

KH&GW Limited

# Mydentist - Bramcote Lane - Nottingham

## Inspection Report

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Date of inspection visit: 15 March 2016  
Date of publication: 16/05/2016

### Overall summary

We carried out an announced comprehensive inspection on 15 March 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**

Mydentist Bramcote is situated on two floors of a building to the west of Nottingham city centre. The practice was registered with the Care Quality Commission (CQC) in May 2011. The practice provides mostly NHS dental treatment (70%). Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are: Monday: 9 am to 5:30 pm; Tuesday: 9 am to 8 pm; Wednesday, Thursday and Friday: 9 am to 5:30 pm. The practice is closed at the weekends.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients should ring the 111 telephone number for access to the NHS emergency dental 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 one oral surgeon; nine dentists; one foundation dentist; one hygienist; one therapists; eight dental nurses; two trainee dental nurses; three receptionists; a practice manager and a treatment co-ordinator.

We received positive feedback from 11 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection and by speaking with patients in the practice.

## **Our key findings were:**

- Patients spoke positively about their experiences of the dental services they received, and said they were treated with dignity and respect.
- Dentists identified the treatment options, and explored and discussed these with patients. However they were not always fully recorded in patients' notes.
- Patients' confidentiality was maintained.
- There were systems in place to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- There was a whistleblowing policy and procedures and staff were aware of these procedures and how to use them. All staff had access to the whistleblowing policy.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment including oxygen and emergency medicines.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Dentists involved patients in discussions about the care and treatment on offer at the practice.
- Patient recall intervals were in line with National Institute for Health and Care Excellence (NICE) guidance.

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

- Review the practice's protocols for recording in the patients' dental care records or elsewhere the reason for taking the X-ray and quality of the X-ray giving due regard to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- Review the practice's protocols for completion of dental records giving due regard to guidance provided by the Faculty of General Dental Practice regarding clinical examinations and record keeping.
- Review its responsibilities to the needs of people with a disability and the requirements of the equality Act 2010 and ensure a Disability Discrimination Act audit is undertaken for the premises.
- Review the practice's audit protocols of various aspects of the service, such as radiography and dental care records at regular intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

# 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.

Accidents and significant events were recorded 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.

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

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

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

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were completed as recommended by the current guidance. Equipment used in the decontamination process was maintained by a specialist company and regular checks were carried out to ensure equipment was working properly and safely.

X-rays were carried out in line with published guidance, and X-ray equipment was regularly serviced to make sure it was safe for use. Record keeping in relation to X-rays did not always identify the reason why the X-ray was taken.

### **Are services effective?**

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

All patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire. The practice used a recognised assessment process to identify any potential areas of concern in patients' mouths, jaws and neck, including their soft tissues (gums, cheeks and tongue).

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

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.

There were systems in place to help maintain patient confidentiality. Staff were able to demonstrate how they achieved this in both the reception area and the treatment rooms.

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

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

# Summary of findings

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

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

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

Patients said they had no problem getting an appointment. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The patient areas of the practice were mostly located on the ground floor. There was good access for patients with restricted mobility.

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

The practice had a hearing loop, to assist patients who used a hearing aid.

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

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

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

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

Audits carried out at the practice were not always effective, and the auditing system was in need of review.

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

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

# Mydentist - Bramcote Lane - Nottingham

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

During the inspection we spoke with five members of staff. We reviewed policies, procedures and other documents. We received feedback from 11 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 kept records and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in February 2013 this being a sharps injury to a member of staff. A sharps injury is a puncture wound similar to one received by pricking with a needle. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had a policy for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) which had been updated in July 2015. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although they were aware how to make these on-line. The accident policy had details of how to make a RIDDOR report together with a flow chart for ease of reference.

The practice recorded significant events. The records showed there had been one significant event in the 12 months up to the inspection visit. This was a computer failure which had made patients' records and X-rays unavailable. We saw that the significant event had been analysed and discussed in a staff meeting. We also saw that the practice had completed a reflection sheet where the consequences had been considered, and learning implemented for the future.

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 on a fortnightly bulletin from head office and were received by the practice manager. The alerts were analysed and information shared with staff if and when relevant. The practice manager showed that the most recent alert had been received in October 2015, on this occasion this had not affected the practice, but the information had been kept on file for information.

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

The practice had separate policies for safeguarding vulnerable adults and children. The children's policy had been reviewed and updated in January 2016 and the vulnerable adults policy in October 2015. Both policies identified how to respond to any concerns and how to escalate those concerns. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. A flow chart and the relevant contact telephone numbers were on display in reception and in the safeguarding file.

