Ravenshead Dental Practice Ltd

Ravenshead Dental Practice

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 28 September 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

Ravenshead Dental Practice is a dental practice which provides private dental treatment. The practice is located in premises in the village of Ravenshead in north Nottinghamshire to the south of Mansfield. There is a small public car park available to the side of the practice; otherwise there is roadside parking in the area. The practice has two treatment rooms, both of which are on the first floor.

Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are – Monday: 7:15 am to 7 pm; Tuesday: 7:15 am to 5:45 pm; Wednesday: 7:15 am to 7:15 pm; Thursday: 7:15 am to 6:15 pm and Friday: 7:15 am to 4 pm. The practice opened two Saturdays per month from 7:45 am to 3:30 pm.

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

The principal dentist 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 two dentists; one dental therapist; and five qualified dental nurses who also work on the reception desk.

We received positive feedback from 51 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:

- The practice was visibly clean and tidy.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Patients at the practice and through CQC comment cards provided positive feedback about their experiences at the practice.
- Patients said they were treated with dignity and respect.
- The practice was well equipped.
- Dentists identified the different treatment options, and discussed these with patients.
- Patients' confidentiality was maintained.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

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

- Review the practice's sharps procedures giving due regard to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care'

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?

No action

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

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 was visibly clean and tidy and there were infection control procedures to ensure that patients were protected from potential risks. The infection control procedures followed the Department of Health guidance HTM 01-05.

X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

No action

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

All patients were clinically assessed by a dentist before any treatment began.

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

The practice made referrals to other dental professionals when it was appropriate to do so. There were clear procedures for making referrals in a timely manner.

Are services caring?

No action

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

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

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

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

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

Summary of findings

Are services responsive to people's needs?

No action

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

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

The practice was located on the first floor with no passenger or stair lift available. As a result patients with restricted mobility were not able to be seen in the practice. This was made clear in practice information and literature. The practice had completed a disabled access audit to consider the needs of patients with restricted mobility.

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

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?

No action

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

There were systems and processes in place for the governance of the practice, this included computerised records and regular analysis of information and data.

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

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

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

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

Ravenshead 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 September 2016. The inspection team consisted of two Care Quality Commission (CQC) inspectors and a dental specialist advisor.

Before the inspection we asked the practice to send information to CQC. This included the complaints the practice had received in the previous 12 months; their latest statement of purpose; and 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.

We reviewed policies, procedures and other documents. We received feedback from 51 patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice recorded and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in February 2016 this being a minor injury to a member of staff. The records showed the staff had taken appropriate action to ensure this accident 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.

The practice was aware of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Staff said there had been no RIDDOR notifications made. A copy of the RIDDOR guidance was available on the practice computer including the necessary forms to make a notification.

Records at the practice showed there had been two significant events in the 12 months up to the inspection visit. The last recorded significant event, which occurred in September 2016 related to a fault with the autoclave. We saw this was discussed and learning was shared with staff.

We saw the practice had sent an e mail requesting to receive 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. However, none had been received and the practice was unaware of recent alerts having being sent out. Following the inspection we were sent confirmation that the practice had contacted MHRA and made arrangements to receive these alerts.

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

Reliable safety systems and processes (including safeguarding)

The practice had policies for safeguarding vulnerable adults and children. The policies had been reviewed in September 2016. In addition there was a copy of the Department of Health document 'child protection and the dental team' which offered guidance to dental professionals. The policies directed staff in how to respond to and escalate any safeguarding concerns. We spoke with staff who were aware of the safeguarding policies, they knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The relevant contact telephone numbers were on display in the staff room. Appropriate forms for recording safeguarding concerns were available to staff on the practice computer.

The principal dentist was the identified lead for safeguarding in the practice. They had received training to level three in child protection to support them in fulfilling that role. We saw evidence that all staff had attended a safeguarding training to level three in May 2014 with update training in May 2016.

The practice had a dental nurse who was the lead person for Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were guidelines to guide staff in the use and handling of chemicals in the practice. The policy identified the risks associated with COSHH. There were risk assessments which identified the steps to take 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. The manufacturers' product data sheets were available to staff in the COSHH file.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 17 May 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in September 2016. 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. Staff said only the dentist and Hygienist handled sharp instruments such as needles.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk

of injury through cutting or pricking.) We saw the sharps bins were located in accordance with the guidance which states sharps bins should not be located on the floor, and should be out of reach of small children. However these were not signed or dated. The National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care' advise – "sharps boxes should be replaced every three months even if not full." Signing and dating would allow the three month expiry date to be identified.

