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Pedmorevalley Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 January 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

Pedmorevalley Dental Practice is situated in a single storey building close to the centre of the Bestwood Park estate in north west Nottingham. The practice was registered with the Care Quality Commission (CQC) in April 2011. The practice provides regulated dental services to patients mostly in the Bestwood Park area of Nottingham. The practice provides mainly NHS dental treatment. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice is open: Monday to Thursday: 9 am to 1 pm and 2 pm to 5:30 pm

Friday: 9 am to 1 pm and 1:30 pm to 3 pm. The practice is closed at the weekend. Access for urgent treatment outside of opening hours is by ringing the practice and following the instructions on the answerphone message. Alternatively NHS patients should ring the 111 telephone number.

Summary of findings

The practice has three dentists, one of whom is the principal dentist and owner of the business. There are also three dental nurses who also work on reception, and one practice manager.

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

Our key findings were:

- The practice had systems to record accidents, significant events and complaints, and any learning points were identified and shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced.
- All staff had received whistle blowing training and were aware of these procedures and how to use them. All staff had access to the whistleblowing policy.
- Patients spoke positively about the dental service they received.
- Patients said they were treated with dignity and respect.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- All staff had been trained to deal with medical emergencies.
- There was the necessary equipment for staff to deal with medical emergencies.
- 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 consultation with the patient and recall intervals are in line with National Institute for Health and Care Excellence (NICE) Patients said they were involved in making decisions about their treatment, and patient care records reflected this.
- Treatment options were identified and explored and discussed with patients.
- Patients' confidentiality was maintained.

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 been trained in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had lead members 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. Regular checks were being completed to ensure the equipment was in good working order.

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

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance. 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.

All patients were clinically assessed by a dental professional before any treatment began. This included completing a health questionnaire or updating one for returning patients. 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 recalls, wisdom tooth removal and the use of antibiotics.

There were clear procedures for referring patients to secondary care (hospital or other dental professionals). The practice kept a log of referrals and tracked their progress. Staff were able to demonstrate that referrals had been made in a timely way when necessary.

The consent policy required an update to ensure that it clearly referenced the relevant legislation and guidance.

Are services caring?

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

Staff understood the need for confidentiality, and took steps to ensure patients' that confidentiality was maintained. This was in all areas of the practice.

Patients were treated in a polite caring manner and with dignity and respect.

Summary of findings

Staff at the practice were welcoming to patients and made efforts to help anxious 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.

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 met their needs. Patients said it was easy to get an appointment. The appointments system included a text message reminder service. Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

The practice was a single storey building with ground floor treatment rooms, so that patients with restricted mobility could access the practice and receive treatment.

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.

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, with a practice manager in post. Staff were aware of their roles and responsibilities within the dental team.

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

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

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

Pedmorevalley 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 28 January 2016. 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 five members of staff.

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, including the principal dentist and three dental nurses, who also worked as receptionists, and the practice manager. We reviewed policies, procedures and other documents. We received feedback from 32 patients about the dental service

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There were procedures for recording, investigating, responding to and learning from accidents, significant events and complaints. Documentation showed the last recorded accident had occurred in November 2015, this being a needle stick injury to a member of staff. The cause had been identified and steps taken to ensure this was not repeated. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

We saw documentation that showed the practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). The practice manager said that there had been no RIDDOR notifications made, 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 kept a log of significant events. The records showed there had been no significant events recorded in the last year. The most recent incident related to a patient becoming unwell in the practice. The records showed that appropriate action had been taken by the practice 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 by the practice manager or principal dentist by e mail and were analysed and information shared with staff if and when relevant.

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. These policies had been reviewed in June 2015. The 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 phone numbers were on display in staff areas of the practice.

The principal dentist and the practice manager were the identified leads 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.

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 1 October 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which had been reviewed in May 2015. We saw one dentist was using a needle block. This was a safe system for handling syringes and needles in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. We discussed this with a dentist, who outlined the steps taken to reduce the risks of sharps injuries. There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the bins in the decontamination room and treatment rooms were located off the floor. The guidance says sharps bins should not be located on the floor, and should be out of reach of small children. The Health and safety Executive (HSE) guidance: 'Health and safety (sharp instruments in healthcare) regulations 2013', was being followed.