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

Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children. This had been completed on-line between January and March 2016.

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

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 31 March 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which directed staff how to handle sharps (particularly needles and sharp dental

# Are services safe?

instruments) safely. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy.

We discussed the use of safer sharps with a dentist and dental nurse, who outlined the steps taken to reduce the risks of sharps injuries. The practice had several 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 bins in the decontamination room and treatment rooms were located off the floor. The guidance indicated sharps bins should ideally be fixed to the wall. We discussed this with the practice manager who said they would look into having the bins wall mounted. The Health and safety Executive (HSE) guidance: 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013', was being followed.

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

Discussions with dentists and review of patients' dental care records identified the dentists were using rubber dams when completing root canal treatments. Guidelines from the British Endodontic Society say that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment.

## Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. We saw there was a system in place for checking and recording expiry dates of medicines, and replacing when necessary.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Two dental nurses had completed a first aid at work course which was valid until June 2017. The dental nurses were the designated first aiders for the dental practice, and a poster in the back of reception informed patients of this.

There was an automated external defibrillator (AED) held in the practice. An AED is a portable electronic device that

automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked on a daily basis to ensure it was working correctly.

Resuscitation Council UK guidelines suggest the minimum equipment required and includes an AED and oxygen which should be immediately available. Staff at the practice had completed basic life support and resuscitation training on 23 February 2016.

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

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

## Staff recruitment

We looked at the staff recruitment files for five 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. 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 and environmental risk assessment; both had been updated in December 2015. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example: slips, trips and falls in the practice.



# Are services safe?

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment was due to be reviewed during 2016. The fire extinguishers had last been serviced in December 2015. Records showed the last fire drill for staff had been on 21 October 2015.

The practice had a health and safety law poster on display on the office door. 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 a copy of which had been reviewed in December 2015. The policy was readily available to staff working in the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that infection control audits had been completed as identified in the guidance HTM 01-05. The last audit in June 2015 scored 89%. This audit was overdue, although the practice manager said the audit was scheduled in the coming weeks. We saw that an action plan had been produced following the last audit, and staff were able to demonstrate the actions taken to address the areas where the score had dropped.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for both mercury and bodily fluids. Both spillage kits were in date.

There was a dedicated decontamination room that had been organised in line with HTM 01-05. The decontamination room had dirty and clean areas, and there was a clear flow between to reduce the risk of cross contamination and infection. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear.

We 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.

The practice used a washer disinfectant (a machine for cleaning dental instruments similar to a domestic dish washer) for cleaning the dental instruments. In addition the practice was also using an ultrasonic bath. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and water. After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's three autoclaves (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.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. The practice had completed records to demonstrate the decontamination processes was effective, and to ensure that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

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

We saw records to demonstrate that staff had received inoculations against Hepatitis B and had 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 this blood borne infection.



# Are services safe?

The practice had a policy for assessing the risks of Legionella; this had been updated in November 2015. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella. The risk assessment identified the practice was a low risk with regard to Legionella. The risk assessment also identified that it was not necessary to complete regular water tests.

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

## Equipment and medicines

The practice maintained a file of 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 during March 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

We saw the Landlord's certificate for gas safety which was dated 29 July 2015. In addition pressure valve checks had been completed on 8 June 2015.

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

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

## Radiography (X-rays)

The dental practice had five intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the

mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull. 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 appointed radiation protection supervisors (RPS) this was all of the dentists. There was also a radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Records showed the X-ray equipment had last been serviced in March 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

The practice used digital X-ray images; these rely on lower doses of radiation, and do not require the chemicals to develop the images required with conventional X-rays. This makes them safer for both patients and staff.

All patients were required to complete 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. There were risk assessments in place for pregnant and nursing mothers.

Guidance from the Ionising Radiation (Medical Exposure) Regulations 2000 identified that dental care records should include grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. Patients' dental care records showed that information related to X-rays was not always recorded in line with the guidance. Records showed that an audit of X-rays was overdue. As a result short comings in record keeping had not been identified and addressed.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

The practice held dental care records for each patient. We saw a small number of dental care records to confirm information we had gathered during the inspection. The dental care records contained information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. The dental care records showed a thorough examination had been completed, and included examination of the soft tissues including the tongue and the jaw and neck.

