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Minster Dental Centre

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 18 March 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Minster Dental Care is located in a single storey building in the north Nottinghamshire town of Southwell. The practice was first registered with the Care Quality Commission (CQC) in June 2011. The practice provided a mostly private dental service. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are: Monday to Thursday: 8 am to 5 pm and Friday: 8 am to 3 pm. The practice is closed at the weekends.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. The practice provides an emergency on call system with several other practices in the local area.

The principal dentist is registered with the Care Quality Commission (CQC) as an individual. 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.

The practice has four dentists; two dental hygienists; ten dental nurses; and one practice manager. The dental nurses also worked on reception.

Summary of findings

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.

Our key findings were:

- Patients spoke positively about their experiences of the dental services they received, and said they were treated with dignity and respect.
- Patients' confidentiality was maintained.
- There were systems in place to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- There was a whistleblowing policy and procedures and staff were aware of these procedures and how to use them. All staff had access to the whistleblowing policy.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included oxygen and emergency medicines.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control.
- Dentists involved patients in discussions about the care and treatment on offer at the practice. Patient recall intervals were in line with National Institute for Health and Care Excellence (NICE) guidance.
- Governance arrangements were in place for the smooth running of the practice; however the practice did not have a structured plan in place to audit quality and safety at the practice. They planned to establish a more detailed system for this.

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

- Review the availability of an automated external defibrillator (AED) to manage medical emergencies giving due regard to guidelines issued by the Resuscitation Council (UK), and the General Dental Council (GDC) standards for the dental team.
- Review its responsibilities to the needs of people with a disability and the requirements of the Equality Act 2010 and ensure an access audit is undertaken for the premises. In addition consider purchasing a portable hearing induction loop to assist patients' who wear a hearing aid.
- Review the practice's audit protocols of various aspects of the service, such as consent and dental care records at regular intervals to help improve the quality of service. Practice should also check all audits have documented learning points and the resulting improvements can be demonstrated.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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. However the practice did not have an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

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

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

X-ray equipment was regularly serviced. X-rays were not carried out in line with published guidance, as not all of the X-ray machines were fitted with a safety feature known as a rectangular collimator.

Are services effective?

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

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

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

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

Are services caring?

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

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

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

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

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

Summary of findings

Are services responsive to people's needs?

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

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

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

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

The practice had not completed an Equality Act (2010) access audit, and did not have a hearing loop, to assist patients who used a hearing aid.

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

Are services well-led?

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

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

The system for audits carried out at the practice was in need of review.

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

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

Minster Dental Centre

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

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

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

During the inspection we spoke with four members of staff. We reviewed policies, procedures and other documents. We received feedback from 32 patients about the dental service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice maintained records and investigated accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in March 2014 this being a minor injury to a member of staff. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

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

The practice recorded significant events. The records showed there had been no significant event in the 12 months up to the inspection visit. The last recorded significant event had been an injury to a staff member in January 2013. We saw that the significant event had been analysed and discussed in a staff meeting.

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. The alerts were analysed and information shared with staff if and when relevant. The practice manager showed that the most recent alert had been received in March 2016 and related to hearing aid batteries. On this occasion this had not affected the practice, but the information had been kept on file for information. The practice manager said if the information was relevant, it was printed and put into the communications folder for staff to read. The information was also instantly messaged to staff if it was relevant and urgent.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children. The policy 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. The relevant contact telephone numbers were on display in the staff room and in the safeguarding file. Safeguarding contact details were also in the patient information folder in the waiting room.

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

Staff training records showed that all staff at the practice had undertaken training in safeguarding adults and children. This had been completed on-line between January 2015 and March 2016.

There was a policy, procedure and risk assessment to assess risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. This policy directed staff to identify and risk assess each chemical substance at the practice. Steps to reduce the risks included the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. There were data sheets from the manufacturer on file to inform staff what action to take if an accident occurred for example in the event of any spillage or a chemical being accidentally splashed onto the skin. A review of the COSHH data showed that the file was in need of updating. We discussed this with the practice manager who demonstrated they had begun the process, and were working through the data to update it.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 3 December 2016. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

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

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

We discussed the use of safer sharps with a dentist, 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 were located off the floor. The guidance indicated sharps bins should ideally be fixed to the wall. We discussed this with the practice manager who said they would look into having the bins wall mounted.

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

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

Medical emergencies

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

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

The practice did not have an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The arrangements were that if required the practice would use one located at a nearby dental practice. Resuscitation Council UK guidelines identify the minimum equipment required and this includes an AED and oxygen which should be immediately available. Staff at the practice had completed basic life support and resuscitation training and we saw a refresher course was booked for 14 April 2016.

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

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

Staff recruitment

We looked at the staff recruitment files for seven staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (schedule 3) identifies information and records that should be held in all staff recruitment 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; both had been updated in October 2015. Risks to staff and patients had been identified and assessed, and the practice had measures in place to reduce those risks. For example: slips, trips and falls in the practice, latex, and radiation.