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

Medical emergencies

The dental practice was equipped to deal with any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the emergency medicines and found they were all in date and stored appropriately. We saw the practice had a designated member of staff who was responsible 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 first aid at work course in April 2016 and we saw copies of training certificates in the practice. A sign in the waiting room identified who the trained first aid staff were and the location of the first aid box.

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

All staff at the practice had completed basic life support and resuscitation training during 2016. However, we saw no evidence of training for staff to raise awareness of different emergency scenarios.

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

Staff recruitment

There was a recruitment policy which had been reviewed in September 2016. 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 recruitment files. This includes: checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in September 2016. In addition the practice had completed environmental risk assessments. For example there were risk assessments for: fire safety, pregnant and nursing mothers and radiography (X-rays).

The practice had a fire safety policy which had been reviewed in September 2016.Records showed that the fire

extinguishers had last been serviced in May 2016. The practice had completed a fire evacuation drill on 1 August 2016. Records showed these were completed on a six monthly basis.

The practice had a health and safety law poster on display in the staff room. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

The practice had a business continuity plan which had been updated and reviewed in September 2016. The plan gave detailed information on how threats to the service would be dealt with and managed to ensure continuity of the service. For example: if there was loss of electricity, heating, computers, or telephones. The plan guided staff in the steps to take to minimise the disruption to patients.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

The practice had an infection control policy which had been reviewed in September 2016. The policy was readily available to all staff working in the practice. We saw that 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 and there were records and documentation to demonstrate this. The principal dentist was the lead person for infection control at the practice.

Records showed that regular six monthly infection control audits had been completed. The most recent audit had been completed on 1 August 2016 and scored 98%. We saw that infection control audits were as recommended by HTM 01-05, being completed on a six monthly basis. An action plan had been completed following each six monthly audit.

The practice had a clinical waste contract with a recognised company. We saw that clinical waste was collected regularly. The waste was stored securely away from patient areas while awaiting collection. The clinical waste contract also covered the collection of amalgam and teeth that had been removed. Amalgam is a type of dental filling which contains mercury and is therefore considered a hazardous material. There was a spillage kits for bodily fluids which was in date.

There was a decontamination room where dental instruments were cleaned and sterilised. There was a clear flow from dirty to clean areas 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 saw how instruments were being cleaned and sterilised at the practice, with a dental nurse demonstrating the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05). Staff training records showed that all staff had received specific infection control training. This had been updated during 2016.

There was an air conditioning unit in each treatment room. This together with the tops of cupboards needed to be cleaned daily to prevent them becoming an infection control hazard. The cleaning records for the practice did not make it clear that these items were being cleaned daily. The principal dentist said the cleaning schedule would be amended to include these items.

The practice used manual cleaning to clean dental instruments. We saw a long handled brush as identified in the guidance (HTM 01-05) was used for manual cleaning. The water temperature during the manual cleaning was being routinely measured and records were kept to demonstrate the water temperature. After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in an autoclave (a device for sterilising dental and medical instruments). The practice had one autoclave, which had both a vacuum and a non-vacuum cycle. At the completion of the sterilising process, all instruments were dried, and pouched in date stamped pouches.

We checked the records to demonstrate that equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. The records demonstrated the equipment was in good working order and being effectively

maintained. We did identify that matrix bands (a metal band secured around the crown of a tooth to hold restorative filling material to be placed into a prepared cavity) needed to be sterilised before assembly. We discussed this with dental nurses and appropriate action was taken as a result.

The practice had access to occupational health facilities through the local hospital. We saw records which demonstrated staff had received inoculations against Hepatitis B. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections such as Hepatitis B.

The practice had a risk assessment for dealing with the risks posed by Legionella. This had been reviewed in February 2016. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The original Legionella assessment had been completed some years previously as a result the practice was considering undertaking a new Legionella risk assessment. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance.

Equipment and medicines

The practice kept records to demonstrate that equipment had been maintained and serviced in line with the manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice on 30 September 2015.

The practice had all of the medicines needed for an emergency situation, as recommended by the British National Formulary (BNF). Medicines were stored securely and appropriately and there were sufficient stocks available for use. However, we noted some doses of medicines were not at the optimum, for example the practice had 75 mg tablets of Asiprin when 300 mg was required. This would mean four tablets would need to be taken instead of one. We brought this to the attention of the principal dentist who said appropriate changes would be made.

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

The pressure vessel checks on the compressor which produced the compressed air for the dental instruments had been completed on 13 January 2016. Copies of certificates were held in the practice.

Radiography (X-rays)

The practice had a Radiation Protection file which contained all of the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth).

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

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being the principal dentist. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS to be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and only by qualified staff.

