability insurance and Public liability certificates which was due for renewal on 23 November 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969. Both certificates were displayed behind reception.

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 September 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the

Are services safe?

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. Practice policy was that only dentists handled sharp instruments. We saw there were devices in each clinical area for the safe removal and disposal of needles and sharps. There were clear instructions for staff in each clinical area regarding the safe management and handling of sharps

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were wall mounted in clinical areas which followed the guidance which indicated sharps bins should not be located on the floor, and should be out of reach of small children. Sharps bins were signed and dated. The National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care' advise – "sharps boxes should be replaced every three months even if not full." Signing and dating allowed the three month expiry date to be identified.

Discussions with dentists and a review of patients' dental care records identified the dentists were using rubber dams when providing root canal treatment to patients. This was in line with guidance from the British Endodontic Society. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We saw the practice had a supply of rubber dam kits in the practice including latex free rubber dams.

Medical emergencies

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

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Three members of staff had completed a first aid at work course which was valid until November 2018.

There was an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training on 15 January 2016. We saw certificates to evidence that staff had completed this training.

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

Staff recruitment

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

We found that all members of staff had received a DBS check. The practice was routinely taking references for new members of staff and were keeping a record of interview notes. We discussed the records that should be held in the recruitment files with the practice manager and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in September 2016. The policy identified four

Are services safe?

dentists and the practice manager as the lead people who had responsibility within the practice for different areas of health and safety. As part of this policy environmental risk assessments had been completed. For example there were risk assessments for: the use of mercury, fire safety and manual handling.

Records showed that fire extinguishers had been serviced in August 2016. The practice had a fire risk assessment which had been reviewed in September 2016. We saw there was an automatic fire detection system installed within the premises. The fire evacuation procedure was displayed within the practice for patients and staff. Records showed the practice held a fire drill twice a year, with the last one completed on 10 October 2016.

The practice had a health and safety law poster on display behind reception. 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.

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 September 2016. A copy of the policy was available to staff in all clinical areas. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last audit was completed on 23 September 2016. The audits had been analysed and action points recorded. The practice produced an annual statement with regard to infection control which identified the strengths and needs

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored

securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for mercury and bodily fluids. Both spillage kits were within their use by date.

There was a decontamination suite. This was where dental instruments were cleaned and sterilised. There was a separate clean and dirty room and pouched sterilised instruments were stored centrally in the clean room. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. The practice was latex free to avoid any potential latex allergy. Daily check sheets were completed by nurses in the decontamination room.

The practice had four washer disinfectors (machines for cleaning dental instruments similar to a domestic dish washer). After cleaning instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had four steam autoclaves which were designed to sterilise unwrapped or solid dental instruments. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

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

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

The practice had a risk assessment for dealing with the risks posed by Legionella. This had been completed by an external contractor in August 2015. Legionella is a

Are services safe?

bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance. The risk assessment identified that key personnel should undertake Legionella awareness training. Following the inspection we were sent certificates for four members of staff who had completed Legionella fundamentals training during October 2016.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in September 2016. Following the inspection we received copies of electrical installation condition reports dated October 2016. These confirmed the safety and condition of the electrics installed at the practice. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in April 2016. Records showed the autoclaves had also been serviced in September 2016. This was in accordance with the Pressure Systems Safety Regulations (2000)

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

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

Radiography (X-rays)

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

The practice had 17 intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth) and two extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull. One OPG was not in use as it was broken. The practice manager said a decision on whether to repair or replace the machine was being taken by the provider.

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being one of the principal 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.

The practice had critical examination documentation for all 17 X-ray machines. Critical examinations are completed when X-ray machines are installed to document they have been installed and are working correctly.

Records showed the X-ray equipment had been inspected in April 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence dated 20 February 2002 confirmed this had been completed following a major refurbishment of the practice.

The practice used digital X-rays which allowed the image to be viewed almost immediately, and rely on lower doses of radiation. Therefore reducing the risks to both the patients and staff.

All patients were required to complete a medical history form and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. The patients provided a digital signature in the treatment room to confirm any information that might influence them having an X-ray.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified with risk factors such as smoking and diet for each patient. Patients were able to supply a digital signature so that they could record their consent and agreement with the medical history directly into their dental care records.

