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City Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 8 December 2015 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

City Dental Practice is situated on the first floor of premises in Nottingham city centre. The practice is not accessible to patients with restricted mobility, such as those who use a wheelchair, as there is no lift available. The practice was registered with the Care Quality Commission (CQC) in December 2011. The practice provides regulated dental services to patients in Nottingham. The practice provides both NHS and private dental treatment, with approximately 60% being NHS patients. Services provided include general dentistry, dental hygiene, teeth whitening, crowns and bridges, and root canal treatment.

The practice is open Mondays to Thursdays: 9:00 am to 5:00 pm; and Fridays: 9:00 am to 4:30 pm. The practice is closed at the weekend. Access for urgent treatment outside of opening hours is by ringing the practice telephone number and following the answerphone message. Alternatively patients could ring 111 and contact the NHS out-of-hours service.

The practice has two dentists, one dental hygienist, five dental nurses and two receptionists.

We received positive feedback from 49 patients about the services provided**.** Patients said the reception staff were friendly, welcoming and put them at their ease, patients also expressed satisfaction with the quality of dental care they received from their dentist. Many patients had been coming to the practice for a number of years, and had total confidence in the dentists and the practice as a whole.

Our key findings were:

Summary of findings

- The practice had systems and processes to record accidents, significant events and complaints. Learning from any complaints and significant incidents was recorded and learning was shared with staff. When necessary apologies were given to patients when things had gone wrong.
- All staff had received whistle blowing training and discussions showed staff were aware of these procedures and how to use them.
- Patients spoke very positively about the dental service they received, and several gave examples of positive experiences they had had at the practice. Patients said they were treated with dignity and respect, from the reception desk through to seeing the dentist.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Staff had been trained to deal with medical emergencies. Emergency medicines, an automated external defibrillator (AED), and oxygen were readily available. 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 practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Patients' care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Patients said they were involved in making decisions about their treatment, and records in the practice supported this view. Options for treatment were identified and explored and discussed with patients.
- Patients' confidentiality was maintained.

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

- Update the practice website to make it clear the practice is not fully accessible to patients with restricted mobility.

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?

The practice had systems and processes to record any accidents and significant events and learning points were shared with staff. The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts and took appropriate action including sharing information with staff.

Staff had been trained in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters.

The practice had the necessary emergency equipment including an automated external defibrillator (AED) and oxygen. 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.

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.

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

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

Are services effective?

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

Patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire or updating one for returning patients who had previously completed a health questionnaire. The practice used a recognised assessment process to identify any potential areas of concern in patients' mouths.

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 recalls, wisdom tooth removal and the use of antibiotics.

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

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). Staff were able to demonstrate that referrals had been made in a timely way when necessary.

Are services caring?

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

Staff were aware of the need for confidentiality, and took steps to ensure patients' confidentiality. This was both in the practice with the patients, and with regard to record keeping.

Patients were treated with dignity and respect. Staff at the practice were welcoming to patients and made efforts to help patients relax.

Patients said they received very 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.

The practice had an appointments system which patients said was accessible and met their needs. The appointments system included a text message reminder service. Patients who were in pain or in need of urgent treatment were usually seen the same day.

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 for patients to make formal complaints, and 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, and staff were aware of their roles and responsibilities. There was a practice manager to organise and manage the day to day events in the practice.

The practice was carrying out 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.

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

City Dental Practice

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 8 December 2015. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor. Before the inspection we reviewed information we held about the provider together with information that we asked them to send to us in advance of the inspection. During our inspection visit, we reviewed a range of policies and procedures and other documents including dental care records. We spoke with seven members of staff, including members of the management team.

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

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

During the inspection we spoke with two dentists and three dental nurses. We reviewed policies, procedures and other documents. We received feedback from 49 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 procedures for recording, investigating, responding to and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in January 2013, this being an injury to a member of staff. The cause had been identified and steps taken to ensure this was not repeated. The staff member was seen at the occupational health department.

We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Information on reporting to RIDDOR was contained within the accident book. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The principal dentist said that there had been one RIDDOR notification made, this had been in 2012 when a patient had an accident at the practice and was injured.

The practice had a system for recording and dealing with significant incidents. The records went back several years. The practice had five recorded significant event in the last year. The most recent incident related to a potential breach of patient confidentiality. As a result staff training on confidentiality and consent had been updated for all staff.

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 into the central e mail box for the practice, and were analysed and shared as appropriate. If relevant the information was shared at the routine Thursday staff meeting, and staff signed the alert to show they had read it. The most recent MHRA alert the practice had received related to issues with a drain cleaner which had caused serious burns to a member of the public from sulphuric acid.