Patients at the practice completed a medical history form, or updated their details. The medical history was then scanned into the patients' notes to become a permanent part of the dental care record. The dentist checked the medical history form with the patient before treatment began. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that 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 dentists used nationally recognised guidelines on which to base treatments and develop longer term plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

The costs for both private and NHS treatments were on display in the practice. Patients also had access to a treatment co-ordinator to explain the difference between NHS treatments and private treatments; explain the different costs, and answer any questions.

### Health promotion & prevention

The practice had a large waiting room, and information for patients was on display. There was assorted literature about the services offered at the practice, as well as health promotion advice.

Discussions with the dentists identified that the practice made patients aware of the risks associated with oral cancer. Posters and leaflets to inform patients of the risks associated with oral cancer were available. The practice was aware of oral cancer awareness month, and the practice manager said staff used this as an opportunity to raise awareness.

A dentist explained that children seen at the practice were assessed on an individual basis to check their risk of dental decay. This resulted in fluoride application varnish and fluoride toothpaste being routinely provided to all children identified as being at risk.

Staff at the practice said they always got involved with national campaigns, such as: national smile month and national no smoking day in March.

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

### Staffing

The practice had one oral surgeon; nine dentists; one foundation dentist; one hygienist; one therapists; eight dental nurses; two trainee dental nurses; three receptionists; a practice manager and a treatment co-ordinator. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

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

# Are services effective?

(for example, treatment is effective)

Records at the practice showed that appraisals had been completed for all staff. The principal dentist said the format had changed each year to have a different focus and emphasis. Appraisals were completed in the first three months of the calendar year for all staff. We saw evidence in four staff files that appraisals had taken place. We also saw evidence of new members of staff having an induction programme. We spoke with two members of staff who said they had received an annual appraisal.

## Working with other services

Staff at the practice said that referrals to other dental professionals were made when it was clinically indicated that a referral should be made. For example: when complex treatment was required, for difficult extractions, sedation services or for orthodontic treatment. The practice usually referred to the community dental service or the maxillofacial unit at the local NHS hospital.

Patients' dental care records within the practice identified that referrals for patients with suspected oral cancer had been made within the two week window for urgent referrals, and these were tracked to ensure they had been received and the patient seen. Records identified that referrals had been sent the same day the patient had been seen.

The practice was following the Department of Health guidance contained in the document 'Delivering better oral

health: an evidence based toolkit for prevention'. Up until October 2015 the practice had been part of the pilot with regard to the implementation of this guidance. We saw evidence of the guidance being followed both through talking to dentists and in records within the practice.

## Consent to care and treatment

The practice had a consent policy which made reference to capacity and the Mental Capacity Act 2005 (MCA) and best interest decisions. The policy had been reviewed in December 2015. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

The practice recorded consent in the patients' dental care record. However, on looking at three randomly identified examples we saw that consent had not been well documented. In the three examples we saw that a tick box approach had been used, with no record of the detail, or the discussion between patient and dentist.

Discussions with dentists showed they were aware of and understood the use of Gillick to record competency for young persons. Gillick competence 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**

Throughout the inspection we observed the interaction between staff spoke and patients. We saw that staff were welcoming, friendly and polite. Our observations showed that patients were treated with dignity and respect throughout the dental practice.

The reception desk was located within the waiting room. We discussed the need for confidentiality with reception staff who explained how this was achieved. Staff said if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen. The practice had a consulting room off the waiting room which was ideal for this purpose. Staff said that if this room was unavailable or in use, an unused treatment room or the manager's office would be used instead. Staff said all details of patients' individual treatment was discussed in the privacy of the treatment or the consulting rooms.

We observed several patients being spoken with by staff throughout the day, and found that confidentiality was being maintained both at the reception desk and in the treatment room. We saw that patients' dental care records were held securely.

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

We received feedback from 11 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in

the practice. Feedback was wholly positive with patients particularly noting the friendliness of the staff and the good dental care that had been delivered. The CQC comment cards identified that patients who responded thought the dentist involved them in decisions about their dental care and treatment. Several patients said the dentists took the time to explain the treatment and there was an opportunity to ask questions.

The practice offered mostly NHS treatments (approximately 70%) and the cost of NHS treatment within the banding scheme were identified in the practice. The costs of private treatment were also displayed within the practice

We spoke with two dentists, and two dental nurses who explained how each patient had their diagnosis and dental treatment discussed with them. The treatment options and costs involved were explained before treatment started. Patients were given a written copy of the treatment plan which included the costs. The treatment co-ordinator was available to discuss treatment options and plans in greater depth, and had models, photographs and literature to help with those discussions.