Records showed the X-ray equipment had last been inspected in May 2014. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years to ensure it is safe and working correctly. Documents in the practice showed the Health and Safety Executive (HSE) had been informed that radiographs were being taken on the premises. Documentation was dated 9 July 2012. This was a requirement of the Ionising Radiation (Medical Exposure) Regulations 2000.

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

All patients were required to complete a medical history form and the dentist considered each patient's individual

Are services safe?

circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. The practice had a rolling audit every day to ensure that every X-ray was graded, views taken and justification for taking the X-ray were recorded, together with the clinical findings. We saw the practice had an in-depth system for the auditing and recording or the processes involved in radiography at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. They contained information about the patients' assessments, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental professionals. The dental care records showed a thorough examination had been completed, and identified risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form which was updated at each visit. Following the patient's first visit the information was transferred into the electronic records and updated at each following visit. This allowed dentists to check the patient's medical history before treatment began. The patients' medical histories included any health conditions, medicines being taken and whether the patient might be pregnant or had any allergies. The hard copy of the form was signed by both the patient and the dental clinician.

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

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

Health promotion & prevention

The practice had a variety of information for patients in the waiting room. There were leaflets in reception and posters about treatments and giving health education information to patients. We saw evidence that all staff had recently attended training for smoking cessation.

Discussions with dentists identified that children were assessed on an individual basis to check their risk of dental decay. This resulted in children being offered fluoride application varnish and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This had been produced to support dental teams in improving patients' oral and general health.

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

Staffing

The practice had two dentists; one dental therapist; and five qualified dental nurses who also work on the reception desk. 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. The practice manager kept detailed records to monitor the number of hours each dental professional had completed each year. Examples of training completed included: radiography (X-rays), infection control, and medical emergencies.

Records at the practice showed that appraisals had been completed for all staff. Staff also completed an annual personal development plan to identify and prioritise training and development needs for the coming year. As part of the process there was a scoring system with the staff member completing a self-assessment.

Working with other services

The practice made referrals to other dental professionals based on risks or if a patient required treatment that was not offered at the practice. The practice particularly referred for implants, difficult lower wisdom tooth removal, orthodontics and suspected oral cancer. Referrals for suspected oral cancer were made via a fast track referral

Are services effective?

(for example, treatment is effective)

system to the local hospital. Referrals were either faxed or sent by recorded delivery and were followed up with a telephone call to the hospital department receiving the referral. The practice routinely telephoned the patient after two weeks to check on the progress. These referrals were tracked through a spreadsheet at the practice and showed referrals were tracked from start through to completion.

Consent to care and treatment

The practice had a consent policy which had been reviewed in September 2016. The policy made reference to the different aspects of consent. The practice also had a policy regarding adults who lacked capacity and this made reference to the Mental Capacity Act 2005 (MCA) and best interest decisions. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves. All staff at the practice had completed training in the MCA. We saw evidence that consent had been discussed in a staff meeting with information shared and updated for all staff.

Consent was recorded in patients' dental care records. For those patients receiving complex treatment such as implants, the practice sent patients' treatment plans by post with embedded photographs where appropriate. This gave the patients the opportunity to understand their treatment plan which would then lead to them being able to give informed consent. We saw a number of examples in dental care records where consent had been clearly recorded.

Discussions with the dentist identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. However, staff said it was unusual for children to come to the practice unaccompanied by either a parent or guardian.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

The reception desk was located within the waiting room. Staff said they were aware of the need for confidentiality and if it were necessary there were areas of the practice where this could happen, such as the staff room. Staff said that patients' individual treatment was discussed in the treatment room not at reception.

We observed staff members throughout the day and were able to see that staff were polite, friendly and welcoming. When patients were called through to the treatment rooms we saw that staff were professional and spoke to patients with due regard to dignity and respect.

We saw that patient confidentiality was maintained at the practice. We asked two patients about confidentiality. Neither patient had any concerns about their confidentiality being breached. Computer screens could not be overlooked by patients standing at the reception desk. We saw that patients' dental care records were password protected and held securely.

Involvement in decisions about care and treatment

We received feedback from 51 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. All of the feedback from patients was positive with patients saying they were satisfied with the dental service they received. Patients spoke positively about the staff and said the facilities were clean and comfortable. Patients said in person and through CQC comment cards they felt involved in their treatment. Patients said they were encouraged to ask questions and talk with staff about their treatment.

The practice only offered private dental treatment and the costs were clearly displayed in leaflet form in the waiting room.

We spoke with one dentist about how each patient had their diagnosis and dental treatment discussed with them. We saw evidence in the patient care records of how the treatment options and costs were explained and recorded before treatment started. All patients were given a written copy of the treatment plan which included the costs.