Reliable safety systems and processes (including safeguarding)

The practice had a safeguarding vulnerable adults and a safeguarding children policy, both of which had been reviewed in September 2015. The policies identified how to respond to any concerns and how to escalate those concerns. The policies also made reference to the Children's Act 1989, the Mental Capacity Act 2005 and the Caldicott policy, all of which were relevant in safeguarding children and vulnerable adults. 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 patient folder in the waiting room contained information about safeguarding including the relevant contact telephone numbers if there were any concerns.

The principal dentist was the identified lead for safeguarding in the practice and had received enhanced training in child protection to support them in fulfilling that role. Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children during September 2015.

The practice had a policy and procedure to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The policy directed staff to identify and risk assess each 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 on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin. We saw that chemicals were stored securely at the practice

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 30 November April 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

We saw dentists used needle guards which were a safe system for syringes and needles in accordance with the sharps regulations 2013. We discussed this with the principal dentist, who outlined the steps taken to reduce the risks of sharps injuries, including the dismantling of equipment likely to cause a sharps injury. We were assured that the practice had considered the risks and taken suitable steps to reduce those risks.

Discussions with dentists and review of patients' dental care records identified the dentists were not always using

rubber dams when completing root canal treatments. Best practice 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. The reason given was that some patients do not like rubber dams, and on occasions the clinical reasoning leads the dentist to choose not to use the rubber dam kit. Alternatives such as high speed suction and the use of cotton wool were used instead on these occasions. The dentist said that each individual case was risk assessed.

Medical emergencies

The dental practice had emergency medicines and oxygen to deal with any medical emergencies that might occur. These were located in a secure central location, and all staff members knew where to find them. We checked the medicines and found they were all in date. We saw the practice had a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

The practice had a first aid box, and we saw the contents were being checked regularly. Three members of staff had completed a first aid at work course, and the training was still in date at the time of our inspection. There was a poster in the waiting room informing patients who the trained first aiders were.

The practice had an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. Records showed all staff had completed basic life support and resuscitation training on 28 November 2015. Resuscitation Council UK guidelines suggest the minimum equipment required includes an AED and oxygen which should be immediately available.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training, and medical emergencies had been discussed in team meetings. We spoke with two members of staff who were able to describe the actions to take in relation to various medical emergencies including a cardiac arrest (heart attack).

Staff recruitment

We looked at the personnel files for six staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff personnel files. This includes: proof of identity; checking the prospective staff members' skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). 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, and in the records we sampled all had been completed within the last year. We discussed the records that should be held in the personnel files with the practice manager, and saw the practice recruitment policy and the regulations had been followed.

There were sufficient numbers of suitably qualified and skilled staff working at the practice to meet the needs of the patients.

Monitoring health & safety and responding to risks

The practice had both a health and safety policy and environmental risk assessments, which had been reviewed and updated in November 2015. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example, the practice had obtained a first aid box and had trained three staff members in first aid at work.

The practice had other specific policies and procedures to manage other identified risks. These included fire safety, manual handling and the risk of latex. Records showed that fire detection and firefighting equipment such as fire alarms and emergency lighting were regularly tested. The fire extinguishers had last been serviced in December 2014. The practice had five fire extinguishers, of two different types - foam and carbon dioxide; in addition there was also a fire blanket. This would allow staff to extinguish a small fire safely with the appropriate type of extinguisher. The last recorded fire drill was in September 2015.

Are services safe?

The practice had a health and safety law poster on display in a staff area of the practice. 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.

Staff training records identified that staff had received up-to-date training in health and safety matters, including fire training.

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, the relevant parts of which were on display in the decontamination room and the treatment rooms. The policy described how cleaning should be completed at the premises including the treatment rooms and the general areas of 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 all staff had received training in infection control with the latest update in November 2015.

Records showed that regular six monthly infection control audits had been completed. The latest was dated 3 December 2015. Where issues had been identified an action plan had been completed to address these. Evidence showed that steps had been taken to address the action plans, and improvements and changes had been completed as a result.

The practice used sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) The bins were located out of reach of small children. The Health and safety Executive (HSE) had issued guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013', and the practice were following the guidance.

We saw that the cleaning cupboard was not organised in a way that would prevent cross infection. Cleaning mops were not stored upright, and were leaning against each other. This would allow cross contamination from mop head to mop head. We brought this to the attention of the practice manager who said that the cleaning cupboard and the arrangements for storing mops would be reviewed.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored away from patient areas while awaiting collection in a locked bin. 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. The mercury spillage kit was in date and stored in a central location where staff could access it when needed.