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. We were told the reason for not using a rubber dam was a clinical decision or on occasions patients' choice. As an alternative dentists were using high speed suction and cotton wool wadding.

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 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. There was also an identified member of staff who had completed first aid training.

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 in January 2015. Resuscitation Council UK guidelines suggest the minimum equipment required includes an AED and oxygen which should be immediately available. The practice also had portable suction and manual resuscitation equipment (a bag valve mask) for use in an emergency.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies. We spoke with two members of staff who was able to describe the actions to take in relation to various medical emergencies including a patient collapsing in the practice. The most recent significant event recorded at the practice showed that when a patient had become unwell in the practice, the staff had responded appropriately.

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 both a health and safety policy and environmental risk assessments, which had been reviewed and updated in July 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 trained staff in manual handling; there were risk assessments for the use of latex in the practice and pregnant & nursing mothers receiving treatment.

Records showed that fire detection and fire fighting equipment such as fire alarms and emergency lighting were regularly tested. The fire risk assessment had been updated in June 2015. The fire extinguishers were last serviced in October 2015, with staff fire training at a staff meeting in April 2015.

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.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' In respect of infection control and decontamination of

equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy which had been reviewed and updated in June 2015. A copy of the policy was readily available to staff working in the practice. The policy described how cleaning should be completed at the practice 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.

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit scored 100%, so no action plan was produced. However, we did see action plans from previous audits.

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.

The practice had 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. 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 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 had a washer disinfector (a machine for cleaning dental instruments similar to a domestic dish washer). After the washer disinfector 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). The practice had one steam autoclave. This was designed to sterilise solid and non-wrapped dental 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.

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.

Information in the 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 Legionella risk assessment. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. Records showed the practice was aware of the risks associated with Legionella and had taken steps to reduce them.

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

Are services safe?

The practice kept records which showed that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had taken place on electrical equipment at the practice during 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

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.

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

Prescription pads at the practice were available and managed effectively. Numbered prescription pads were allocated to each dentist, and the 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). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the whole mouth including the teeth and jaws. 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 radiation protection supervisors (RPS) this was the principal dentist, and a radiation protection advisor (RPA). This was 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.

Emergency cut-off switches for the X-ray machines were located away from the machines and were easily accessible for staff.

Records showed the X-ray equipment had last been serviced in January 2016. 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 (X-rays) with a dentist to confirm the practice was monitoring the quality of the radiograph images. We saw records to demonstrate that this was happening.

The three intraoral X-ray machines had been fitted with rectangular collimation. The Ionising Radiation Regulations (Medical Exposure) Regulations 2000 recommend the use of rectangular collimation to limit the radiation dose a patient receives during routine dental X-rays. Rectangular collimation is a specialised metal barrier attached to the head of the X-ray machine. The barrier has a hole in the middle used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient received and the size of the area affected.

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.

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. Discussions with the principal dentist identified that grading of the radiographs occurred every time an X-ray was taken, to judge if the equipment was working correctly. We saw examples of this in practice.

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. We saw a small number of patient care records to confirm what the dentists had told us during the inspection. These records included all information about the assessment, diagnosis, treatment and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and included examination of the soft tissues including the tongue and the jaw and neck.

The practice used a form to record the patients' medical histories. The patients' medical histories form included any health conditions, 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.

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. Discussions with dentists showed they were aware of NICE guidelines, particularly in respect of recalls of patients, antibiotic prescribing and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

There was a range of literature in the waiting room and reception area about the services offered at the practice. In addition there were some posters giving general health advice, and information about other local services in the community. There were also posters and leaflets providing information about improving patients' oral health; much of this was aimed at children. For example: Avoiding tooth decay and acid erosion, and advice about sugar. For adults there was information about the risks associated with smoking, and information about helplines and support with stopping smoking.

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

Staffing

The practice had three dentists, one of whom was the principal dentist and owner of the business. There were three dental nurses who also worked on reception, and one practice manager.

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 of training completed included: Medical emergencies, Infection control, Introduction to oral health promotion and Radiography.

