Calverton Dental Practice

# Calverton Dental Practice

## Inspection Report

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## Overall summary

We carried out an announced comprehensive inspection on 28 February 2017 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**

Calverton Dental Practice is located in premises situated in the village of Calverton to the north of the city of Nottingham. There are two treatment rooms both of which are situated on the first floor. Access for patients with restricted mobility is by a chair lift. The practice provides mostly NHS dental treatments (95%) There is a small car park for dental patients close to the practice.

The practice provides regulated dental services to both adults and children. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours were – Monday: 9 am to 3:30 pm; Tuesday: 9 am to 5 pm; Wednesday: 9 am to 5 pm; Thursday: 9 am to 3 pm and Friday: 9 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. Alternatively patients can telephone the NHS 111 telephone number direct. An NHS out-of-hours dentistry service also operates in Nottingham.

The practice has two dentists; two hygienists; one qualified dental nurse who also works on reception and two trainee dental nurses.

The principal dentist is the registered manager. A registered manager is a person who is registered with the

# Summary of findings

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.

Before the inspection we sent CQC comments cards to the practice for patients to complete to tell us about their experience of the practice and during the inspection we spoke with patients. We received responses from 24 patients through both comment cards and by speaking with them during the inspection. Those patients provided positive feedback about the services the practice provides. Among the themes we identified from patient feedback were: patients were listened to and involved in discussions about treatment options; the practice was clean and hygienic; staff were caring; staff were responsive and friendly.

**Our key findings were:**

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- The systems to record accidents, significant events, complaints and the resulting learning points were recorded and used to make improvements.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- The practice held information related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002. This included risk assessments. However, this information was not well ordered which would make finding information in a hurry difficult.
- The practice had a consent policy including reference to the Mental Capacity Act 2005.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect and were able to get an appointment that suited their needs.
- Dental care records demonstrated that the dentists involved patients in discussions about treatment options.
- Patients' confidentiality was protected within the practice.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- Many of the policies at the practice were not dated which made it difficult to assess if and when they had last been reviewed.
- 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 about a colleague's practice.
- 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, medical oxygen and emergency medicines.

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

- Review how information is stored in the Control of Substances Hazardous to Health (COSHH) file so that information is more easily accessible in an emergency situation.
- Review the frequency that policies and procedures are reviewed and record a date to indicate when the review has been completed and the next one due.

# 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.

There were systems for recording accidents, incidents and complaints.

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 held information and risk assessments related to the Control of Substances Hazardous to Health (COSHH) Regulations 2002.

The practice had emergency medicines and medical 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 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.

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 used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

Discussions about treatment options were recorded in dental care records.

All staff were supported to meet the requirements of the General Dental Council (GDC) in relation to their continuing professional development (CPD).

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

There was a consent policy which made reference to the Mental Capacity Act 2005.

The practice had systems in place for making referrals to other dental professionals when it was clinically necessary.

# Summary of findings

**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 paper dental care records were secure.

Feedback from patients identified staff were friendly, and treated patients with care and concern. Patients also said they were treated with dignity and respect and had no concerns with regard to confidentiality at the practice.

There were systems for patients to be able to express their views and opinions and the practice encouraged patients to do so.

**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 who were in pain or in need of urgent treatment could usually get an appointment the same day. There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays

The practice was located on the first floor with access by stairs or a stair lift. The practice had an induction 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?**

No action

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

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns. Staff said they felt well supported and there were systems for peer review and clinical discussion.

The practice had a system for 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.

# Calverton 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 registered provider 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 February 2017. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

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

We reviewed the information we held about the practice and found there were no concerns.

We reviewed policies, procedures and other documents. We received feedback from 24 patients about the dental service.

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

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

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

# Are services safe?

## Our findings

**Reporting, learning and improvement from incidents**

There were systems for recording and investigating accidents, significant events and complaints. The practice had an accident book to record any accidents to patients or staff. The last recorded accident had been in May 2011 when a staff member had a minor injury.