The practice did not have a dedicated decontamination room. Decontamination was carried out in the treatment rooms, where an area had been identified for the purpose. The age, layout and the constraints of the building had prevented a designated decontamination room being provided. We saw there was a clear flow through from dirty to clean to reduce the risk of cross contamination and infection. In addition there was an area in the clean side for bagging clean and sterilised dental instruments and date stamping them. Staff wore personal protective equipment during the process to protect themselves from injury. These included gloves, aprons and protective eye wear.

We found that instruments were being cleaned and sterilised in line with the published guidance (HTM 01-05). A dental nurse demonstrated the decontamination process, and we saw the procedures used followed the practice policy. Guidance and instructions were on display within the decontamination areas for staff reference.

The practice had two ultrasonic baths. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. After the ultrasonic bath instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in the practice's autoclave (a device for sterilising dental and medical instruments). At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

Are services safe?

The practice had two steam autoclaves. These were designed to sterilise non-wrapped or solid instruments. At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising was maintained and serviced regularly in accordance with the manufacturers' instructions. There were daily, weekly and monthly records to demonstrate the decontamination processes to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

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

The practice had a policy for assessing the risks of Legionella, and a risk assessment had been completed. This was to ensure the risks of Legionella bacteria developing in water systems had been identified and measures taken to reduce the risk of patients and staff developing Legionnaires' disease. Legionella is a bacterium found in the environment which can contaminate water systems in buildings.

The practice was flushing the 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 in the water lines.

Equipment and medicines

Records showed that equipment at the practice was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had taken place on electrical equipment with the last testing recorded as 20 November 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures. Records showed the fire extinguishers had been serviced annually.

Medicines used at the practice were stored and disposed of in line with published guidance. Medicines were stored securely and there were sufficient stocks available for use. A log recording batch numbers was kept for antibiotic and local anaesthetic medicines.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. Emergency medicines and oxygen were available, and located centrally and securely ready for use if needed.

Prescription pads at the practice were numbered and a log was kept. Prescription pads were stored securely when not in use.

Radiography (X-rays)

The dental practice had three intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). X-ray equipment was located in each treatment room. X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The local rules identified the practice had a radiation protection supervisor (this was the dentists working at the practice) and a radiation protection advisor (a company specialising in servicing and maintaining X-ray equipment). 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 measures in place protected people who required X-rays to be taken as part of their treatment. We saw the quality of X-rays taken at the practice were audited on a regular basis. The most recent X-ray audit having been completed in September 2015.

Records showed the X-ray equipment had last been serviced within the last two years. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

We discussed the use of radiographs with the principal dentist to confirm the practice was monitoring the quality of the radiograph images and that there were records to

Are services safe?

demonstrate this. The practice was using digital radiograph images which relied on lower doses of radiation, and did not require the chemicals to develop the images required with conventional radiographs.

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

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice kept dental care records for each patient. These records included all information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. We reviewed the dental care records for five patients, we found that an up to date medical history had been taken on each occasion.

Patients' completed a medical history form, and information provided included: any health conditions, current medicines being taken and whether the patient had any allergies. These were taken for every patient attending the practice for treatment. For returning patients the medical history focussed on any changes to their medical status. We saw that dentists were signing the medical history forms to show they had seen the information and verified it with the patient.

The dental care records showed that comprehensive assessment of the periodontal tissues (the gums) and soft tissues of the mouth had been undertaken. 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 that dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Dental care records showed that treatments had been relevant to the symptoms or findings, treatment options were explained and that adequate follow up had been arranged. Discussions with dentists showed they were aware of NICE guidelines, particularly in respect of recalls of patients, antibiotic prescribing and wisdom tooth removal.

Health promotion & prevention

There was literature in the waiting room and reception area about the services offered at the practice. There was also information about how to improve patients' oral health. For example: information about the risks associated with smoking and alcohol. In addition the practice had leaflets and posters warning of the signs of oral cancer.

We saw examples in patients' dental care records that advice on smoking cessation, alcohol and diet had been discussed. With regard to smoking dentists had highlighted the risk of periodontal disease and oral cancer.

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

Staffing

The practice has two dentists, one dental hygienist, five dental nurses and two receptionists. 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 reviewed staff training records and saw staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the General Dental Council (GDC). The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples included: consent and medical emergencies.

The practice appraised the performance of its staff with annual appraisals. We saw evidence in three staff files that appraisals had been taking place. We also saw evidence that new members of staff followed an induction programme. We spoke with two members of staff who said they had received an annual appraisal.