Patients at the practice completed a medical history form which was checked by the dentist in the treatment room with the patient. The form was part of the electronic dental records and was used to capture any changes to the patients' medical history. Patients provided a digital signature in the treatment room to confirm the medical history form was correct. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

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

We saw the dentist used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentist showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients. Posters relating to NICE guidelines with regard to recall intervals were on display throughout the practice.

Health promotion & prevention

The practice had two waiting rooms where posters and leaflets relating to good oral health and hygiene were on display.

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

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

Staffing

The practice had 15 dentists; eight qualified dental nurses; ten trainee nurses; and one practice manager. Dental nurses also worked on the reception desk when required. In addition two oral surgeons visited the practice on a sessional basis several times a month. 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. On the day of our inspection we also saw evidence of current professional indemnity cover for all relevant staff.

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

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

Records at the practice showed that all staff had an annual appraisal. As part of the appraisal process staff completed a

Are services effective?

(for example, treatment is effective)

review of their own learning objectives and identified the CPD they had completed. Staff completed a personal development plan as part of the appraisal process. We also saw evidence of new members of staff having an induction programme.

Working with other services

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. We saw the practice referred to the clinical assessment service where referrals were sorted and triaged. This was for services within the practice such as oral surgery too. The clinical assessment service allowed the patients to choose where they went for their treatment rather than only having the option of treatment in-house. The practice also made referrals for orthodontics (where badly positioned teeth are repositioned to give a better appearance and improved function) and sedation. Children who required multiple extractions were referred to community services.

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

The practice referral system was monitored through a tracking system at reception. All referrals were recorded in folders and telephone calls were made to ensure referral letters had been received and check progress.

Consent to care and treatment

The practice had a consent policy which had been reviewed in September 2016. The policy had the General Dental Council (GDC) and the British Dental Association (BDA) guidelines on consent as an addendum. These made reference to the Mental Capacity Act 2005 (MCA). The issue of capacity was explored within the guidelines and this included making best interest decisions as identified in the MCA. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

We saw how consent was recorded in the patients' dental care records. The records showed the dentist had discussed the treatment plan with the patients, which allowed patients to give their informed consent. Patients provided a digital signature to demonstrate their agreement and consent. This was inserted directly into the patients' dental care records.

The consent policy made reference to obtaining consent from children under the age of 18. We talked with dental staff about this and identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

The practice had a multi-faith prayer room located on the first floor. This was primarily for staff to use, although the practice manager said patients did occasionally use the prayer room particularly during the holy month of Ramadan. The practice made also adjustments for staff during Ramadan with staff working shorter shifts.

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

We saw examples that showed patient confidentiality was maintained at the practice. For example the reception desk could not be overlooked so that information with the receptionist was secure. Patients' dental care records were held securely and password protected.

Involvement in decisions about care and treatment

We received positive feedback from 32 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by talking with patients in the practice.

The practice offered mainly NHS treatment and the costs were clearly displayed in the practice, with posters in the waiting rooms and at reception. Private fees were also on display in the reception area.

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

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was located on two floors of premises in the Hyson Green area of Nottingham. The practice provided mostly NHS dental treatments (95%). There were a number of free car parks in the area including the park and ride at the nearby tram stop. There were 17 treatment rooms 14 of which were located on the ground floor.

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

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To facilitate this the practice made a specific appointment slots available for patients who were in pain. The practice provided emergency treatment to patients who were referred via the 111 NHS service, often on a Saturday, even if they were not registered at the practice.

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

Tackling inequity and promoting equality

The practice had an equality and diversity policy and an equal opportunities policy which had both been reviewed in September 2016.

Patient areas were situated on both the ground floor and the first floor. There were 14 ground floor treatment rooms all of which allowed patients with restricted mobility easy access for treatment. The treatment rooms were large enough for patients to manoeuvre a wheelchair or push chair.

The practice had two ground floor toilets which were suitable for patients with restricted mobility. Both toilets had lever operated taps, hot air hand dryers and a bell to summon assistance if needed. The bell would alert staff in reception and had a different ring tone for each toilet. Following the inspection we were sent photographic evidence that wall bars had been fitted in both toilets.