The practice had not needed to make any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they were aware how to make these reports.

The records identified there had been two significant events in the twelve months leading up to this inspection. There were forms in the practice for recording any significant events and recording learning points.

The most recent significant event occurred in August 2016 and related to a complaint from a patient. The principal dentist arranged meetings to discuss any significant events as and when they occurred. There were minutes from two significant event meetings which took place in 2016. These related to complaints received which had been discussed as significant events. We saw that the issues had been analysed and measures had been put in place to address those issues demonstrating the practice had been responsive in dealing with the significant events.

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. The principal dentist received these direct and shared the information with staff as necessary if the alert was relevant to the practice or dentistry.

The practice had a Duty of Candour policy. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Discussions with the principal dentist identified there had been no examples of the policy needing to be put into action. Discussions with the principal dentist identified they knew when and how to notify CQC of incidents which caused harm.

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

The practice had a policy for safeguarding vulnerable adults and children which had been reviewed in November 2016. The policy identified how to respond to and escalate any safeguarding concerns. The relevant contact telephone numbers for protection agencies were available for staff within the policy. 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 principal dentist said there had been no safeguarding referrals made by the practice.

The principal dentist was the identified lead for safeguarding in the practice. They had received training in child protection and safeguarding vulnerable adults to level two in June 2015. We saw evidence that all staff had completed safeguarding training to level two in August 2016.

The practice had guidance for staff on the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The COSHH policy formed part of the overall health and safety policy. There were risk assessments for all products and there were copies of manufacturers' product data sheets. Data sheets provided information on how to deal will spillages or accidental contact with chemicals and advised what protective clothing to wear. However, the information was not presented in a user friendly way and this could lead to delays in an emergency situation.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 18 October 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969. The certificate was on display behind reception.

The practice had a policy for dealing with sharps injuries. It was practice policy that only dentists' handles needles and needles were not re-sheathed. There were devices to allow this to be completed safely. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

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 where they were accessible to dentists but not to patients. The 2013 regulations indicated sharps bins should not be located on the floor and should be out of reach of small children.

Sharps bins were signed and dated which was in line with the National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care'.

Discussions with the principal dentist identified they 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. We saw the practice had a supply of latex free rubber dam kits available.

**Medical emergencies**

The practice had in place emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. The practice also had access to an automated external defibrillator (AED), a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm; medical oxygen; along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The emergency medicines and medical oxygen we saw were all in date and stored in a central location known to all staff.

The practice had a first aid box and a member of staff had completed a first aid at work course during 2016.

**Staff recruitment**

We looked at the staff recruitment files for two 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.

We saw that staff recruitment records were in line with the regulations. Every member of staff had received a Disclosure and Barring Service (DBS) check (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. The DBS checks were renewed every three years. We discussed the records that should be held in the recruitment files with the principal dentist.

**Monitoring health & safety and responding to risks**

The practice had a health and safety policy which identified the principal dentist as the lead person who had responsibility for health and safety. As part of this policy each area of the practice had been risk assessed to identify potential hazards and identify the measures taken to reduce or remove them.

Records showed that fire extinguishers had been serviced in January 2017. The practice had a fire risk assessment which identified the steps to take to reduce the risk of fire. The risk assessment had been reviewed in July 2016. We saw the practice had emergency lighting installed and the emergency exit was clearly identified with an illuminated sign. Fire evacuation notices were displayed for staff and patients outlining the action to take if a fire occurred. Records showed the practice held a fire drill monthly with the last one completed on 10 January 2017.

The practice had a health and safety law poster on display in the OPG X-ray 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.

A Business Continuity Plan was available in the practice and a copy was held off site. The plan identified the steps for staff to take should there be an event which threatened the continuity of the service. A list of emergency contacts formed part of the plan.

**Infection control**

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

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

The practice had an infection control policy, a copy was available to staff in the decontamination room. 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. The principal dentist was the lead for infection control at the practice. We saw that all dental nurses had completed infection control training during November 2016.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last three audits were completed in February 2016, October 2016, and January 2017. The latest audit had scored 95% and an action plan was in place to address issues highlighted in the audit.