Working with other services

The practice made referrals to other dental professionals when it was clinically indicated that a referral should be made. For example referral for treatment at the dental hospital if there was suspected cancer or the patient required advanced oral surgery. The practice used a standard referral form when referring to the oral and maxillofacial surgery within Nottingham city. For referral to

Are services effective?

(for example, treatment is effective)

other dental services the practice had an NHS referral form, which identified the reason for the referral. These included: learning difficulties, bleeding disorders and severe physical problems.

We saw from posters and leaflets within the practice that the dentists were very oral cancer aware. Discussions with staff identified that referrals were made promptly if there was any suspicion of oral cancer. The practice was also aware of the two week referral window for oral cancer, and was confident that any suspicions were acted on and referred straight away.

Consent to care and treatment

The practice had a consent policy which had been reviewed and updated in October 2015. Reception staff explained how consent forms, were part of the estimate and treatment plan, and patients signed to show their consent.

Discussions with a dentist showed they were aware of and understood the use of Gillick competency for young persons. Gillick competence is used to decide whether a child (16 years or younger) is able to consent to their own medical or dental treatment without the need for parental permission or knowledge. The practice consent policy provided information about Gillick competence.

The consent policy also had a description of competence or capacity and how this affected consent. The policy linked this to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Discussions with two members of staff identified their awareness and understanding of the MCA.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the inspection we took time to observe how the staff spoke with patients and whether they treated patients with dignity and respect. Our observations showed that there was a good relationship between the staff and the patients. Staff spoke politely, and in a professional manner, and on two occasions we saw staff reassuring patients and putting them at ease.

Care Quality Commission (CQC) comment cards completed by patients identified they thought the staff treated people with dignity and respect. Many of the patients said they had been coming to the practice for many years, and their confidence and satisfaction had been built over time. All of the comment cards were positive, with a third identifying the friendliness of the reception staff as a positive factor in their dental experience.

Reception staff told us that they were aware of the need for confidentiality when conversations were held in the reception area. The practice had a television to make it difficult for other patients to hear conversations at the reception desk. As a result the practice had both a Performing Rights Licence (PPL) and a Performing Rights Society (PRS) licence. If a patient conversation was required to be held in private, staff said that an unused treatment room or a staff area was usually available.

The practice had a chaperone policy for patients, and posters in the waiting room identified that patients could be accompanied by family or friends into the treatment room. This was especially good for nervous patients.

We observed several patients being spoken with by staff throughout the day, and found that confidentiality was being maintained. We saw that patient dental care records were held securely and computers were password protected.

We received positive feedback from 49 patients about the dental practice from a variety of sources. This was from speaking with patients in the practice, through Care Quality Commission (CQC) comment cards we left at the practice prior to our inspection, from comments on the NHS Choices website and comments sent directly to CQC through the 'have your say' feature on the CQC website. Feedback from all sources was positive, with many patients expressing their satisfaction with the dental service provided and the friendliness and approachability of the staff.

Involvement in decisions about care and treatment

Patients said the dentists involved them in decisions about their care and treatment; this included the opportunity to ask questions. Patients also said dentists explained treatment in a way they could easily understand.

The practice offered both private and NHS treatments and both sets of costs were clearly displayed in the practice.

We spoke with dentists, and a dental nurse who said that each patient had their dental treatment and diagnosis discussed with them. Treatment options and costs were explained before treatment started. Comments from patients were particularly clear about being involved in discussions about treatment options. The patients we spoke with in the practice said the dentist discussed treatment options and also provided explanations if the patient did not understand. Where necessary information about preventing dental decay was given to improve patients' oral health. The dental care records were updated with the proposed treatment after discussing the options. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Feedback from patients about appointments was positive. Five patients made specific reference to the appointments system, and being seen quickly in an emergency. Three others had commented that it was easy to get an appointment at a time that suited. One patient had been delayed in getting to their appointment and commented that staff had not made a fuss, but rearranged the appointment at a suitable time. When patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day.

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

New patients were asked to complete a confidential medical history form produced by the British Dental Association. This allowed the practice to gather important information about the patient's previous and current dental and medical history. Information requested included any medicines being taken, alcohol and smoking information and allergies and health conditions. For returning patients the medical history was updated so the dentists could respond to any changes in health status.

The treatment rooms were spacious and well equipped. We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Tackling inequity and promoting equality

The practice was situated on the first floor of a building in the city centre. The first floor was accessed by a flight of stairs; consequently the practice was not fully accessible. The NHS Choices website identified that the practice did not provide wheelchair access, or have an assisted toilet. However, this information was not available o the practices' own website.