Where necessary dentists gave patients information about preventing dental decay. This included discussions about smoking and diet on the patient's teeth, gums and mouth. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. Information posters for patients regarding the frequency of dental visits and the NICE guidelines were displayed within the practice.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice was situated in a building on a main road, with a bus stop nearby. There was car parking available close to the practice. There were four ground floor treatment rooms.

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

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

We spoke with two patients during the inspection. Patients said they had found getting an appointment fairly easy, and there had no unreasonable delay in getting their appointments. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient within 24 hours, and usually the same day.

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

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

The practice was located on two floors of a building with most of the treatment rooms and patient areas on the ground floor and accessible to patients with restricted mobility.

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

The practice had completed a Disability Discrimination Act (1995) access audit in September 2008. Following this audit the practice had considered the needs of patients with restricted mobility. Particularly in respect of them accessing the service and meeting their dental needs. The legislation had been updated and replaced by the Equality Act (2010). However, the practice had not reviewed its access audit, or taken account of the new legislation.

There was a portable hearing induction loop situated in reception, to assist those patients who used a hearing aid.

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

The practice had access to a recognised company to provide interpreters, and this included the use of sign language.

### Access to the service

The practice's opening hours were: Monday: 9 am to 5:30 pm; Tuesday: 9 am to 8 pm; Wednesday, Thursday and Friday: 9 am to 5:30 pm. The practice was closed at the weekends.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could ring the 111 telephone number for access to the NHS emergency dental service.

Patients were sent a text reminder that their appointment was due the day before their appointment.

### Concerns & complaints

The practice had a complaints procedure which had been reviewed in December 2015. 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 Parliamentary and Health Service Ombudsman.

Information about how to make a complaint was displayed in the practice waiting rooms, and a shorter version in the practice leaflet.

From information received before the inspection we saw that there had been nine complaints received in the past 12 months. These included an anonymous comment posted on the NHS Choices website. We saw from documentation in the practice that complaints had been addressed in a timely way, and apologies had been given for the distress caused. Where there had been learning points from the complaints these had been shared with the staff team.

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## Our findings

### Governance arrangements

We reviewed a number of policies and procedures at the practice and saw that they had been reviewed and where relevant updated during 2015 and 2016. There was a management plan to review and update policies and procedures.

Staff said they understood their roles and could speak with the practice manager or a dentist if they had any concerns. Staff said they understood the management structure at the practice, and within the wider organisation. We spoke with three members of staff who said they were happy working at the practice, and felt part of a team.

We were shown a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw suggested there was a need for a clinical record keeping audit at the practice. Ideally to be completed by someone with a clinical background to assess the quality of the note taking.

### Leadership, openness and transparency

There was a practice manager in post who said they would shortly be undertaking a practice management development course to gain additional skills in practice management.

The practice held staff meetings throughout the year, with full staff meetings scheduled on a monthly basis. We saw that in the past staff meetings had not been minuted. However, since January 2016 minutes of staff meetings had been kept and were available to all staff. We saw minutes identified topics such as: Patient feedback, health and safety and quality assurance.

We spoke with several different grades of staff at the practice. We were told there was an open culture, with staff able to voice their views, and raise concerns. Dentists were available to discuss any concerns and there was support available regarding clinical issues. There was also support from the wider organisation, including training opportunities and peer support. Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. We discussed the whistleblowing policy with two dental nurses who were able to describe the purpose of the procedures, and when and how to use them. The policy was available on the staff room notice board and also on any computer in the practice.

### Learning and improvement

We saw there was a schedule of audits completed throughout the year. This was for both clinical and non-clinical areas of the practice. However, past records were not detailed and there was a need to review the auditing process at the practice. This was to ensure all necessary audits had been completed, and contained enough detail to make an evaluation. Discussions with the practice manager showed that audits were an area that had been identified as in need of improvement. The practice had started working on those improvements.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period. The practice manager was monitoring clinical staff members' CPD on behalf of the organisation.

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

The practice had a NHS Friends and Family (F and F) comment box which was located on the reception desk. The F and F comment box was used specifically to gather regular feedback from the NHS patients, and to satisfy the requirements of NHS England. The responses within the boxes were analysed on a monthly basis. Feedback from patients by means of the F and F box was sparse, with six responses in January 2016 and four in February 2016. All 10 respondents said they would recommend the practice to their family and friends.

We visited the NHS Choices website and reviewed the information and comments that patients had left about the practice. The website identified that six patients had



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provided feedback since 2013. The responses were a mixture of positive and negative comments. The practice had responded to all of the comments and where necessary apologies had been given.