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. A separate company collected amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had a spillage kit for mercury and a bodily fluids spillage kit both of which were in date.

The decontamination room was split into two separate rooms where dental instruments were cleaned and sterilised and then bagged. One room was used for the 'dirty' part of the process where instruments were cleaned. The other room was the 'clean' area where the dental instruments were sterilised, bagged and date stamped. 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. The practice was latex free to avoid any risk to staff or patients who might have a latex allergy.

A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice used manual cleaning techniques and had the necessary equipment to complete manual cleaning including a digital thermometer, long handled brush and heavy duty gloves. The practice had a protocol for manual cleaning however, this was not dated and therefore it was not possible to identify when it was due for review. After cleaning, instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in the practice's autoclave (a device for sterilising dental and medical instruments). The practice had one autoclave which was designed to sterilise dental instruments. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by 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 records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

The practice had a policy for dealing with blood borne viruses. Records showed that staff had completed training to help them understand the necessary actions to be taken to reduce the risk. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received boosters when required. Records showed that blood tests to check the effectiveness of the inoculation had been taken. 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.

The risks associated with Legionella had been assessed. This assessment had been completed by an external contractor in November 2015 and was due for renewal in November 2017. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had taken steps to reduce the risks associated with Legionella with regular flushing of dental water lines as identified in the relevant guidance. We saw documentary evidence to identify that quarterly dip slides had been completed. Dip slides are a means of testing the microbial content (bacteria) in a liquid through dipping a sterile carrier into that liquid and monitoring any bacterial growth.

**Equipment and medicines**

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's

guidelines and instructions. Portable appliance testing had been completed on electrical equipment at the practice in June 2015. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in November 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced and validated in November 2016. The contract was for pressure vessels to be checked every six months.

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities. The practice kept a log of prescription numbers to monitor the security of the prescription pads and maintain an audit trail. Prescription pads were not pre-stamped which added to their security and the stamp was held securely.

**Radiography (X-rays)**

We were shown a well-maintained radiation protection file in line with the Ionising Radiation Regulations 1999 and Ionising Radiation Medical Exposure Regulations 2000 (IRMER).

The practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth) and one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull. The principal dentist said the OPG machine was not used although it was serviced regularly and was in working condition.

The practice used non-digital X-rays. We saw that regular checks were completed on the equipment used to process the X-rays to ensure the effectiveness of the process.

This file contained the names of the Radiation Protection Advisor and the Radiation Protection Supervisor and the necessary documentation pertaining to the maintenance of the X-ray equipment. Included in the file were the critical examination packs for each X-ray set along with the three yearly maintenance logs, Health and Safety Executive notification and a copy of the local rules. The maintenance logs were within the current recommended interval of three years.

Dental care records we saw where X-rays had been taken showed that dental X-rays were justified, reported on and quality assured.

Both intraoral X-ray machines were fitted with rectangular collimation (a specialised metal barrier attached to the head of the X-ray machine used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient received).

# Are services effective?

(for example, treatment is effective)

## Our findings

**Monitoring and improving outcomes for patients**

The practice held paper dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment. The care records showed a thorough examination had been completed, and identified any risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form which was discussed with the patient and added to their record card. Returning patients updated their information which was reviewed with the dentist in the treatment room. The patients' medical histories included any health conditions, medicines being taken, whether the patient might be pregnant or had any allergies.

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. The dentists were using BPE for all patients other than young children.

We saw the dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the 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 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 one waiting room for patients. The waiting room had several posters and leaflets providing positive oral health information. This included advice to parents in caring for their children's' teeth and advice to pregnant patients. Numerous leaflets were available with information about different treatments and dental conditions. There were free samples of toothpaste for patients available in the practice.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. The use of fluoride varnish was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with the principal dentist showed they had a good knowledge and understanding of 'delivering better oral health' toolkit. Posters in the waiting room informed patients about oral health issues, including: fluoride application, god tooth brushing technique and the risks of oral cancer.