There were leaflets in the waiting room for a number of self-help support groups in Nottingham covering a range of health issues both physical and mental. There was also information for patients who were gay or transgender.

The practice did not have a hearing induction loop. A hearing induction loop would enable a person wearing a hearing aid to hear more clearly by simple adjustment of their hearing aid. The Equality Act (2010) required where 'reasonably possible' hearing loops to be installed in public spaces.

The practice had good access to all forms of public transport being situated in the city centre. It was a short walk from the nearest tram stop, and there were a number of pay and display car parks within a short walk of the practice.

Patients said that they were usually seen on time, and making an appointment was easy, as the reception staff were both friendly and helpful.

Access to the service

The practice was open: Mondays to Thursdays: 9:00 am to 5:00 pm and Fridays 9:00 am to 4:30 pm. The practice was closed for lunch each day 1:00 pm to 2:00 pm.

Access for urgent treatment outside of opening hours was by ringing the practice telephone number and following the answerphone message. Alternatively patients could ring 111 and contact the NHS out-of-hours service. This information was available in the practice, in the practice leaflet and on the practice website.

The practice operated a text message service to remind patients they had an appointment. This service had been set up following feedback from patients who had requested the service.

Concerns & complaints

The practice had a complaints procedure for patients who wanted to make a complaint. The procedure explained the process to follow, and included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included NHS England and the Health Service Ombudsman

Information about how to make a complaint was displayed in the practice waiting room, in the practice leaflet and on the practice website.

The NHS Choices website had received one comment from a patient during 2015 about this dental practice. The comment was wholly positive.

From information received before the inspection we saw that there had been no formal complaints received in the past 12 months. Records within the practice showed that

Are services responsive to people's needs?

(for example, to feedback?)

complaints received previously had been handled in a timely manner, and there was evidence of investigation into the complaints with the outcomes recorded. The records also showed that apologies had been given for the concern and upset the patients had experienced.

Are services well-led?

Our findings

Governance arrangements

There was a clear management structure at the practice. Staff said they understood whom they could speak with if they had any concerns. Staff said that the practice held regular staff meetings, approximately once every six weeks. During the inspection we saw copies of minutes from those meetings. Two staff members said there was good communication within the staff team, and that the practice was a good place to work.

We reviewed a number of policies and procedures at the practice and saw that most had been reviewed and where relevant updated during 2015.

The principal dentist registered with the Care Quality Commission as an individual provider in December 2011. The registration status of being an individual did not require a registered manager to be in place.

We saw that audits were taking place throughout the year for both clinical and non-clinical areas of the practice. For example: medical emergencies and infection control had both been audited during 2015.

Leadership, openness and transparency

The practice manager had been in post for four years, they had responsibility for organising and managing the day to activity of the practice.

Staff said there was an open culture at the practice which encouraged honesty. Staff said they were confident they could raise issues or concerns at any time with the practice management team without fear of discrimination. Staff told us that they could speak with the principal dentist if they had any concerns. Staff members said they felt part of a team, were well supported and knew what their role and responsibilities were.

The practice had a whistleblowing policy which identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with external agencies. We discussed the whistleblowing policy with two members of staff. They were aware of the policy, and knew the circumstances when it could or would be used.

Learning and improvement

We found staff were aware of the practice values, such as promoting good oral health for patients attending the practice for care and advice, understanding and meeting the needs of patients and involving them in decisions about their care. Staff showed awareness of national guidelines, as these were discussed at staff meetings, and were on display within the practice. Staff were able to demonstrate that they worked towards these values. Leaflets and posters within the practice gave a positive message with regard to oral health. Discussions with staff identified they were aware of the practice's position and reinforced the views.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Documentation at the practice showed that training opportunities were available to all staff, and this was encouraged by the management team. Staff said they had good access to training, mostly in-house, but some external training too.

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

The practice had an NHS Friends & Family (F&F) box in the waiting room to collect the views of patients. In the previous month 14 patients had responded by completing comment cards. Analysis of the F&F information showed positive comments, and a poster in the waiting room informed patients of the action taken.

The patients we spoke with said they were aware of the F&F box in the waiting room. However, only one had ever completed a questionnaire, or provided any formal feedback to the practice.

The practice had stopped using their own patient satisfaction survey when the F&F box had been introduced in April 2015. This was because patients said they felt overloaded by too many suggestion boxes and cards to complete. Therefore the practice had streamlined their system and just used the F&F box. The practice reviewed feedback from patients, and held regular staff meetings where feedback from patients was discussed.

There were clear lines of responsibility and accountability; staff knew who to report to if they had any issues or concerns.