Where it was necessary dentists gave patients information about preventing dental decay and gum disease. We saw examples of this in patients' dental care records. Dentists had discussed the risks associated with smoking and diet, and this was recorded in patients' dental care records. The practice had a member of staff trained to deliver smoking cessation advice and posters in the waiting room gave additional information.

Patients' follow-up appointments were 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

There was a small car park at the side of the premises; some street parking was also available. The practice had two treatment rooms, all of which were on the first floor.

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

We saw there was a sufficient supply of instruments to meet the needs of the practice.

We spoke with one patient during the inspection. They said they had not had a problem getting an appointment. They found reception staff were polite, friendly and professional. Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day.

Tackling inequity and promoting equality

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

The practice was situated in first floor premises with all patient areas on the first floor. This included two treatment rooms. This did not allow patients using a wheelchair or with restricted mobility to access treatment at the practice. This was made clear in the practice leaflet and on the practice website.

The practice had a toilet for the use of patients. The toilet had a grab handle and an emergency bell.

The practice had completed an access audit in line with the Equality Act (2010) which had been reviewed in July 2016. This identified the practice was compliant with legislation relating to access in the Equality Act. The practice had a hearing induction loop to assist patients who used a hearing aid. The Equality Act required where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. A member of staff had completed a level one course in the use of sign language.

Access to the service

The practice's opening hours were – Monday: 7:15 am to 7 pm; Tuesday: 7:15 am to 5:45 pm; Wednesday: 7:15 am to 7:15 pm; Thursday: 7:15 am to 6:15 pm and Friday: 7:15 am to 4 pm. The practice opened two Saturdays per month from 7:45 am to 3:30 pm.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message.

The practice opening hours made it easier for patients to get an appointment outside of office hours and school, college or university hours. The practice sent text message reminders two days before an appointment was due, if patients had signed up for the service.

Concerns & complaints

The practice had a complaints procedure which had been reviewed in September 2016. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction. Information about how to complain was on display in the practice leaflet and on the practice website, where detailed information about making a complaint was available.

From information received before the inspection we saw that there had been no formal complaints received in the 12 months prior to our inspection.

Are services well-led?

Our findings

Governance arrangements

We saw that all policies were updated on a regular basis, usually in early September. We saw a number of policies and procedures at the practice and saw they had been reviewed and where relevant updated in the year before this inspection visit.

The provider used the computer system to manage the governance of the practice. We saw that all policies were linked to other policies which were relevant, and also relevant staff training. For example the safeguarding policy included a computer link which identified which staff had completed safeguarding training and showed copies of their training certificates.

Discussions with staff at the practice identified they understood their roles and were able to speak with the dentist if they had any concerns. We spoke with two members of staff who said the practice had a close knit team. They said they felt well supported and were clear about their roles and responsibilities. Several staff members indicated they were happy to be working as part of this dental team. Every member of staff had a memory stick which contained policies and risk assessments. Staff said the memory sticks were updated when necessary, such as when a policy had been updated or some other core piece of practice information changed.

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

Leadership, openness and transparency

The principal dentist was the management lead at the practice. There was a detailed planner which identified which management tasks were to be completed and when. This allowed all staff to understand the governance arrangements at the practice and to be clear about their responsibilities in reporting and recording information to the principal dentist.

We saw that staff meetings were scheduled for once a month throughout the year. Staff meetings were minuted and minutes were available to all staff.

Staff said they were a close team and they were able to express their views and raise points in team meetings. Staff said the dentist was approachable and staff were available to discuss any concerns. Observations showed patients were welcomed with a friendly attitude from staff at the practice. Discussions with different members of staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a whistleblowing policy which had been reviewed in September 2016. This policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies.

Documentation relating to accidents, significant events and complaints identified theculture of the practice encourages candour, openness and honesty.

Learning and improvement

The principal dentist used the computer to record information and data on an on-going basis. This allowed a 'live' audit to be carried out. We saw that results were analysed and discussed with staff to promote improvements and share successes. Six monthly infection control audits were being completed in line with the guidance (HTM 01-05). The X-rays and dental care records were audited daily to ensure their quality. In addition we saw completed clinical audits for: root canal treatment, implants and bridges which had all been completed during 2016.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council (GDC). 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 principal dentist had an overview of staff CPD and this was monitored through the six monthly appraisal meeting for all staff. Computerised records showed individual staff progress and was linked to copies of training certificates.

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

Are services well-led?

The practice had its own patient satisfaction survey which was completed on a six monthly basis. The last survey having been completed in June 2016. We saw the results were analysed and points raised by patients were discussed with the staff team.

Data from surveys were analysed and compared to indicate where there had been improvements or need for action.