We saw several examples in patients' dental care records that the dentist had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, the dentist had particularly highlighted the risk of dental disease and oral cancer. The dental care records contained an oral cancer risk assessment. In some dental care records we saw the risk assessments for caries (tooth decay) and periodontal disease (gum disease) were also recorded.

We noted that with regard to smoking cessation there were leaflets in the waiting room pointing patients towards the NHS Smokefree service. The NICE guidelines: Oral health promotion: general dental practice (NG30) suggests that patients should be signposted to specialist smoking cessation agencies such as the NHS service.

**Staffing**

The practice had two dentists; two hygienists; one qualified dental nurse who also worked on reception and two trainee dental nurses. 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.

The principal dentist had a system for checking that staff registered with the GDC were up to date with their registration.

Records within the practice showed there were sufficient numbers of staff to meet the needs of patients attending the practice for treatment.

We looked at staff training records for clinical staff to identify that they were maintaining their continuing

# Are services effective?

## (for example, treatment is effective)

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. Training records for clinical staff were clear and we saw copies of training certificates and CPD details for relevant staff during the inspection. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, and safeguarding.

Records at the practice showed that all staff had received an annual appraisal. This was completed with the principal dentist. We saw evidence of new members of staff having an in-depth induction programme.

**Working with other services**

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. We saw the practice referred to other local dental services for minor oral surgery.

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere either to a dental practice who provided sedation or to one of the local hospitals who provided this service. Children or patients with special needs who required more specialist dental care were referred to the community dental service.

Referrals were made to the Maxillofacial department at the local hospital or a local practice with a contract for minor oral surgery for wisdom tooth removal. For patients with suspicious lesions (suspected cancer) referrals were sent through to the hospital within the two week window. The practice had a system or monitoring these referrals and chasing if there was any delay.

**Consent to care and treatment**

The practice had a patient consent policy which referenced the Mental Capacity Act 2005 (MCA). 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. Discussions with the principal dentist showed an understanding on the MCA and how it might apply to dentistry.

The consent policy identified that the standard NHS FP17DC form would be used to record patients' consent. This form recorded both consent and provided a treatment plan. The dentists discussed the treatment plan with the patients and explained the treatment process. This allowed the patient to give their informed consent. A hard copy of the consent form was retained by both the practice and the patient.

We saw how consent was recorded in the patients' dental care records. Dentists had identified the different treatment options and recorded these had been discussed with the patients. This led the patients concerned to make informed choices about their treatment and give valid consent. When consent either verbal or written was obtained this had been recorded in the patients' dental care records.

The consent policy referenced 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. We saw that staff had an understanding of Gillick competency. Records showed that the principal dentist had completed training in legal and ethical issues which included Gillick competency.

# Are services caring?

## Our findings

**Respect, dignity, compassion & empathy**

During the inspection we observed staff speaking with patients. We saw that staff were polite, and had a friendly and welcoming manner. We saw that staff spoke with patients with due regard to dignity and respect.

The reception desk was located at the top of the stairs. We asked reception staff how patient confidentiality was maintained at reception. Staff said that patients' individual treatment was only discussed in the treatment rooms with the clinical staff. If it was necessary to discuss a confidential matter, there were areas of the practice where this could happen such as an unused treatment room.

We saw examples that showed patient confidentiality was maintained at the practice. For example we saw that computer screens could not be overlooked at the reception desk. Patients' dental care records were held securely and protected by closed circuit television (CCTV).

**Involvement in decisions about care and treatment**

We received positive feedback from 24 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 during the inspection.

The practice offered mostly NHS treatments (95%) and the costs of NHS treatments were clearly displayed in the waiting room. Private costs were available on request. If patients were receiving treatment they were given a treatment plan which included the costs.

We spoke with dentists about how patients had their diagnosis and dental treatment discussed with them. Dentists demonstrated in the patient care records how the treatment options and costs were explained and recorded.