The practice carried out annual appraisals for all staff. The records showed that appraisals had last been completed during May and June 2015. We saw evidence in three staff files that appraisals had been taking place. We also saw evidence of new members of staff having an induction programme. We spoke with three members of staff who said they had received an annual appraisal with the principal dentist or practice manager.

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 a difficult extraction.

Are services effective?

(for example, treatment is effective)

Records within the practice identified that for suspected oral cancer referrals had been made within the two week window for urgent referrals. The practice kept a record of other practices and services who accepted referrals, and the reason why that referral would be made.

The practice mainly referred patients to the Maxillofacial surgery department at Queens Medical Centre (QMC) or to the City Assessment Services (CAS team). Referrals to the QMC would usually be for more urgent surgical cases. Referrals to the CAS team would usually be for children or patients who had a learning or physical disability.

Patients' care records showed that referrals had been made, and that patients' had been involved in discussions about the referral and the reasons why it was necessary.

Consent to care and treatment

The practice had a consent policy which was reviewed and updated following the inspection visit. The policy made reference to informed consent and voluntary decision making, and was updated to make reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provided a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

The practice used both the standard NHS treatment plan and consent form (FP17DC) for NHS patients and a treatment plan for private patients. These forms allowed the practice to record consent, and also identified the cost of the treatment for the patient.

Discussions with the principal dentist showed they were aware of and understood the use of Gillick to record 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's consent policy made reference to the ability to give consent and identified the age of 16 as being relevant when considering consent. However, the policy did not make specific reference to Gillick competence.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

During the course of the inspection we observed staff speaking with patients. We saw that staff were friendly, polite and professional. We noted two incidents where reception staff took time and trouble to put particular patients at ease. Our observations showed that patients were treated with dignity and respect.

The reception desk was located in the waiting room and was open plan. We discussed the need for confidentiality with reception staff who told us that the practice took positive steps with regard to confidentiality. Treatment was discussed with patients in the privacy of the treatment room. Staff said that if a confidential or sensitive conversation was needed; either the office or an unused treatment room was available for privacy.

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 patient dental care records were held securely and computers were password protected.

Involvement in decisions about care and treatment

We received feedback from 32 patients on the day of the inspection. Patients said the dentists involved them in decisions about their care and treatment. Eight patients made specific reference to dentists explaining treatment clearly and giving the patient the opportunity to ask questions.

The practice offered mostly NHS dental treatments and costs for both private and NHS treatments were clearly displayed in the practice.

We spoke with dentists, and two dental nurses who said that each patient had their dental treatment and diagnosis discussed with them. Treatment options and costs were explained before treatment started, and patients were given a written treatment plan including costs. Within the treatment room there were leaflets giving information and advice about a range of dental treatments. Where necessary information about preventing dental decay was given to improve patients' oral health. This included discussions about smoking and diet, and the effects of carbonated drinks on the patient's teeth, gums and mouth. 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

The practice was situated in a building which had been converted for the purpose several years previously. As a result considerable thought had been put into the layout of the practice, and it was well suited to meeting patients' needs. There were separate staff and patient areas, which helped with confidentiality and security. The treatment rooms were spacious and well equipped, and the whole practice was situated at ground level.

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. Both patients said they had not had a problem getting an appointment. Both patients said they had been able to make appointments that were convenient for them, and there had not been any significant delay. One patient said they had needed urgent treatment in the past, and had been seen the same day. 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.

New patients were asked to complete a medical and dental health questionnaire. This allowed the practice to gather important information about the patient's previous and current dental and medical history. For returning patients the medical history was updated so the dentists had the best available information available to them to meet patients' needs safely.

Tackling inequity and promoting equality

The practice was situated in a single story building close to centre of the Bestwood Park estate in north west Nottingham. The ground floor location allowed patients who may have difficulty accessing services due to mobility or physical issues to be seen. The practice had an equality and diversity policy to direct staff in meeting needs and promoting equality. This policy had been reviewed and updated in June 2015.

The practice had good access to all forms of public transport with a bus stop located close by. There were also disabled parking spaces close by. The practice was located in a small shopping precinct and free patient parking was available either in the small car park at the precinct or on nearby roads.