Records showed that fire detection and firefighting equipment such as fire alarms and emergency lighting

were regularly tested. The fire risk assessment was due to be reviewed in January 2017. The fire extinguishers had last been serviced in August 2015. Records showed the last fire drill for staff had been on 14 March 2016.

The practice had two health and safety law posters on display one at the back of reception and one 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 identified for review in September 2016. The policy was readily available to staff working in the practice. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed as identified in the guidance HTM 01-05. The last audit had been on 1 March 2016.

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

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

Following a discussion with the principal dentist and a review of the guidance (HTM 01-05) the practice made changes to ensure they were following the guidance. A dental nurse then demonstrated the decontamination process.

The practice used both manual cleaning and an ultrasonic bath to clean dental instruments. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and an appropriate cleaning solvent. We saw the water temperature was being monitored in both processes, this being crucial to the effectiveness of the cleaning. After cleaning the dental instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's four autoclaves (a device for sterilising dental and medical instruments). At the completion of the sterilising process, instruments were dried, packaged, sealed, stored and dated with an expiry date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. 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.

The saw records to demonstrate that staff had received inoculations against Hepatitis B and had received regular blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting this blood borne infection.

The practice did not have an up to date Legionella risk assessment. Within a week of the inspection the practice informed the Care Quality Commission (CQC) that a new

risk assessment had been completed. A copy of the documentation would be forwarded to CQC when it had been received by the practice. The practice was monitoring the water quality to assess for the risk of Legionella. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella, and was testing and recording water temperatures. However, the Legionella risk assessment was in need of updating. A test certificate dated 27 August 2014 showed no legionella present in one tap.

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

Equipment and medicines

The practice maintained a file of records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice during February 2016. The fire alarm had been serviced in August 2015. Fire extinguishers were checked and serviced by an external company and staff had been trained in the use of equipment and evacuation procedures.

We saw the Landlord's certificate for gas safety which was dated 17 March 2016. In addition pressure vessel checks on the compressor which produced the compressed air for the dental instruments had been completed on 22 September 2015.

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

Emergency medical equipment held at the practice was monitored regularly to ensure it was in working order.

Radiography (X-rays)

The dental practice had a radiation protection file which contained all of the information related to the X-ray machines and their use within the practice.

There were four intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth). There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw. We saw that X-rays were carried out in line with the local rules that were relevant to the practice and each specific piece of X-ray equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

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

Records showed the X-ray equipment had last been serviced in October 2015. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is serviced at least once every three years.

All patients were required to complete medical history forms and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Guidance from the Ionising Radiation (Medical Exposure) Regulations 2000 identified that dental care records should include grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. Patients' dental care records showed that information related to X-rays was recorded.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held dental care records for each patient. The dental care records contained 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.

Patients at the practice completed a medical history form, or updated their details. The forms were then checked by the dentist, so they could be informed of any changes to the patients' health or medicines which could affect the dental treatment. The medical history was then added to the dental care record. The medical history forms included any health conditions, medicines being taken and whether the patient had any allergies.

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

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

The costs for both private and NHS treatments were on display in the practice.

Health promotion & prevention

The practice had a large waiting room, and information for patients was on display. There was assorted literature about the services offered at the practice, as well as health promotion advice. This included photographs to give patients a visual representation of various conditions associated with the mouth. A staff member had produced a display which identified the amount of sugar present in individual food and drink. This was represented by bags containing measured amounts of sugar. The display was visually striking and a number of patients commented on the display during the inspection. We saw evidence that in the past the practice had given oral health promotion talks at a range of venues. These included: local schools, nurseries and for local child minders. The practice had arranged these, and received no funding, but had initiated the talks themselves.

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

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

We saw examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet with regard to oral health. With regard to smoking dentists had particularly highlighted the risk of dental disease and oral cancer. There was a smoking cessation clinic run through one of the local GP surgeries, and patients were signposted to this service.

The Department of Health had produced guidance called: 'Delivering better oral health: an evidence-based toolkit for prevention'. We saw a copy of this guidance in the practice and saw that dentists were following the guidance contained within it.

Staffing

The practice had four dentists; two dental hygienists; ten dental nurses; and one practice manager. The dental nurses also worked on reception. 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

Are services effective?

(for example, treatment is effective)

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

Records at the practice showed that appraisals had been completed for all staff. We saw evidence in three staff files that appraisals had taken 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.

Working with other services

Staff at the practice said that referrals to other dental professionals were made when it was clinically indicated that a referral should be made, or when the practice was unable to offer the required treatment. For example: when complex treatment was required, for difficult extractions, sedation services or for orthodontic treatment. The practice usually referred to the gateway referral service, where the patients' referrals were triaged and passed on to the appropriate service.