Where necessary the dentist gave patients information about preventing dental decay and gum disease. In particular the dentist had highlighted the risks associated with smoking and diet, and we saw examples of this recorded in the dental care records. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting patients' needs**

The patient areas of the practice were located on the first floor with access by stairs or a stair lift. There was parking including disabled parking close to the dental practice.

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.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. The practice had a sit and wait policy for patients who were in pain or required emergency treatment.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The appointment book also identified where patients were being seen in an emergency.

**Tackling inequity and promoting equality**

The practice had a disability rights under the Equality Act (2010) policy which gave staff guidance on treating patients without respect and equality.

There were two treatment rooms both of which were situated on the first floor. Access to the practice was either by a staircase or a chair lift fitted to the stairs. This allowed patients with restricted mobility to access treatment at the practice. The principal dentist said that if a patient was unable to access the practice they would be referred to another local practice which provided ground floor treatment.

The practice had one toilet for patients to use. This was located on the first floor.

The practice had a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

Discussions with reception staff identified that there had not been a need to use interpreters. However, staff said that should the need arise there were ways to overcome the problem either by using an on-line translation service or a smart phone with a translation application.

**Access to the service**

The practice's opening hours were – Monday: 9 am to 3:30 pm; Tuesday: 9 am to 5 pm; Wednesday: 9 am to 5 pm; Thursday: 9 am to 3 pm and Friday: 9 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. Alternatively patients could telephone the NHS 111 telephone number direct. An NHS out-of-hours walk in dentistry service also operated within Nottingham.

The practice operated a text message reminder service for patients who had appointments with the dentist 24 hours before their appointment was due.

**Concerns & complaints**

The practice had a complaints policy which explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the complaints policy.

Information about how to complain was on display in the patient waiting room.

From information reviewed in the practice we saw that there had been two formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient when required. Both complaints had been discussed at significant events meetings and the action taken in response was recorded.

# Are services well-led?

## Our findings

**Governance arrangements**

We saw a number of policies and procedures at the practice. Very few of the policies were dated; as a result it was not possible to identify when the policies had been reviewed or when the next review was due.

We spoke with staff who said they understood the structure of the practice. Staff said if they had any concerns they would raise these with the principal dentist. We spoke with two members of staff who said they liked working at the practice.

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

**Leadership, openness and transparency**

The practice held three types of meetings: a general staff meeting for all staff, a clinical governance meeting and a significant event meeting. Both the general staff meeting and the clinical governance meetings took place on a monthly basis and there were minutes available for all staff. The third meeting for significant events were arranged as and when necessary. There were minutes from two meetings in 2016 where complaints received had been discussed as significant events. We saw that measures had been put in place to address the issues demonstrating the practice had been responsive in dealing with the events.

Discussions with staff identified they felt valued, involved and able to express their opinions within the practice.

Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a policy relating to the Duty of Candour which directed staff to be open and to offer apologies when things had gone wrong. Discussions with staff showed they understood the principles behind the duty of candour. There had been no examples where the Duty of Candour policy had been used.

The practice had a whistleblowing policy which identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. This was both internally and with identified external agencies.

**Learning and improvement**

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Regular six monthly infection control audits. We saw that audits of radiography (X-rays) were completed regularly. The radiography audits checked the quality of the X-rays including the justification (reason) for taking the X-ray and the clinical findings which had been recorded in the dental care records. The practice had audited their dental care records for each clinician.

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 are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

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

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. The practice submitted information directly to NHS England on-line. Information in the practice showed patients who responded provided positive feedback with all patients who responded saying they would recommend the practice to family and friends.

# Are services well-led?

There were eight patient reviews recorded on the NHS Choices website between December 2014 and July 2015. The practice changed hands with new ownership in June 2015. There had been no reviews since the change of ownership.

The practice operated its own satisfaction survey on an on-going basis. A poster in the waiting room provided feedback to patients regarding the issues raised through the survey, and identified action taken.