The practice purchased a hearing induction loop after the inspection, and sent evidence to CQC that this had been done. The Equality Act (2010) requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

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

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Staff said that there were very few patients who could not speak English, and if language was a problem the patient usually brought someone to interpret therefore avoiding the need for interpreters. In addition staff at the practice were able to speak and understand a few languages other than English, such as Swedish, Iraqi, and Iranian.

Access to the service

The practice leaflet identified the practice was open: Mondays to Thursdays: 9 am to 5:30 pm; Fridays 9 am to 3 pm. The practice was closed for lunch between 1 pm and 2 pm (1 pm to 1:30 pm on Fridays). This information was also available within the practice.

Access for urgent treatment outside of opening hours was by calling the 111 the NHS out-of-hours service. This information was available in the practice and in the practice leaflet.

The practice operated a text message service to remind patients they had an appointment. This service operated two days before the appointment was due.

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, the Parliamentary and Health Service Ombudsman and the dental complaints service.

Are services responsive to people's needs?

(for example, to feedback?)

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

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 complaints had been handled in a timely manner previously, with the last recorded complaint in 2014. This complaint had been investigated and the outcome was 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 they could speak with the principal dentist if they had any concerns, and understood the management structure. We spoke with four members of staff who said there was good communication within the staff team, and observations during the day, identified relaxed and positive working relationships.

We reviewed a number of policies and procedures at the practice and saw that they had been reviewed and where relevant updated during 2015. The practice manager had a management plan which included the review and updating of policies and procedures.

Leadership, openness and transparency

There was an experienced practice manager who had management and leadership qualifications.

The practice was holding full staff meetings on an approximate three monthly basis. In addition there were meetings for the dental nurses with a similar time frame. Full staff meetings were minuted, and those minutes were available to all staff. We saw minutes identified topics such as health and safety, updates to practice policy and staff training.

Staff said there was an open culture at the practice, with all of the dentists readily available for discussions about clinical issues. Staff said the principal dentist was approachable, and they felt confident to raise issues or concerns at any time with the principal dentist. Observations showed there was a relaxed but professional attitude among the staff. Discussions with different members of the team showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy which was had been reviewed in June 2015. This policy 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 three members of staff. They were aware of the policy, and knew the circumstances when it could or would be used.

Learning and improvement

We talked with several staff about the practice values. Staff were able to identify promoting good oral health for patients, and providing a patient centred approach to care as among the core values. Staff showed awareness of national guidelines, as these were discussed at staff meetings. Staff were able to demonstrate that they followed national guidelines in respect of delivering good dental care.

The practice manager demonstrated that a detailed schedule of audits were completed throughout the year. This was for both clinical and non-clinical areas of the practice. The information within the audits identified areas for improvement, and confirmed that quality was being achieved particularly in respect of clinical areas such as the taking of radiographs (X-rays). The practice was able to demonstrate where improvements had taken place following audits. For example: Patient record cards and referrals for each dentist were being audited every three months. Other audits included: medical histories and the quality and justification for radiographs.

Staff working at the practice were supported to maintain their continuing professional development as required by the General Dental Council. Training records at the practice showed that training opportunities were available to all staff. This was a mixture of in-house and external training.

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

The practice had a feedback form and box in the waiting room to collect the views of patients. The results were analysed on a three monthly basis. Results from the 12 months leading up to the inspection were all positive.

The practice also used the NHS Friends & Family comment box which was located in the waiting room. This was 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. Since the Family & Friends test was introduced in April 2015 the practice has received an average of five responses per month. Analysis of the Friends & Family information showed all of the responses were positive. All respondents were either likely or highly likely to recommend the practice to their family and friends.

Are services well-led?

However, the practice had not fed back to the patients what action had been taken in response to Family & Friends comments from patients. This was discussed with the practice manager and the principal dentist. Consideration was being given to providing feedback each month in the waiting room.

We visited the NHS Choices website and reviewed the comments that patients had left about the practice. In the 12 months leading up to the inspection there had been three comments posted on the website. Two comments were positive and one was negative. The practice had not provided a response to any of the comments. We discussed this with both the practice manager and the principal dentist, and both agreed that it would be in the practice's interests to provide a written response. The practice manager said this was something the practice would be doing going forward.