Large print leaflets were available if required.

The practice had information relating to access in line with the Equality Act (2010) A formal access audit had been completed in October 2016 which identified that the practice was fully accessible to patients with restricted mobility or who were using a wheelchair. The practice could accommodate patients with restricted mobility; with level access from the street to the ground floor treatment room. The practice had a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

The practice leaflet and website identified that staff at the practice were conversant with: English, Spanish, Punjabi, Urdu, Swedish, Swahili, Luganda, Romanian, Polish, Arabic and Turkish. In addition the practice had access to a recognised company to provide interpreters and this included the use of sign language. The practice had seen deaf patients in the past and arrangements had been made to ensure there were no communication difficulties.

Access to the service

The practice's opening hours were – Monday to Saturday: 9 am to 6 pm. The practice was closed at weekends.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message or by telephoning the 111 NHS service.

The practice had a text message reminder service and patients received a text reminder three working days before their appointment was due. Patients also received confirmation telephone calls the day before their appointment was due.

Concerns & complaints

The practice had a complaints procedure for private patients which had been reviewed in September 2016. The procedure explained how to complain and identified time scales for complaints to be responded to, and other agencies to contact if the complaint was not resolved to the patients satisfaction.

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

Are services responsive to people's needs?

(for example, to feedback?)

From information received before the inspection we saw that there had been eight formal complaints received in the 12 months prior to this inspection. Documentation within the practice showed the complaints had been handled appropriately and in a timely way.

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 in September 2016. The practice manager identified that all policies were updated on an annual basis usually in September. Staff said if they had any concerns they would raise these with the practice manager. We spoke with two members of staff who said they liked working at the practice and there was a close working team. Staff said there was a supportive approach from management at the practice and personal development was encouraged.

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

We saw that full staff meetings were scheduled for once a month throughout the year. Staff meetings were minuted and minutes were available to all staff. When there were learning points to be shared with staff we saw evidence these had been discussed and shared as appropriate. However, we saw no evidence of audits or complaints being discussed in staff meetings.

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

The practice had an underperformance and whistleblowing policy which had been reviewed in September 2016. The whistleblowing policy identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. This was both internally and with external agencies. A copy of the policy was available in the induction pack for all staff a copy of which every staff member had received.

The practice had information relating to the duty of candour which had been taken from the Care Quality Commission (CQC). This information led the practice to be open and honest in their dealings with patients. The practice also had information relating to duty of candour

from a defence organisation. Following this inspection we were sent a duty of candour policy dated 17 October 2016 which had been produced from the aforementioned guidance.

Learning and improvement

The provider had an internal audit manager who oversaw and analysed the audits at the practice. There were a range of audits completed throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Regular six monthly infection control audits with the last two having taken place in February and September. An audit of patient satisfaction had last been completed in July 2016. An audit of fluoride application had been completed in February 2016 Antibiotic prescribing in May 2016 and a domestic cleaning audit in April 2016. We saw that all audits had been reported on and there were action plans in place for each one.

The practice had a number of trainee dental nurses who were undertaking their dental nurse training course. They were supported in their learning by the other dental nurses as well as the dentists. We saw that each trainee nurse was enrolled on a course with an established college or training agency.

The practice ensured that all staff underwent basic life support and resuscitation training, infection control, safeguarding of children and vulnerable adults and dental radiography (X-rays). Staff development was by means of internal training, staff meetings and attendance on external courses.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays) and safeguarding had been completed by all relevant staff.

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

Are services well-led?

The practice had its own patient satisfaction survey which was completed twice a year. The analysis of the results in January 2016 identified that patients were happy with their treatment. The most recent audit in July 2016 showed patients found it easy to get an appointment, the reception staff were courteous, and the majority of patients 97% were satisfied with the level of care and treatment they received.

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the reception area. The FFT is a national programme to allow patients to provide

feedback on the services provided. The FFT comment box being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England.

The NHS Choices website: www.nhs.uk had eight patient reviews recorded in the year up to this inspection. These were seven positive comments and one negative comment. The provider had responded to the patient reviews and had offered patients the opportunity for further discussion. The latest figures on the NHS Choices website showed 289 patients had responded and 99% would recommend this dentist to their family and friends.