Patients' dental care records within the practice identified that referral for patients with suspected oral cancer had been in a timely manner for urgent referrals, and these were tracked to ensure they had been received and the patient seen. The practice had identified one member of staff to deal with referrals. This ensured there were no errors due to multiple members of staff being involved.

Consent to care and treatment

The practice had a consent policy which had been reviewed in August 2015. The policy made reference to capacity and 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 recorded consent in the patients' dental care record. Patients were given a copy of the treatment plan including the costs, and signed copies were retained indicating the patients' consent.

Discussions with dentists showed they were aware of and understood the use of Gillick to record competency for young persons. Gillick competence refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

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

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

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

Involvement in decisions about care and treatment

We received feedback from 32 patients on the day of the inspection. This was through Care Quality Commission (CQC) comment cards, and through talking to patients in the practice. Feedback was wholly positive with patients saying the staff were friendly and approachable. Patients also spoke positively about the dental care they had received. The CQC comment cards identified that patients who responded thought the dentist involved them in decisions about their dental care and treatment. Several patients said the dentists explained the treatment and gave an opportunity to ask questions.

The practice offered mostly private dental treatments. The costs of private treatment were displayed within the practice and on the practice website.

We spoke with two dentists, and two dental nurses who explained that each patient had their diagnosis and dental treatment discussed with them. The different treatment options and the costs were explained before treatment started. Patients were given a written copy of the treatment plan which included the costs.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice was situated in a building on a main road, with a bus stop nearby. There was car parking available at the front of the practice. There were six ground floor treatment rooms.

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

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

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

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

Tackling inequity and promoting equality

The practice was located in a bungalow with designated disabled parking to the front of the practice. All of the treatment rooms and patient areas were on the ground floor and had level access for patients with restricted mobility.

The practice had not completed an Equality Act (2010) access audit. This would allow the practice to formally consider the needs of patients with restricted mobility. Particularly in respect of them accessing the service and meeting their dental needs. The practice did not have a portable hearing induction loop. The Equality Act requires where 'reasonably possible' hearing loops to be installed in public spaces, such as dental practices. Staff acknowledged the practice had older patients who might use a hearing aid.

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

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

Access to the service

The practice's opening hours were: Monday to Thursday: 8 am to 5 pm and Friday: 8 am to 3 pm. The practice was closed at the weekends.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. The practice provided an emergency on call system with several other practices in the local area.

The practice provided a private dental service, with an NHS contract for children, full-time students up to the age of 19 and fee exempt adults.

Patients were sent a text reminder 48 hours prior to their appointment, to remind them their appointment was due, and give them the opportunity to cancel or re-arrange the appointment.

Concerns & complaints

The practice had a complaints procedure which explained the process to follow for making complaints or raising concerns. The procedure included other agencies to contact if the complaint was not resolved to the patients satisfaction. This included NHS England and the Parliamentary and Health Service Ombudsman.

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

From information received before the inspection we saw that there had been several complaints received in the past 12 months. Many related to an increase in the cost of the private dental plan the patient used. For each complaint the practice had recorded the action taken and the outcome, including any learning from the complaint. We saw from documentation in the practice that complaints had been addressed in a timely way, and apologies had been given for the distress caused.

Are services well-led?

Our findings

Governance arrangements

We reviewed a number of policies and procedures at the practice and saw that many had been reviewed and where relevant updated during 2015 and 2016. However, some were not dated. We discussed this with the practice manager who had come into post fairly recently. The practice manager identified their plan for reviewing all of the policies in the practice and recording the dates.

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

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

Leadership, openness and transparency

There was a practice manager in post who was a qualified dental nurse, and who also had a diploma in practice management.

The practice held monthly staff meetings throughout the year which had been minuted and actioned. In addition the practice held monthly clinical meetings to discuss issues related to patients and their dental care.

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

The practice had an employee handbook. This contained selected policies and procedures and offered staff guidance around key areas of the practice.

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

Learning and improvement

The practice manager said they had inherited a system of auditing which was not effective. Audits of infection control and radiography had been competed. However, audits of other areas of the practice such as record keeping and consent had not been carried out regularly in the past and action plans were not clear. In addition dates for re-auditing had not been identified. We discussed this at length with the practice manager who identified the system that was being introduced. A schedule of when audits were due was being drawn up for both clinical and non-clinical areas of the practice.

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

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

The practice had an NHS Friends and Family (FFT) comment box which was located on the reception desk. The responses within the boxes were analysed on a monthly basis. Feedback from patients by means of the FFT box was good, with 60 responses recorded the month before the inspection. All of the responses were positive with respondents saying they would recommend the practice to their family and friends.

The practice had produced its own patient survey in the past. However, this had not been used for some time and the practice manager said it was under review. In the meantime the FFT box was used to gather the views of all patients at the practice.